Leeds Community Healthcare NHS Trust
Board Meeting (held in public)
Friday 25 May 2018, 9.00am – 12noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2018-19 (1)	Welcome, introductions and apologies	Brodie Clark	N
9.05	2018-19 (2)	Declarations of interest	Brodie Clark	N
9.10	2018-19 (3)	Questions from members of the public	Brodie Clark	N
9.15	2018-19 (4)	Patient's story: musculoskeletal service	Marcia Perry	N
9.30	2018-19 (5)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 29 March 2018 b. Actions' log c. Committees' assurance reports: i. Quality Committee: 21 May 2018 ii. Business Committee: 23 May 2018 iii. Audit Committee: 23 May 2018	 Brodie Clark Brodie Clark Ian Lewis Brodie Clark Jane Madeley	 Y Y N N N
		Quality and delivery		
9.50	2018-19 (6)	Chief Executive's report	Thea Stein	Y
10.00	2018-19 (7)	Annual report and accounts 2017-18 a. Annual report b. Annual accounts c. Letter of representation d. ISA 260 external auditor's opinion	Bryan Machin	Y
10.15	2018-19 (8)	Quality account 2017-18	Marcia Perry	Y
10.30	2018-19 (9)	Operational plan 2017-18: end of year report	Bryan Machin	Y
10.45	2018-19 (10)	Performance brief and domain reports a. Performance report April 2018	Bryan Machin	Y
11.00	2018-19 (11)	a. Serious incidents report b. Patient experience annual report: complaints and experience report	Marcia Perry	Y
11.15	2018-19 (12)	Guardian for safe working hours: annual report	Phil Ayres	Y
11.20	2018-19 (12.5)	**Progress on CAMHS Tier 4 development and approval of fees**	Bryan Machin	Y
		Governance		
11.30	2018-19 (13)	Significant risks and risk assurance report	Thea Stein	Y
11.40	2018-19 (14)	Corporate governance report: • Board and committee effectiveness review • Audit Committee annual report 2017-18 • Committees' terms of reference review • NHS provider licence compliance • Standing orders/standing financial instructions: review • Register of sealings	Thea Stein	Y
11.45	2018-19 (15)	West Yorkshire Mental Health Services Collaborative: committees in common memorandum of understanding	Thea Stein	Y
11.50	2018-19 (16)	Urgent decisions: Cybersecurity submission	Bryan Machin	N
11.55	2018-19 (17)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2018-19 (18)	Approved minutes for noting: a. Audit Committee: 16 March 2018 b. Business Committee: 16 March 2018 c. Quality Committee: 19 March 2018 d. Leeds Safeguarding Adults Board: 14 November 2017 e. Leeds Safeguarding Children Partnership (formerly Leeds Safeguarding Children Board):23 January 2018 (taken in the private section of the Board meeting.	Brodie Clark	 Y Y Y Y Y
12.00	2018-19 (19)	Close of the public section of the Board	Brodie Clark	N

Date of next meeting (held in public)
Friday 3 August 2018, 9.00am -12noon

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (5a)

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public)

Boardroom, Stockdale House, Victoria Road, Leeds LS6 1PF

Thursday 29 March 2018, 9.00am – 12.00noon

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Phil Ayres	Interim Executive Medical Director
	Ann Hobson	Interim Director of Workforce
Apologies:	Brodie Clark	Non-Executive Director
In attendance:	Diane Allison	Interim Company Secretary
	Nicola Waddington	Clinical Advisor, Speech and Language Therapy Service (for item 93)
	Hana Haziem	Speech and Language Therapist (for item 93)
	Janet Addison	Head of Speech and Language Therapy and Project Manager for the Children's Services Strategy (for items 93 and 101)
Minute taker:	Liz Thornton	Board Administrator
Observers:	Ravinder Panesar	Finance Manager, Specialist Services
Members of the public:	None in attendance	

Item	Discussion points	Action
2017-18 (90)	**Welcome and introductions** The Trust Chair welcomed Trust Board members and extended a welcome to a member of staff from the Trust attending as an observer. **Apologies** Apologies were received from a Non-Executive Director (BC). **Chair's opening remarks** The Trust Chair said he wished to make some opening remarks in order to provide a strategic context for the Board's deliberations during the course of the meeting, he set out a number of key strategic issues for the Trust: • ***Quality:*** ensuring and evidencing our services are safe, caring, effective,	

	responsive and well-led. We need to pursue the actions linked to the Care Quality Commission report and maintain the many examples of excellent care. Quality performance indicators still needed to be a continuing focus for the Board and particularly for the Quality Committee. • ***Financial performance***: the Trust's financial performance remained satisfactory in 2017/18 and the focus needed to be on maintaining a viable and sustainable organisation. • ***Leadership:*** meeting the need to grow and retain good leaders to build on achievements in 2017/18 and to continue to address the quality, financial and workforce challenges in 2018/19. • ***Working within the wider Leeds health and social care economy***: working co-operatively with partners in the best interests of patients and their families to achieve change strategically and operationally in the context of the Leeds Health and Care Plan would be a top priority. The Chair spoke in particular about recent conversations he had had with leaders across the city.	
2017-18 (91)	**Declarations of interest** A Non-Executive Director (JM) declared an interest in item 95 in relation to the Trust's links with the University of Leeds to deliver the Apprentice Nurse Degree programme and item 96 in relation to the involvement of the University of Leeds in the development of the Leeds Health and Social Care Academy. There were no declarations of interest made in relation to any items on the agenda.	
2017-18 (92)	**Questions from members of the public** No questions from members of public had been notified.	
2017-18 (93)	**Patient's story: Children's speech and language therapy** The Executive Director of Nursing introduced the patient's story item. She welcomed the Head of Speech and Language Therapy, a Clinical Advisor from the Speech and Language Therapy Service, a Speech and Language Therapist and the mother of a child who had received support from the service. The child's mother introduced herself to the Board and said that she was attending the meeting to speak about her seven year old son's experience of the Trust's Speech and Language Therapy Service. She explained that three years ago she had noticed that her son was experiencing difficulty with social interaction and communication, following referrals to the appropriate specialists he was diagnosed with an autistic spectrum condition and a plan had been put in place to support his development including his education in a mainstream school. She said that last year the family had moved into the Leeds area and were concerned to find that the support previously available to her son had not automatically transferred with him. It was at this point she had contacted the Trust's Speech and Language Therapy Service to seek help and advice. The child's mother said that the service had responded quickly, she had been very impressed by the Speech and Language Therapist who had been allocated to work with her son and the support and guidance she had provided. The family had worked with the Speech and Language Therapist and the education service to develop an Education, Health and Care (ECH) plan which described the education, health and care support that their son needed to achieve his key life outcomes. She explained that although the EHC plan was steered by the education service with the help of the Speech and Language Therapy Service, the family had been able to significantly influence the development of the support package.	

	Overall she said that her family's experience of the service had been extremely positive and she praised the Speech and Language Therapy Team for their caring, professional attitude and the quality of the support and advice they had given. The child's mother said that she felt the service could be even better if the Speech and Language Therapy Team had more opportunity to influence how the intervention programmes and sessions were delivered in schools and other educational settings. She highlighted the difficulties she had experienced in ensuring that the school implemented the support plan and delivered the associated targets. The Chief Executive thanked the mother for attending the Board meeting and said that it was a pleasure to hear such a positive account of a service delivered by the Trust. She said that it was clear that liaising with all the different parties involved in her son's case had proved to be a significant challenge and she had taken the role of both case manager and mother during this time. She added that not every family would be able to deal as effectively with all the parties involved. The Executive Director of Operations advised that a number of workshops had been arranged to bring together the partners across the city with the aim of developing a more streamlined approach to drafting EHC plans. She added that the Trust was also working with education leaders to improve engagement across schools. A Non-Executive Director (JM) asked the mother whether her son felt that he was being singled out for special attention as a result of following an EHC plan. In response she said that from her son's perspective the group activities and work in the one to one sessions were part of his normal routine and he was very relaxed and content in a mainstream school setting. The Trust Chair thanked the parent on behalf of the Board for taking time to attend the meeting, speaking so confidently about her son's experience of the Trust's Speech and Language Therapy Service and highlighting some issues for the Trust to consider further.	
2017-18 (94a)	**Minutes of the previous meeting held on Friday 2 February 2018 and matters arising** The minutes were reviewed for accuracy and agreed as a true record of the meeting subject to two amendments: <u>Item 2017-18 (79cii) Quality Committee 22 January 2018</u> – the final sentence in the second bullet point to be deleted and replaced with *"The Committee had reinforced the need to sustain the systematic effort to reduce the incidence of avoidable pressure ulcers."* <u>Item 2017-18 (81) Performance brief and domain reports: safe domain</u> – third paragraph to be deleted and replaced by *"The Trust Chair observed that although it was important for the focus to be on reducing the incidence of avoidable pressure ulcers, this should not deflect from wider quality issues."* (94b) **Items from the actions' log** The Trust Chair asked for a verbal update on two completed (blue) actions: • *Analysis of re-admissions:* The Executive Director of Operations advised that for the period October 2016 to September 2017 the re-admission rate within 30 days at Leeds Teaching Hospitals NHS Trust (LTHT) was 7.96%.	

She assured the Board that these re-admissions were not the result of poor care provided by the Trust and where re-admissions to the acute hospital were deemed necessary information about each case was escalated to the Chief Nurse at LTHT.

- *Guardian for Safe Working Hours:* the Interim Executive Medical Director reported that a clear reporting framework had been discussed with the Guardian which would allow meaningful reports to the made to Board in future to meet the required reporting timetable.

The completed actions from previous meetings were noted.

(94c) **Assurance reports from sub-committees**

Item 94c(i) – Audit Committee 16 March 2018

The report was presented by the Chair of the Committee and Non-Executive Director (JM) who highlighted the key issues for the Board's attention, namely:

- **Internal Audit –** the Committee had received reports and assurance opinions on three audits completed as part of the 2017/18 audit plan: key financial systems, contract management framework and the Trust's recruitment and retention strategy. All three audits had received a reasonable assurance opinion. The Committee had reviewed progress against the 2017/18 internal audit plan and remained concerned about progress against the plan in anticipation of the year-end reporting timetable and assurance required. Whilst the Internal Auditor anticipated the overall audit opinion for the Trust would be 'reasonable', this was caveated whilst the outstanding audits were completed.

- **European Union General Data Protection Regulation (GDPR) –** the Committee had received details of the General Data Protection Regulation (GDPR) action plan, which was aligned with the Information Commissioner's Office (ICO) '12 steps' guidance. The Committee was reasonably assured by the discussion around the presentation of the plan but requested a follow up paper, specifically responding to questions about assurance of a satisfactory compliance position by 25 May 2018 be brought to the next Committee meeting in April 2018.

- **Counter fraud annual work plan**
  The counter fraud specialist had presented the 2018/19 work plan. Three key areas were highlighted: the possibility of an NHS Counter Fraud Authority inspection to check compliance with NHS standards, the increasing risk of cybercrime and the consequent disruption to services, the outsourcing of back office and healthcare functions and the increased risk of conflicts of interest. The Committee had also requested that a cybersecurity maturity assessment to be performed in 2018/19.

Item 94c(ii) – Business Committee 16 March 2018

The report was presented by the Non-Executive Director (TD) who drew the main items to the Board's attention, namely:

- **Children's strategy –** the Committee had considered the final draft of the strategy and was content to recommend it to the Board for final approval.

- **E-rostering –** the Committee had received an update on the e-rostering project. A project initiation document (PID) was being drafted and would be available for the Committee to review in April 2018.

- **Trust operational and financial plans 2018/19 –** the Committee had discussed both plans in detail and had agreed that they should progress for consideration by the Board.

Item 94c(iii) – Charitable Funds Committee 16 March 2018
The report was presented by the Trust Chair who drew two items to the Board's attention namely:

- **Customer service training with John Lewis –** the Committee had received an update on the positive work being undertaken with John Lewis and also details of a staff event planned for 10 April 2018 to encourage participation.

- **Working with partners –** the Trust Chair reported on a positive meeting with the Chair of the Charitable Funds Committee at LTHT where he had discussed the potential for working more closely on areas that would benefit local communities.

Item 94c(iv) – Nominations and Remuneration Committee 16 March 2018
The report was presented by the Trust Chair who drew one item to the Board's attention namely:

- **Employer based Clinical Excellence Awards –** the Committee had received a paper which outlined the number of awards available and an indicative timetable for administering the scheme.

Item 94c(v) – Quality Committee 22 January 2018
The report was presented by the Chair of the Committee and Non-Executive Director (IL) who highlighted the key issues for the Board's attention, namely:

- **Musculoskeletal Service –** the Committee had received a presentation from the musculoskeletal service (MSK). The Team's work in a number of areas was highlighted and the challenges they faced in maintaining staff capacity. The Committee also learned about the outcome measures used and various research opportunities that had been developed.

- **Clinical audit programme 2017/18 –** the Committee was concerned about the number of clinical audits which remained outstanding and asked for a clear plan to be developed for next year to ensure timely completion of qualitative audits.

- **Quality Improvement Plan –** the Committee had received an update report on the Quality Improvement Plan actions relating to the Leeds Sexual Health Service and the Community Neurological Rehabilitation Centre following concerns which had been raised about progress. The update had shown that actions were progressing in line with the timetable. The Committee would receive a further report on progress against all the actions in the plan in May 2018.

- **Quality Committee terms of reference –** following consideration of its future work plan and ways of working, the Committee had agreed to retain a schedule of ten meetings per year, six formal business meetings to mirror meetings of the Board and four workshop style meetings.

Outcome: The Board noted the update reports from the committee chairs and the matters highlighted.

2017-18 (95)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • Operational challenges due to adverse weather conditions • Care Quality Commission Inspection of Wetherby Youth Offending Institute • Ofsted report • General Data Protection Regulation • Gender pay gap • Multi Agency Discharge Event (MADE) The Chief Executive said that she particularly wished to highlight the recent review of HM Young Offenders Institute Wetherby by Her Majesty's Inspector of Prisons and the Care Quality Commission (CQC) who had inspected the healthcare element of the service. Informal feedback from the CQC following the review was outstanding and the healthcare team based at Wetherby should be congratulated. Referring to the Trust's infection prevention and control team's nomination for the 'flu fighter champion' award, a Non-Executive Director (RG) asked how the Trust identified services to put forward for awards. The Chief Executive explained that the Trust had established a small group who were tasked to identify services and initiatives to be put forward for awards. A Non-Executive Director (IL) referred to the presentation of data on the gender pay-gap and noted the data on the mean average which showed there was a significant gap in the top quartile where women were paid 35.1% less than men. In response, the Chief Executive explained that within the Trust this quartile comprised of predominantly senior medical roles and had a greater weighting towards men, which contributed to this gap. The Trust would now undertake further action to ensure there was equality in the recruitment and development processes. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2017-18 (96)	**Leeds Health and Social Care Academy – Partner Board briefing** The Chief Executive presented the update report on the progress of the Academy project which had been produced by the Leeds Health and Care Academy for presentation to all the partner Boards and Executive Groups in the city. Referring to the summary of potential long term outcomes for the Academy, a Non-Executive Director (IL) observed that it would be interesting to see the results of the ongoing benefits realisation work. **Outcome:** The Board: • acknowledged progress made to date on the Leeds Health and Care Academy project • noted the decision of the Project Board to progress the delivery and enabling work streams and commit to the follow up actions of making these happen • awaited a detailed business case that specified the financial and people resourcing model with the objective of gaining partner Board sign off.	
2017-18 (97)	**Performance brief and domain reports** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during February 2018	

	The Executive Director of Finance and Resources said that the report highlighted any current concerns relating to contracts held by the Trust, a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. He highlighted the following: ***Safe*** The Trust was achieving the majority of its targets within the safe domain for the year to date. The exception was avoidable category 4 pressure ulcers where three had been recorded for the year to date. ***Caring*** All indicators were expected to be rated as green at the end of 2017/18. The percentage of inpatients recommending care (FFT) in February 2018 was 100%. ***Effective*** The Clinical Audits measure forecast remained rated as green for the year but it was noted that seven audits had been cancelled from the programme due to reconfiguration of services. ***Responsive*** The Trust continued to perform well in respect of its indicators relating to waiting lists and all remained green for February 2018. A Non-Executive Director (JM) asked what progress had been made to investigate the reasons behind the data on activity levels. The Executive Director of Operations said that she was confident that the Trust was meeting patient need but the current measure i.e. contacts did not reflect this. Work was underway to identify a more effective way to evidence the impact of the increasing complexity of patient contacts. A Non-Executive Director (IL) observed that the Trust might wish to explore the opportunity to develop an academic research partnership in this area. It was agreed that the Executive Director of Nursing would make contact with colleagues at the University to discuss this proposal. **Action:** The Executive Director of Nursing to explore opportunities to form an academic research partnership to improve the understanding of caseload complexity in relation to activity levels. ***Well-led*** The Board noted that total sickness absence remained above target but was now rated as amber for short term absence which stood at 2.4% in February 2018. Long term sickness absence was improving and stood at 3.6% and was rated as green for February 2018. ***Financial position*** The Executive Director of Finance and Resources reported that the Trust's financial performance remained strong overall at the end of February 2018 and was £0.2million ahead of the financial plan. The forecast outturn position demonstrated that the Trust would achieve the control total surplus of £3.034 million and a further £150,000 of the risk reserve had been released into the surplus bottom line following discussions with NHS	**Executive Director of Nursing**

	Improvement. **Outcome:** The Board noted the Trust's performance for February 2018.	
2017-18 (98)	**Annual staff survey** The Interim Director of Workforce presented the report which included the findings of the 2017 NHS national staff survey for Leeds Community Healthcare NHS Trust. The Interim Director of Workforce reported that the response rate was higher than last year at 54% and this was above the national average. A total of 1491 staff had completed the survey. The Interim Director of Workforce reported that key improvements were evidenced in: • care as a top priority for the organisation • recommending the organisation as a place to work • communication between senior management and staff The key areas of dissatisfaction related to level of pay and immediate manager support. The Interim Director of Workforce said that next steps would be to share the granular detail within each business unit and corporate team to allow each team to review their information and develop their own local action plan. The local action plans will be collated and reviewed by general managers and corporate heads of service by June 2018. A comprehensive communications plan was being developed to share the 2017 results with all staff and to prepare for the 2018/19 survey. The Chief Executive said that the results would be discussed in detail at the Board workshop on 4 May 2018. **Outcome:** The Board received and noted the report and key next steps.	
2017-18 (99)	**Child and adolescent mental health services Tier 4: new care model** The Executive Director of Finance and Resources presented the report. In December 2017, the Board had approved in principle a proposal to commence the New Care Model pilot for Children and Adolescent Mental Health Service (CAMHS) Tier 4 on 1 April 2018. The Executive Director of Finance and Resources reported that since that meeting a change had been made to the financial assessment which meant further confirmation of approval was required by the Board. He explained that it had been agreed with NHS England that a cohort of CAMHS Tier 4 patients whose needs were being addressed by Transforming Care Partnerships were not in scope for this New Care Model. As a consequence the budget and reported savings had been reduced and, on very prudent assumptions, suggested a non-recurrent deficit for 2018/19. The Executive Director of Finance and Resources explained that there was a small financial risk to the Trust from up-front investment and infrastructure to manage the budget but the recurrent savings for reinvestment would be significant. Members discussed the detailed changes in the financial assessment and the	

	Board confirmed its approval for the Trust to take lead provider responsibility for the West Yorkshire CAMHS Tier 4 from 1 April 2018. **Outcome**: The Board confirmed its approval for the Trust to take lead provider responsibility for the West Yorkshire CAMHS Tier 4 on 1 April 2018.	
2017-18 (100)	**Operational plan 2018/19** The Executive Director of Finance and Resources presented the operational plan 2018/19. The Board was asked to approve the Trust's operational plan including the budget proposals for 2018/19. The Executive Director of Finance and Resources reported that the operational plan had been developed in line with discussions which had taken place in the Board and sub-committee meetings held over recent months regarding the Trust's priorities and resources for 2018/19, in line with 2017-2019 plan submitted to NHS Improvement on 23 December 2016 and the summary changes for 2018/19 submitted on 8 March 2018 in line with national planning requirements. In response to a question a Non-Executive Director (RG), the Executive Director of Finance and Resources confirmed that uncompleted priorities for 2017/18 had been factored into the priorities for 2018/19. **Outcome:** The Board approved the operational plan for 2018/19 and the supporting financial plan within it, subject to any issues which arose as part of the discussions in the Private Session of the Board meeting.	
2017-18 (101)	**Children's services strategy** The Executive Director of Operations presented the strategy for children' services within the Trust. She explained that the Trust was an active partner in the Leeds Children's Trust Board and the development of the strategy was influenced by the Children and Young People's Plan as well as the Leeds Health and Wellbeing Plan. The purpose of the strategy was to define the children's offer and to ensure that the Trust played a more influential part in the development of a children's strategy for Leeds. A Non-Executive Director (IL) said that he welcomed the development of a co-ordinated children's strategy within the Trust which was underpinned by a detailed implementation plan. He cautioned that the strategy would only be successful if considered in partnership in the wider context of the city and the partner agencies including primary, secondary and social care as well as third sector organisations and education. The Executive Director of Operations said that the success of the strategy would be dependent upon several underpinning principles including engagement with and a commit to meaningful dialogue with all partners across the city including colleagues at LTHT. **Outcome:** The Board approved the strategy and supported the future positioning of the Trust in playing a more influential role in the development of a children's strategy for Leeds.	
2017-18 (102)	**Significant risks and board assurance framework** The Chief Executive presented the report which comprised: • the risk register report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation	

	measures. It also provided an analysis of all risk movement, presented the risk profile, identified themes and linked risks to the strategic risks on the Board Assurance Framework. • the Board Assurance Framework (BAF) summary report which gave an indication of the current assurance level determined for each of the Trust's strategic risks. A Non-Executive Director (JM) reported that the Audit Committee had suggested that the audit of risk management and the BAF in 2018/19 should be a 'deep dive' approach to two selected strategic risk areas. **Outcome:** The Board noted: • the content and revisions to the risk register • the current assurance levels provided by the BAF summary	
2017-18 (103)	**Corporate governance report** The Chief Executive presented the report which included: • the draft annual governance statement 2017/18 • 'going concern' statement • Board of Directors declarations of interest and compliance with fit and proper person requirements for 2017-18 (in draft) • non- executive membership of the Board and committees A Non-Executive Director (JM) asked for the annual governance statement to be amended to reflect the Audit Committee's role in the scrutiny of risks by reviewing the BAF twice each year. There were no additional comments or issues raised about the report or any of the components of the governance framework included within it. **Action: Amend annual governance statement to include Audit Committee oversight of BAF twice a year.** **Outcome:** The Board noted the report, annual governance statement 2017/18, going concern statement, approved the conclusion that the Trust is a going concern and noted the declarations of interest made by directors for 2017/18 (in draft). The Board also approved the change to the membership of the Business Committee.	**Interim Company Secretary**
2017-18 (104)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information and noted that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	
2017-18 (105)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Audit Committee: 8 December 2018 b. Quality Committee: 22 January 2018 and 19 February 2018 b. Business Committee: 24 January 2018 and 21 February 2018 c. Leeds Health and Wellbeing Board minutes: 19 February 2018	
2017/18 (106)	**Any other business** The Executive Director of Finance and Resources raised one item.	

	Police custody suite services contract approval The Executive Director of Finance and Resources reported that the contract value for police custody suite services had increased over the aggregate of the four previous separate contracts and the Board were required to approve the new contract value. **Outcome:** The Board approved the sign off of the new contract value for policy custody suite services.	
2017-18 (107)	**Close of the public section of the Board** The Trust Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 25 May 2018, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

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Signed by the Trust Chair: Neil Franklin
Date: 25 May 2018

AGENDA ITEM 2018-19 (5b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 25 May 2018

Agenda Number	Action Agreed	Lead	Timescale	Status
1 December 2017				
2017-18 (65)	**Guardian for safe working hours:** future reports to indicate actions taken to address outstanding issues	Executive Medical Director	May 2018	Completed
2017-18 (68)	**Organisational development strategy:** six monthly report to Business Committee in April 2018 to include identification of evidential measures eg KPIs and outcome measures	Interim Director of Workforce	April 2018	Completed
29 March 2018				
2017-18 (97)	**Performance brief and domain report –responsive domain:** to explore opportunities to form an academic research partnership to improve the understanding of caseload complexity in relation to activity levels.	Executive Director of Nursing	May 2018	Completed
2017-18 (103)	**Corporate governance report:** amend the annual governance statement to include Audit Committee oversight of BAF (2 x yearly)	Interim Company Secretary	April 2018	Completed

Key		
Total actions on action log	**4**	
Total actions on log completed since last Board meeting: 29 March 2018	**4**	
Total actions not due for completion before 25 May 2018; progressing to timescale		
Total actions not due for completion before 25 May 2018; agreed timescales and/or requirements are at risk or have been delayed		
Total actions outstanding as at 25 May 2018; not having met agreed timescales and/or requirements		

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Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (**6**)

Meeting: Trust Board 25 May 2018	**Category of paper**	
Report title: Chief Executive's report	**For approval**	
Responsible director: Chief Executive **Report author:** Chief Executive	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This report updates the Board on the Trust's activities since the last meeting and draws the Board's attention to any issues of significance or interest. It also recognises recent developments and achievements within the Trust.

Main issues for consideration

The main features of the report are:

- An update on the CQC visit to Hannah House
- Developing our culture of quality improvement
- Flu-fighter champion's award

A further verbal update will be provided at the Board meeting.

Recommendation

The Board is recommended to:

- Note the contents of this report

Chief Executive's report

1. Trust news

1.1 Hannah House CQC inspection

As previously highlighted to the Board, there has been an intense programme of work and support to Hannah House following the CQC Inspection of the Trust in February 2017, which had found the unit to 'require improvement' and other issues that had also been identified through internal processes.

The CQC undertook their planned engagement visit as planned in April 2018. There were two elements to this visit. The first involved a detailed review of the Quality Improvement Action Plan for the unit. The inspectors were pleased with the progress made and that actions were either completed or on track to complete. They then undertook a new style informal engagement visit to the unit where they were able to see the unit, a number of children using the service and talk to some of the staff. There is no formal feedback for this engagement visit however the inspector reported that they found it very helpful and the frequency of review meetings will remain quarterly at this time.

1.2 Closure of the LCH Staff Foundation Trust Membership Database

The General Data Protection Regulation (GDPR) has new rules about how organisations can store and use people's personal information. This includes gaining positive opt-in consent from people to have their details on a database to be used for a specific reason. As a result and to protect people's personal information the Trust has closed the LCH Staff Foundation Trust Membership Database. The Trust has already established internal communications channels for staff including Elsie, Community Talk and Community Health Matters. It also has a range of ways for staff to continue to provide feedback, give views and help to shape the future of services. These include; 50 Voices, Ask Thea and via staff side representatives. Staff have been provided with the option to opt-in and become a 'Friend of LCH' instead.

Additionally members of the public who were on the Foundation Trust Membership Database were asked for their views on changing the term 'members' to the term 'Friends of LCH'. 75% of people that responded said they were supportive of the name change. Those not in support were concerned that members have a stronger influence than friends. The Trust will assure people that by changing the name it will not change the relationship people have with the Trust or the impact they can have. The term 'Friends of LCH' will be used in future.

1.3 Flu-fighter champion's award for Lead Nurse for Infection Prevention and Control

The NHS Employers Flu Fighter Awards were hosted in April 2018. Our own Jo Reynard, Lead Nurse for Infection Prevention and Control (IPC) was awarded the National Flu Fighter Champion award. This is a great acknowledgement of the work that Jo and the IPC team have led. Joanne's drive and energy has been a real asset to the Trust's flu fighter campaign. She has led a social media campaign, given the

campaign its own brand through the creation of ‘Frankie and Flo’ flu bug mascots and a switch to the computer based system of recording vaccines.

1.4 NHSE filming Diabetic Foot Protection Service and invitation to an All-Party Parliamentary Group (APPG) for Diabetes

This month NHS England (NHSE) is filming the Diabetic Foot Protection Service to produce a foot protection resource for healthcare professionals to be available on its improvement website.

In addition, an All-Party Parliamentary Group (APPG) for Diabetes, chaired by The Rt Hon Keith Vaz MP, invited members of the community Foot Protection Service team to attend the Houses of Parliament in order to hear about the work it does.

1.5 UNICEF Gold Standard Accreditation

Our Trust, and in particular the Health Visiting Service has worked to promote breastfeeding across Leeds and this work has been recognised through the UNICEF accreditation programme. The 2017 UNICEF baby friendly initiative audit recognised Leeds health visiting service’s approach to infant feeding as implementing ‘Outstanding’ standards across all levels of the service in achieving excellent support for mothers around feeding practice whilst also promoting close relationships between mother and baby. It recognised that the service has embedded ‘extremely high standards of care’ whilst delivering a ‘strategic and compassionate’ approach for women in Leeds and recommended that Leeds health visiting service should apply for Gold standard accreditation.

If achieved, ours will be one of only a few Health Visiting services in the country to have Gold accreditation.

The audit was conducted in mid-May. Following this, a decision is usually communicated within a short timeline. This is an important opportunity for the Trust to lead the way and to focus on the work of exemplary work of the health visiting service in supporting breastfeeding and the many positive impacts for parents and child health.

1.6 Development of the District Nurse apprenticeship standard

The Trust’s Children’s Business Unit General Manager/Clinical Lead Steph Lawrence has had a submission accepted to become a trailblazer to develop the District Nurse apprenticeship standard..

1.7 Customer service partnership with John Lewis

Members of the Trust’s front of house team met with John Lewis staff to explore a series of customer service ideas. The event was held at Shine in Harehills, with identical sessions in the morning and afternoon opened by the Executive Director of Nursing.

John Lewis Leeds' Selling Coach Team shared their own expertise while LCH staff from an array of sites and different services reflected on what customer service meant to them. The Administration Services Manager will now pull together ideas from the event to create a training package that recognises the vital work of front of house staff.

1.8 Developing our culture of quality improvement

Our work continues to build a culture of quality improvement across the organisation. Frontline staff have been asked to identify areas of improvement work which matter to them, and have been in discussion with leaders around priority improvement areas within the business plan. This has created a long list of improvement projects which we will be progressing throughout the year; examples including:

- Improving attendance, health and well-being
- Redesigning the CUCS service model – focus to include what matters to staff and patients
- Rolling out safety huddles across neighbourhood teams
- Improving the coordination of care for children and young people with continuing care needs
- Reducing e-coli infection rates
- Improving the transfer of care for patients in inpatient beds
- Improving admin processes within CAMHS

We are in the process of finalising the four learning projects from the long list to commence in June 2018 ensuring they meet our operational plan. Senior leaders in the organisation have participated in quality improvement methodology training during May; further training for staff involved in projects is being planned for the summer. The Improvement Academy will also be delivering training in understanding and reducing variation, and engaging our leaders in discussions about 'letting go safely'.

1.9 Award nomination for founder of Giving Voice Choir

Wendy Neill, who is a Speech and Language Therapist at the Trust, formed the Giving Voice Choir in June 2014 after seeing growing evidence through her work that singing promoted health and wellbeing. Since then the Choir, which is sponsored by Leeds Community Healthcare Charity, and is for all adults with neurological conditions and their carers, has gone from strength to strength. It performs publicly at a range of events across Leeds and develops its members' confidence in the process.

The Choir performed at the White Rose Shopping Centre on 11 April 2018, in support of World Parkinson Day,

Wendy, who runs the choir on a voluntary basis on top of her day job, has now been recognised with a nomination in the Community category at Sue Ryder Yorkshire Women of Achievement Awards 2018.

1.10 **Five year long service awards**

Leeds Community Healthcare staff who have been with the Trust for more than five years came together at Elland Road for a special Long Service Awards ceremony in March 2018.

There were more than 170 people in attendance as staff received long service award certificates and enjoyed an afternoon of storytelling, networking and refreshments.

1.11 **Leeds Infant Mental Health Service and Health Visiting service success at Journal of Health Visiting Awards**

The Leeds Infant Mental Health Service and Health Visiting service were awarded runner-up in the Innovation in Health Visiting Practice award, for their cutting edge innovative practice and a productive collaborative relationship. They were recognised for their work on the Early Attachment Observation (EAO) that supports health visitors across the city to identify emerging relationship difficulties between infants and their care-givers in the first few weeks of life so that the difficulties can be addressed quickly and effectively.

2. Local activity

2.1 **Scrutiny Board Working Group**

The Executive Director of Operations attended Scrutiny Board Working Group in April 2018.

Scrutiny Board members received a briefing paper on a pilot involving the Community Dental Service (CDS) which has been trialling a new state-of-the-art consultant and specialist-led Assessment Centre for children since October 2017 and for adults since November 2017. The Children's Assessment Centre is based at Beeston Hill Community Health Centre (1 day per week) for all children under 16, including children with dental anxiety or those with complex or additional needs. The Adult Assessment Centre is based at Reginald Centre, Chapeltown (1 day per week) for adults with extreme dental anxiety or with complex or additional needs. At the same time CDS has temporarily reduced the service available at Seacroft Clinic to two sessions per month. The Care Team has been deployed in a more effective way ensuring appropriate skills mix, temporarily moving them across to work in the new Assessment Centres. The Scrutiny Board Working Group is keen to see the full evaluation in June 2018.

Members were also given sight of the Chief Executive's report and the performance reports from the Board meeting held on 29 March 2018. Scrutiny Board members highlighted a number of areas and may wish to pick up on these in the new year, including:

- Equality of access to physiotherapy appointments
- The reported gender pay gap
- Current levels of vacant clinical posts within the Trust
- Performance against appraisal and training targets

2.2 Leeds Health and Care Partnership Executive Group

The Leeds Health and Care Partnership Executive Group (PEG) hold a monthly meeting to discuss issues across Leeds that requires local health and social care partners to work collectively to help and support each other to use our money in the best way possible (the Leeds £) and our people most flexibly.

The directors of finance from the partner organisations of PEG held a workshop in March where they shared their 2018/19 savings. There were two objectives for this workshop. The first was to gain visibility across the partnership of the plans of the three NHS Trusts and LCC and assurance that there are no inadvertent consequences for other partners. The second was to understand the financial impact that the CCG plans would have on the four statutory partners and agree how this impact would be managed.

This workshop was discussed by PEG. PEG continued to discuss winter planning learning for next year.

Three events have been held across Leeds for system leaders in all organisations to come together and learn together. These have been well received, and led and coordinated by Steve Keyes on secondment from LCH to the City.

3. National information and involvement

3.1 Cyber-security

The House of Commons Public Accounts Committee released its review of the impact on the NHS of May 2017's global WannaCry ransomware attack. Reviews of the attack have highlighted lack of investment in IT infrastructure, including not updating and replacing older versions of the Windows operating system, such as XP, as factors. As a result, the NHS has now signed a new national contract with Microsoft to provide Windows 10 nationally.

The Trust maintains its cyber defences and remains vigilant to the threat of cyber-attack with unusual network activity identified during the week of the 16th April where a potential denial of service attack was observed. This was dealt with by the Trust's IT team and treated as a potential cyber incident, being logged with the NHS CareCert response team.

3.2 Consultation on Serious Incident framework

NHS improvement is currently consulting on how and when the healthcare system should investigate and respond to serious incidents. This will inform the review of the Serious Incident framework in order to provide national guidance on the systems, processes and behaviours that providers, commissioners and oversight bodies are expected to adopt to ensure there is an appropriate response when things go wrong.

Once the engagement has closed, NHSI will analyse the feedback and use it to inform a new version of the Serious Incident framework. The revised framework will

be drafted over the summer and it is anticipated that the new framework will be published by the end of 2018.

4. Recommendations

4.1 The Board is recommended to:

- Note the contents of this report

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (7ai)

Meeting: Trust Board 25 May 2018	**Category of paper**	
Report title 2017/18 Annual report, annual accounts and associate documentation	**For approval**	√
Responsible director Executive Director of Finance & Resources **Report author** Executive Director of Finance & Resources	**For assurance**	
Previously considered by Senior Management Team 11 April 2018, Audit Committee 23 May 2018	**For information**	

Purpose of the report

This paper covers a number of agenda items linked to the production of the Trust's annual report and accounts for 2017/18.

The Audit Committee has received and reviewed in detail the final accounts along with the auditors' report prior to the formal submission to the Board for adoption.

Main issues for consideration

This agenda item comprises:

- Draft annual report 2017/18
- Audited annual accounts for 2017/18
- Draft letter of representation which the Trust will issue to KPMG, external auditors
- ISA260 external audit opinion from KPMG

The ISA260 contains no matters that should preclude the adoption of the accounts by the Board.

The annual report is presented to the Board for approval and, in addition, will be made available more widely at the annual general meeting 18 September 2018.

Recommendations

The Board is recommended to:

- Approve the annual report 2017/18
- Approve the annual accounts 2017/18 as supported by the external auditors' opinion
- Approve the letter of representation

Leeds Community Healthcare NHS Trust

Annual Report and Accounts 2017/18

Welcome from our Chief Executive and Chair.

The scale of the challenges facing the NHS nationally and locally are well known but we have been overwhelmed by the excellent way in which all of our teams have responded and continued to deliver high quality services consistently and often in very difficult circumstances.

This is perhaps most evident through our upgraded Care Quality Commission (CQC) rating. The CQC published the results of its follow up inspection report in August 2017 and, in doing so, confirmed what we always believed to be true. That is, we have made significant improvements across our services since the CQC's last visit in 2014, a position affirmed by the Trust's upgraded CQC rating from overall 'Requires Improvement' to 'Good'.

This accolade is well-earned across our organisation. It is testament to the hard work and determination of colleagues from both corporate and clinical disciplines to provide the most effective health care to the people of Leeds and beyond. It is worthy of note that we were able to evidence this during a time of unprecedented demand across our services, not least within our Neighbourhood Teams, which were a key focus of the inspection. In doing so, adult services were rated overall **Outstanding** for caring - a fantastic achievement. Placed alongside the Children and dental services overall rating of 'Good' across all domains this demonstrates our shared vision to simply provide 'the best care to every community we serve.'

Over the past year we have been working to make improvements in the working lives of our colleagues here at Leeds Community Healthcare. We know great care must start with happy and fulfilled teams. It is therefore most encouraging and assuring to note that results from the NHS Staff Survey 2017 show significant increases in the confidence that colleagues have in LCH as both an employer and as a provider of services, and that they would recommend our care, without hesitation, to friends and family.

Certainly, a key Trust objective for 2018/19 will be to continue our unrelenting focus on the recruitment and retention of high quality, motivated team members.

Of course, this is still a very testing time in health care and a priority for LCH over the next 12 months must be to continue our work with key partners within the West Yorkshire and Harrogate Health and Care Partnership, and within the city of Leeds, to provide the best possible care outside of a hospital setting. We want to ensure that admissions to hospital are reduced and, similarly, discharges out of hospital are managed quickly and well, with appropriate packages of care wrapped around the patient. We'll be working with key partners including those within our teaching hospitals, Leeds City Council and GP partners to make sure we keep moving forward in this aim.

We also want to invite our patients too, to support us in this aim and become partners in their care. An important part of what we are doing across our services is rolling out a new approach known as Health Coaching. In the past, a patient may have come to a health professional with a view that they would be 'told what to do' Our expert teams are now trained to work even more closely with a patient to

understand the expert knowledge they (and their family) can bring to their care. Working together with our clinicians we want patients to feel empowered to take a much more involved role in managing their care and setting goals that are meaningful for them and the lives they hope to lead.

And so, we would like to say a final thank you the individuals and teams who continue to support us in this very important work. We look forward to working with you all over the coming year with a view to providing even better care, every day.

Design note: Add electronic signatures

Neil Franklin
Chair

Design note: Add electronic signatures

Thea Stein
Chief Executive

Who we are and what we do

Established in 2011, Leeds Community Healthcare NHS Foundation Trust provides community healthcare services to the people of Leeds. We work with the whole family and often the city's most vulnerable people. Some of our specialist care is provided across Yorkshire and the Humber.

We work where patients live and alongside every other part of the NHS. We also work with partners in social care, the criminal justice system and the third sector.

Our services are organised into three groups: Adult, Specialist and Children and Families. These services are supported by a range of corporate teams.

Adult Services	Specialist Services	Children and Families
• Neighbourhood Teams • Health Case Management Service • Early Discharge Assessment Team • Recovery Hub East Leeds Recovery Hub South Leeds • Recovery Hub North West Leeds **Specialist nursing:** • Wound Prevention and Management • Continence, Urology and Colorectal Services	• Primary Care Mental Health/ Improving Access to Psychological Therapies (IAPT) • Podiatry (foot health) • Musculoskeletal and Rehabilitation Services • Nutrition and Dietetics • Specialist Dental Services • Prison Health (Young Offenders Institute, Wetherby) • Healthcare services for police custody suite across Yorkshire and the Humber • Community Intravenous Antibiotics Service (CIVAS) • Community Tuberculosis (TB) **Long term conditions which include:** • Neurology • Stroke Team • Rehabilitation Unit • Speech and Language Therapy • Cardiac, Respiratory and Diabetes services • Continuing Care Neuro - Physiotherapy	**Integrated Services for Children with Additional Needs (ICAN) including:** • Child Development Centres • Paediatric Neurodisability clinics and children's outpatient clinics • Specialist child protection medical services • Community Eye service • Audiology and New Born Hearing • Physiotherapy • Occupational Therapy • Speech and Language Therapy • Nutrition and Dietetic Services • Day time wetting service (April 18 introduced) **Child and Adolescent Mental Health Services (CAMHS)** Community Nursing Services: • Continuing Care Nursing Team • Hannah House Healthy Child Pathway Early Start Service: • Health Visiting • School Nursing • Sickle cell and Thallasaemia • Watch-It weight management

For more detailed information about any of our services, please visit our website: **leedscommunityhealthcare.nhs.uk**

Our vision

When providing care, our vision is simple:

'We want to provide the best possible care to every community we serve'.

To do this, we make sure we live our values every day:

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously, listening, learning and improving.

Quality priorities

To help us achieve our vision, we worked with patients, carers and public members throughout 2017/18 to develop our quality priorities.

LCH continues to review all feedback it receives including ongoing feedback, satisfaction surveys, complaints and incidents as part of its quality improvement.

The quality priorities we have set for next year (2018/19) are aligned to these main themes:

- Prevention, proactive care and self-management
- Patient experience
- New models of care
- Our workforce

What next?

The Quality Strategy sets out the work we need to do over the next 3 years to support our vision and achievement of our strategic goals. This is a key enabling strategy and provides the framework for other Trust strategies that also have a fundamental role in achievement of the Trust's vision.

Additional areas of quality improvement take place within individual services and these are managed through services' own quality improvement plans.

You can found out more about our quality priorities in our Quality Account **leedscommunityhealthcare.nhs.uk**

How we're meeting our goals

Alongside our quality priorities, we've been working hard against four key goals for the people we serve.

Our Four Key Goals:

1: Delivering high quality care – every time
2: Continuing to improve staff morale
3: Taking a lead in delivering New Models of Care and integrating health care
4: Ensuring services are sustainable (quality, efficiency, value for money)

Goal 1: Delivering high quality care – every time

Our first priority is always high quality patient care. Our quality strategy sets out how we aim to achieve 'good' and 'outstanding' across our services.

To achieve this, we assess how well we are doing by using the same questions the Care Quality Commission use in their inspections:

We ask ourselves: Are services **Safe, Caring, Responsive, Effective and Well-led**?

The CQC published the final reports on its announced inspection, 31 January – 2 February 2017, and unannounced inspections of Hannah House, Leeds Sexual Health and the Single Point of Urgent Referral on 29th August 2017. We were delighted that the CQC rated the Trust overall as **'Good**', the CQC's previous rating being 'Requires Improvement'.

The CQC found several areas of outstanding practice particularly within:

- Community health services for adults
- A project to improve patient flow
- The development of pharmacy technicians which had supported staff and improved patient compliance
- Speech and language therapy and musculoskeletal services.

Adult services were rated overall 'Outstanding' for caring and all other services were rated 'Good'.

Design note: Thumbnail picture of staff holding 'Feeling Good' sign.

Safe

- We achieved 58% of patient safety incidents being reported as 'no harm'. We are working hard to meet our 70% target.
- No cases of infections such as MRSA or Clostridium Difficile acquired by patients in our care.
- No admission of patients under 16 years of age to adult services
- 100% of incidents applicable for Duty of Candour were dealt with appropriately (see Saying Sorry below)
- We achieved a **50.0**% reduction against the target for the number of avoidable category 3 pressure ulcers.
- We aimed to have no avoidable category 4 pressure ulcers in 2017/18. There have been three in the year to date. This is improving, year on year with much focussed work and training
  We achieved the Serious Incident Rate target consistently through the year
- There were 4 falls in our Community Inpatient Units meaning we achieved the target to reduce falls to 12. We continue to monitor the Trust's Sign up to Safety pledge to '*reduce falls causing avoidable harm in inpatient units by 10%'* on a quarterly basis".

To help monitor the safety of our services, our Board use key performance indicators (KPIs) and information gained from:

- Listening and talking to patients, carers and families,
- Visiting services
- Meeting with staff as they deliver care

Saying Sorry (Duty of Candour)

If a patient is harmed as a result of a care and treatment they have received from us, or if an error is made in the care being delivered to them, we are committed to being open and honest. We would always provide the patient with an explanation of what happened, we would say sorry and we would explain what we are doing to put things right and to prevent the incident (as much as is possible) from happening again.

- The Trust has in place a Being Open and Duty of Candour Policy and Procedure to make sure all staff are aware of their responsibilities.
- We deliver briefing sessions at service and team meetings
- Duty of Candour is featured in the Trust's induction day for all new starters.

The Trust is 100% compliant with the requirements placed upon it. In its report published in August 2017, the CQC were positive in its appraisal of staff understanding and the work of the Trust in this area.

What next? We continue to review incidents which trigger Duty of Candour. Currently, there is one incident where the full process has not been fully completed and this is being followed up with the service.

Caring

- The Friends and Family Test shows 100.0% of our Inpatients would recommend our services against a target of 95%. It also shows that we achieved our target of 95% of community patients recommending LCH care
- If things don't go as well as expected, we welcome complaints. We respond to complaints within legally set timescales most of the time, but often much quicker (see Patient Experience below).

Patient Experience
Including concerns, queries and complaints

We believe strongly in listening to our patients and really hearing what they have to say. This is even more important when something has gone wrong or when we are dealing with patients who have had a poor experience.

The Patient Experience Team is here to help those who have a question or want to tell us something about our services. The team is also here as an alternative to approaching the services directly.

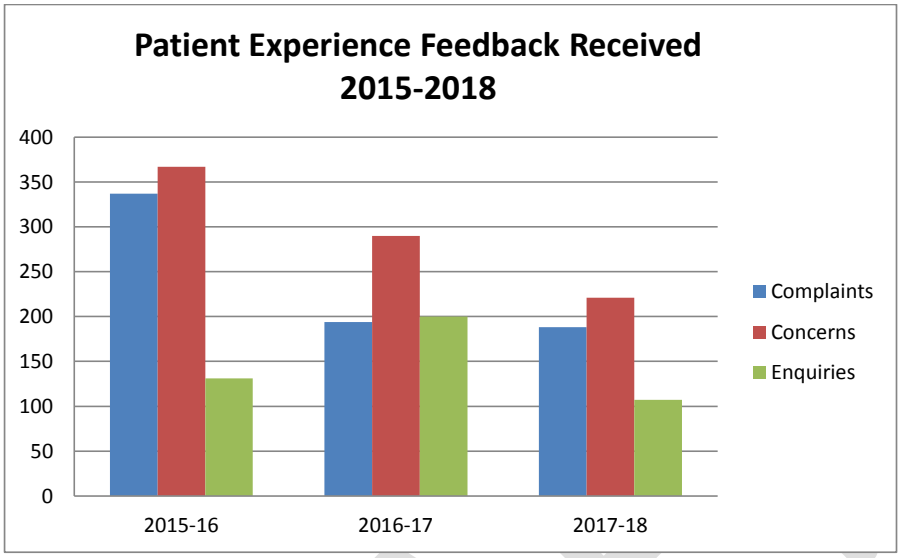
In 2017, we began updating our approach to Patient Experience at the Trust. We moved away from using the description of Patient Advice and Liaison Service (PALS) in order to more accurately reflect the scope of services the Patient Experience Team can offer.

The Patient Experience Team works with all services in the Trust and with other health and social care partners in the city. We ensure a 'no wrong door' policy, an approach that has been agreed with *Healthwatch Leeds. This means that no matter which health or social care organisation in the city a person contacts in the first instance, the receiving organisation will pass the relevant information on. This is to make sure that a person with a complaint, concern or question is not faced with several contact numbers or having to explain their issue over and over again.

For example: Mr S called to ask how to arrange for a piece of equipment to be collected from his home following the death of his family member. The deceased patient had not received care from LCH services but in line with our 'no wrong door' policy the Patient Experience Team called the care provider responsible for the patient's care and the Leeds Community Equipment Service to arrange for equipment to be collected.

During 2017/18 we received 188 complaints relating to services provided by Leeds Community Healthcare NHS Trust services. During the year, 11 complainants asked the Trust to re-open their complaints to look at issues again. Three referrals were made to the Parliamentary and Health Services Ombudsman; (two of the referrals were about the same complaint) none of these were upheld by the Ombudsman. There were also 221 concerns and a total of 107 enquiries recorded.

The table below shows the number of complaints, concerns and enquires received by the Patient Experience Team over the past three years.



The top themes for complaints in 2017/18 were:

1. Appointments (for example, the waiting time, being unable to get an appointment or the failure or delay in a referral process).
2. Clinical Judgement / Treatment
3. Attitude, conduct, cultural and dignity issues.
4. Communication issues with the patient
5. Access and availability (for example, availability of home visits, issues with the entrance to health centres or car parking facilities)

We welcome all of your feedback about the services we provide; whichever way you want to tell us. You can contact us by phone, e-mail, via the Friends and Family Test, social media, our website or even face to face.

More detailed information about the service provided by our Patient Experience Team can be found in our Quality Account available on our website: **leedscommunityhealthcare.nhs.uk**

*Healthwatch Leeds helps local people get the best out of their local health and care services by bringing their voice to those who plan and deliver services in Leeds.

Responsive

- We meet all nationally reportable and internal targets for waiting times.
- At year end the Trust was seeing 97.6% of patients on consultant-led pathways within 18 weeks, no patients waited more than 52 weeks during the year

- Activity levels at the end of March are 6.4% less than planned for the year predominantly due to Adult Neighbourhood Teams being some 8% below the contacts target agreed with the CCG over a year ago. Significant improvements in the productivity of the Neighbourhood Teams have resulted in reduced numbers of contacts but no reduction in care.
- At year end 97.9% of patients were waiting less than 6 weeks for diagnostic tests at year end. This was 100% from Quarter 2 and 3.
- 98.5% of patients were treated within 18 weeks of referral to Improving Access to Psychological Therapies (IAPT) and 91.8% were seen within 6 weeks.

Effective

- We have achieved the 65% target for clinical supervision, at the year-end, 72.0% of staff were compliant with clinical supervision.
- 76 clinical audits were completed in the year.
- We have achieved our Commissioning for Quality and Innovation (CQUIN) 4 goals associated with piloting outcomes measures in Musculoskeletal Services (MSK), the Neighbourhood Teams and Integrated Children's Additional Needs (ICAN)
- During 2017/18, we have put in place NICE guidance (within two years of publication) for 76% of relevant guidelines. Action plans are in place for the remaining seven guidelines.
- We are not meeting the target we set ourselves for compliance with other NICE guidance. In February 2018 we updated our NICE Guidance Policy and now allow ourselves two years to put in place complex care pathways with our patients.
- During 2017 the Trust's Learning from Deaths Policy has been written and is in the process of being put in place. The Policy is in line with national requirements and builds on the work already underway in LCH. This ensures that all deaths in the organisation, where our services were delivering direct care and case managing the patients care, are investigated appropriately to determine if there is any learning.
- We are actively involved in LeDeR (Learning disabilities mortality review programme)
- Trusts are now being asked to report and update on the 'Learning from Deaths' process that was instigated across the NHS in 2017.
- Learning is shared at our strategic mortality surveillance group. It is also shared within business units and more widely across the whole organisation if required.

Well-led

We have continued to identify challenges and make progress in meeting them as our performance assessment shows:

- Good progress continues to be made in reducing our staff turnover rate, which continues to be below the Trust's target of 14.5%, and remains below other benchmark comparator community provider Trusts. Our overall stability index is 85.5%
- Our temporary staffing fill rate stands at 75%
- Our sickness absence levels across the year have fluctuated, on the whole, with year-end position of 5.8% which is 0.6% above our target. Detailed analysis is being undertaken to look at the detail behind the figures in terms of compliance with reporting targets and identification of trends
- We recognise the importance of annual appraisal for all staff and have consistently had overall monthly Trust appraisal rates above 78% across the year
- Our statutory and mandatory training percentage has consistently been at or above 90% across the year and we continue to look for new ways to support staff accessing and completing this important requirement
- We have been named in the 2017 NHS Workforce Race Equality Standard (WRES) data analysis report as performing better than other NHS Trusts in two of the indicators

Design note: Breakout box

We're proud of…

our overall rating of 'Good' from the Care Quality Commission (CQC). The award was received in August 2017 following the CQC's inspection in January of the same year. Our adult services also received a rating of 'Outstanding' for caring as part of the same inspection.

… our membership of the Inclusive Top 50 UK Employers, our continued membership of the Stonewall Diversity Champions programme and our improved performance in the Stonewall Workplace Equality Index

Goal 2 – Continuing to Improve Staff Morale

Our aim is to attract the best people…we're doing this by:

- Developing the Trust's website to promote the full range of benefits on offer. The 'Work for Us' section of the website has been redesigned to; improve the look and feel of the section; to improve navigation and ease of finding information; and to better showcase the Trust's careers, development opportunities, the full range of employment benefits and the advantages of living and working in Leeds.
- Using social media (chiefly Facebook and Twitter) to share our offer with a targeted audience, and to showcase the culture of the Trust and what it's like

working here. To date over 140,000 people have seen our roles advertised on Facebook.
- Attending careers fairs and Universities in Nottingham, Bradford, Manchester, Salford, Leeds and Liverpool, to support our ability to recruit and attract high quality candidates to Leeds this year.
- Hosting a recruitment bus tour to showcase our trust to potential applicants to our neighbourhood teams.
- Continually adapting our recruitment approach and introducing a number of initiatives aimed at improving our selection and assessment process. For example, support with relocation costs, refer a friend scheme and improving on our design of assessment centres which are used where a high number of recruits are needed.
- Further developing our preceptorship programme, to support recruitment, induction and development of newly registered and newly recruited registered nurses and therapists.

We also want to keep the best people…

We want to make sure that when we attract the best staff, we keep them happy and motivated to remain with us. Keeping good people is not about one single approach but a range of approaches that fit under the following areas:

- Staff engagement: Social media and the Leaders' Networks form part of this work. This is alongside discussion at local team level using the Trust's 'Engagement Star'.
- Leadership Development: leadership capability continues to be a focus through our coaching strategy. This supports managers via 1-2-1, team and health coaching courses as well as our 'Manager As Coach' (MAC) programme
- Career progression: Maintaining focus on professional development and new roles for example, Preceptorship and Nurse Associate Roles and making sure people are supported with development and educational opportunities. Work will continue with our Leeds partners to develop opportunities for career progression across the health and social care system.
- Staff Wellbeing: Supporting staff to feel psychologically and physically well at work providing opportunities for flexible working and time off for study and development.
- Recognition and reward: Staff feeling valued from their local management as well as the Trust forms part of this work. This can be as simple as local development opportunities for example, assignments that provide stretch and opportunities for praise. It also includes more wide ranging corporate schemes, for example, our monthly 'Thanks a Bunch' recognition scheme and the Trust's annual 'Thank You Event.'
- Recruitment: Ensuring opportunities are available for all staff to progress internally through secondments, apprenticeships and developmental projects.

Design Note: The Wellbeing Poster pack thumbnails.

NHS National Staff Survey 2017

Every year we take part in the NHS National Staff Survey. This year 1,491 staff completed the survey compared to 1,425 in 2016, a good response rate of 54% and well above the national average of 43%. We looked at our key findings and found the following changes on last year:

Some good news:

- Care of patients / service users is my organisation's top priority +7%
- I would recommend my organisation as a place to work +6%
- Communication between senior management and staff is effective +5%
- My organisation acts on concerns raised by patients / service users +5%
- I am confident that my organisation would address my concern +5%
- We are given feedback about changes made in response to reported errors, near misses and incidents +5%
- I am able to deliver the patient care I aspire to +4%
- I am satisfied with the quality of care I give to patients / service users +4%
- I am satisfied with the extent to which my organisation values my work +4%
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation +4%
- When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again +4%

Some areas of development:

- I am satisfied with my level of pay -7%
- My immediate manager can be counted on to help me with a difficult task at work -3%
- My immediate manager encourages those who work for her/him to work as a team -2%

Health and Wellbeing

Within the last year we've launched our 'Feel Good Pledge' which further underlines our commitment to look after our staff, supporting them to remain physically healthy and mentally well, so that they can continue to provide quality care to the most vulnerable people across the City of Leeds and, in some cases, beyond.

The basis of our pledge is to develop and maintain a working environment that supports our physical mental health and wellbeing and as part of this we've developed an information hub on our intranet that brings together all the resources dedicated to staff support and wellbeing.

The resources range from access to professional Occupational Health services to comprehensive, supportive employment policies and from helping staff with dyslexia to providing new cutlery and crockery to help improve the working environment (and the lunch experience).

Design Note: The Wellbeing Poster pack thumbnails.

What next?

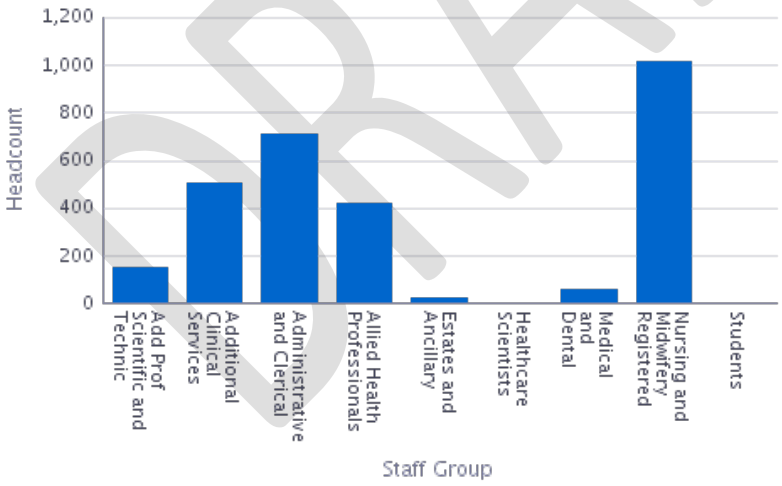
Over the coming year we intend to look closely at the responses to the health and wellbeing questions in our staff survey outcome, to examine what colleagues are telling us. We'll compare this with other local level information to see if, for example, the way some policies and processes are being interpreted and actioned is right for all concerned.

Appraisals

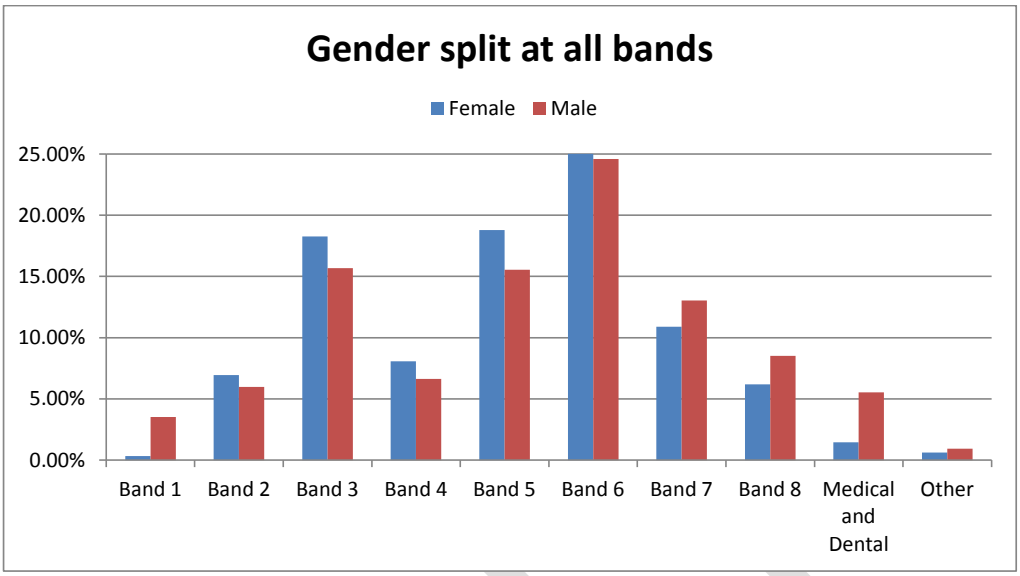
Our average appraisal percentage rate for the year is 83% but we can do better. To help us do this staff engagement data from the 2017 staff survey results will be explored further.

Workforce profile

We employ a workforce of 2,475 whole time equivalent posts which equates to 2,891 people.



Our workforce is 88% female and 12% male. The table below demonstrates how these percentages are broken down across the pay bands.



The Trust complied with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and published its gender pay gap details in March 2018. The information published indicated that there is a significant gap in the top quartile with members of the female workforce being paid less than their male counterparts. Whilst this gap can be partly accounted for by the fact that this quartile contains a greater number of senior medical roles occupied by males, the Trust will undertake further action to ensure equality in recruitment and development processes.

Staff flu campaign

In September 2017, a 'cake and cuppa' drop in session marked the launch of the Trust's 2017/18 flu immunisation campaign at Trust headquarters.

Led by our Infection Prevention and Control (IPC) team, the campaign was supported by the Trust's now famous flu mascots 'Flo' and 'Frankie' who helped us hit our vaccination rate target of 70% by the beginning of December 2017.

Public Health England statistics for December 2017 showed we had the second-best vaccine uptake by frontline healthcare workers for a community trust. By the end of January 2018, 76% of patient-supporting staff had received their jab.

We're proud of…Our IPC team, who bring creativity and drive to this annual campaign. The team's first priority is always to make sure that the vulnerable people we treat are at a lower risk of contracting the virus. This year they also helped us achieve the associated NHS England Commissioning for Quality and Innovation (CQUIN) payment for reaching the target it set.

Design note: Include photo and caption

Jo Reynard, IPC Lead receiving NHS Employers Flu Fighter of the Year Award 2017/18

Goal 3: Leading Role in Delivering New Models of Care and Integrating Health care.

This year we've continued our work with key partners within the West Yorkshire and Harrogate Health and Care Partnership, and within the city of Leeds, to provide the best possible care outside of a hospital setting. Our aim is to make sure that admissions to hospital are reduced and that discharges out of hospital are managed quickly and well, with appropriate packages of care wrapped around the patient.

Here are some of the ways we've achieved this across our services.

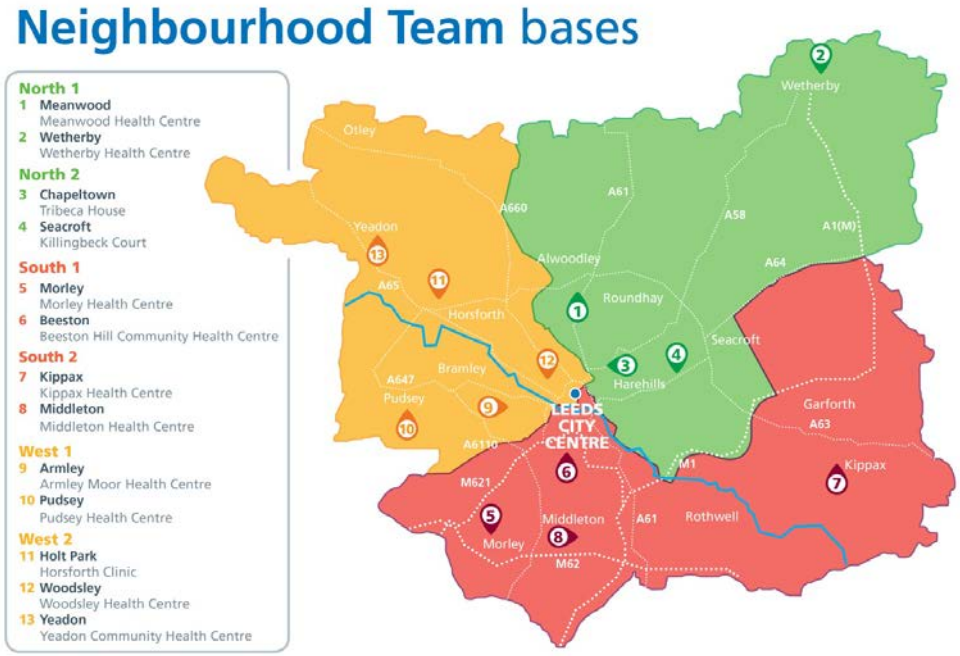
Adult Services

We've continued our work this year to bring together adult services to provide multidisciplinary, nursing and therapy care for frail and elderly people and those with long term conditions.

This work has been guided by feedback that the people of Leeds, patients, carers and our staff told us what they want:

"Support that is about me, my life, where services work closer together by sharing trusted information and focusing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect."

We have worked in partnership with primary care, Adult Social Care, mental health and hospital providers to jointly understand local needs and improve our joined up response for people in Leeds.



Neighbourhood Teams

- ✓ Alongside colleagues in social care we have 13 Neighbourhood Teams across the city. These are based around GP registered practices
- ✓ Staff from Leeds Community Healthcare and Adult Social Care work together from the same base to provide seamless care.
- ✓ Staff who were previously district nurses, intermediate care nurses, community matrons and adult domiciliary physiotherapists work together as one team across the 13 neighbourhoods from 7am to 10pm.
- ✓ Each team works in caseload clusters which cover one or more practices within an area. This is to make sure care is consistent and that we work with other health and care professionals to deliver proactive joined up care to people and their families.
- ✓ Teams really get to know their community and are able to respond in a timely way.
- ✓ During the evening hours when demand reduces, Neighbourhood Teams come together to work out of 3 hubs, each covering 4 or 5 Neighbourhood Teams. The Neighbourhood Night Nursing Service then takes over from 9:30pm.
- ✓ Our Neighbourhood Teams provide 24 hours a day care, 365 days a year.

Adult Services also provide a range of services that work alongside Neighbourhood Teams. These are:

- **Health Case Management:** A new service which began in October 2017. It provides specialist citywide case management for people aged 18 years and over who are eligible for NHS Fast Track and Continuing Healthcare funding
- **Leeds Integrated Discharge Service:** Working in partnership with Leeds Teaching Hospitals Trust, Adult Social Care and Age UK to work with people who require additional support to plan for discharge from hospital.
- **Citywide Services:** continence, wound prevention and management, falls, end of life and pharmacy technicians
- **Nursing and Therapy:** For some Community Care Beds (new model commissioned in 2017)
- **Citywide Bed Bureau:** Matches people requiring community bed provision with available beds.
- **Single Point of Urgent Referral (SPUR):** Manages referrals from community and hospital settings into a range of community services.

Service Development

We're always looking for ways to improve the care we offer. Here are some ways we've been doing this during 2017:

- We have developed a Clinical Care Framework for End of Life Care, Holistic Assessment and Wound Care. Clinical Care Frameworks provide best practice guidance to staff in teams. They have been developed in partnership with specialist and generalist colleagues. In 2018/19 we will work on further Clinical Care Frameworks for mental health and continence pathways.
- We are trialling some weekend clinics to understand if this will help in working more effectively and well with our weekend patient caseload. To date, feedback from patients and staff is positive. Based on this and in partnership with primary care colleagues, we are looking at if we can make this a long term addition to our offer.
- We have taken another look at our internal and external reporting processes; to make sure they work well with city-wide plans for how organisations work together during periods of pressure.
- We regularly review the reasons why people are delayed in hospital to better understand and address these delays wherever possible.
- Working together with colleagues in primary and secondary care we have launched a new template for community referrals. This is so we can organise the right care, in the right place more easily and quickly. We will continue to develop this approach in response to feedback from partners and teams.
- Regular caseload reviews to make sure they are up to date and that all our patients are appropriately reviewed and risk assessed.

Responding well under pressure

During the winter period Adult Services, along with other parts of the health and care system experienced a period of increased pressures, a further challenge was the heavy snow and ice. Our teams continued, often in very challenging circumstances, to support patients, families and each other.

Breakout boxes:

We're Proud of…

…Our Middleton Neighbourhood team. They pulled together to overcome challenges over the last year while continuing to manage caseloads and promote high quality.

…Gemma Cannon, Neighbourhood Night service Clinical Quality Lead. Gemma goes above and beyond to ensure the delivery of high quality care every day and night across this often 'unseen' service.

… Senior Nurse, Michelle Eaglen. She has shown tireless commitment, dedication and quality care for a particularly complex patient with multiple health and social problems.

… Neighbourhood Team Clinical Lead Chris Richardson. Chris regularly goes the extra mile and is always prepared to support and challenge her team to improve.

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Children's Services

Our new children's services strategy reflects the shared ambition of LCH and individual children's services to develop a more 'joined up' way of working in order to deliver services which promote a better experience and outcome for children and young people.

Our support pyramid below shows how our care is delivered across Leeds and West Yorkshire. The base of the pyramid is where most children in Leeds will meet our teams, as this care is offered to every child. The tip of the pyramid is the support we deliver to a smaller number of children and young people as it is much more specialist.

Examples of some of the pathways which we will have in place include:

- continence,
- communication,
- eating and drinking,
- sleep and social
- emotional mental health.

We want to place the focus on care that is wrapped around the needs of a child, with all the services a child may need working together around that child, instead of lots of different services working on their 'bit' of a child or young person's needs.

For example, Amir:

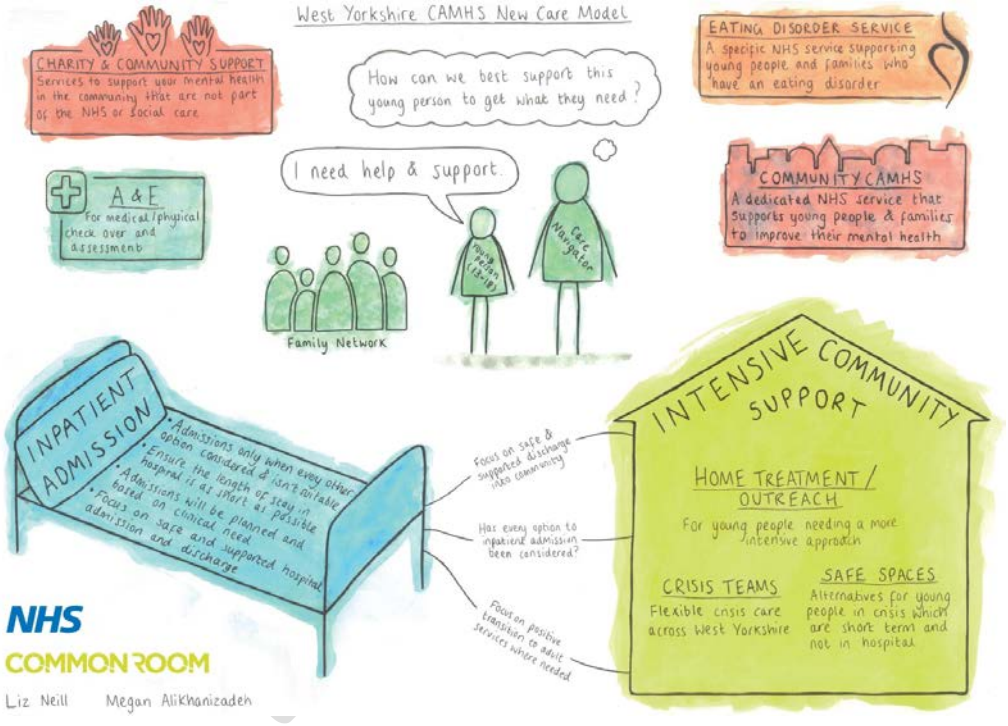
Next steps

Over the course of 2018/19 we will review all our current pathways and agree the additional pathways that require development. This is so that we can create a fully comprehensive 'offer' for children and young people.

Working even more closely with key partners, commissioners, GP practices and partners at the acute trust to develop 'joined up' approaches to the delivery of care for children and young people across Leeds is really important to us.

One of the ways we'll be doing this during 2018/19 is to lead on a pioneer project to promote a new model of care. Working with *key partners in West Yorkshire, we're looking at how we can improve Child and Adolescent Mental Health Services. The main aim is to reduce the number of admissions for children and young people into inpatient beds. Where an inpatient bed is necessary we want to achieve this much closer to home in a modern, fit for purpose space.

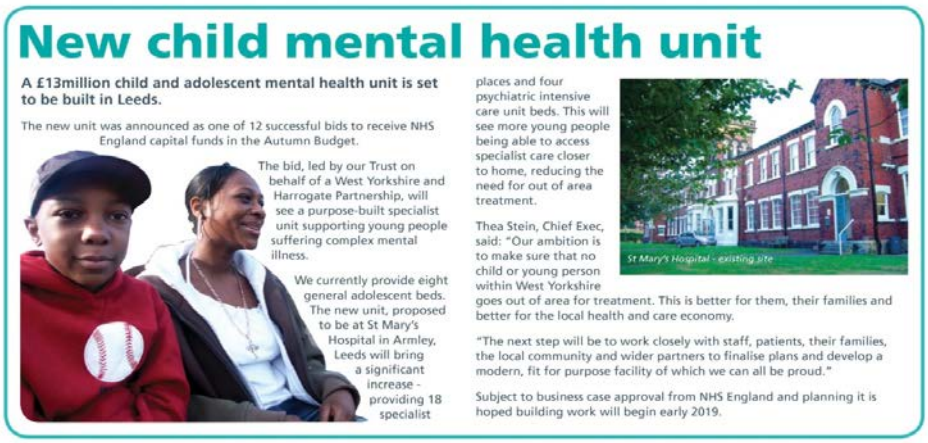
This infographic shows how that care could be organised:



*** West Yorkshire and Harrogate Health and Care Partnership.**

Four NHS trusts that provide the region's NHS mental health services across West Yorkshire and Harrogate are working together to improve acute and specialist mental health services for local communities, as part of the wider health and care partnership. Leeds Community Healthcare NHS Trust (LCH), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Bradford District Care NHS Foundation Trust (BDCFT) and Leeds and York Partnership NHS Trust (LYPFT)

When an inpatient admission is the best option we want to make sure that a stay is as short as possible and that it takes place in a modern, fit for purpose space. Funding was announced during the year and 2018/19 will see us working with our partners to deliver the right inpatient setting for children and young people.



New child mental health unit

A £13million child and adolescent mental health unit is set to be built in Leeds.

The new unit was announced as one of 12 successful bids to receive NHS England capital funds in the Autumn Budget.

The bid, led by our Trust on behalf of a West Yorkshire and Harrogate Partnership, will see a purpose-built specialist unit supporting young people suffering complex mental illness.

We currently provide eight general adolescent beds. The new unit, proposed to be at St Mary's Hospital in Armley, Leeds will bring a significant increase - providing 18 specialist places and four psychiatric intensive care unit beds. This will see more young people being able to access specialist care closer to home, reducing the need for out of area treatment.

St Mary's Hospital - existing site

Thea Stein, Chief Exec, said: "Our ambition is to make sure that no child or young person within West Yorkshire goes out of area for treatment. This is better for them, their families and better for the local health and care economy.

"The next step will be to work closely with staff, patients, their families, the local community and wider partners to finalise plans and develop a modern, fit for purpose facility of which we can all be proud."

Subject to business case approval from NHS England and planning it is hoped building work will begin early 2019.

Our ambition to work even more with children and young people

We are proud of the range of work we do to involve children, young people and their carers in the development of our services. Next year we want to take this even further and plan to establish a Children and Young Peoples (including parents and carers) consultation group to advise us on strategy, service delivery and service developments. We will also be working with Children and Young people to co-produce a new-look website.

Meet Chris – he's a Participation Worker

Meet Chris… he's a CAMHS Participation Worker

What does your average day look like?

Each day is very different. My role is city-wide and I work from all CAMHS bases across Leeds. My day today, involves reviewing feedback from the Friends and Family Test. I then attend a meeting with a young person and her mum with the people who 'buy our services' from us (known as a Clinical Commissioning Group). They'll be sharing their experiences of CAMHS services and how they have helped them. I then meet a young person at one of our CAMHS bases who would like to join the community CAMHS participation group for young people.

What's the best part of your role?

Involving young people! I help them to get involved in everything from projects to staff recruitment events. It is so important for our service and it's a great way of building confidence, self-esteem, developing new skills and making young people feel valued.

We're proud of…

…Our UNICEF UK Baby Friendly accreditation. The Health Visiting team received 'outstanding' status during the year, as part of the UNICEF UK process, which acknowledges high standards in infant and maternity healthcare nationally. The team is now aiming for 'Gold' status.

Design note: Chartermark?

...The School Nursing Single Point of Access team. The team has transformed the School Nursing service by developing processes to ensure all colleagues are following the same procedures, pathways and packages of care.

…Our CAMHS StepUp! App, a digital innovation that takes therapy into the real world. The app offers more effective and efficient services to young people.

…Paula Groves. Described as an 'outstanding role model' by colleagues, Paula cares passionately about the services we deliver and has helped colleagues in both Health Visiting and School Nursing to develop and grow.

…Consultant Clinical Psychologist, Sue Ranger. Sue was awarded the Association for Infant Mental Health UK Louise Emanuel award. The award is given to 'a person who has demonstrated a significant contribution to Infant Mental Health in terms of practice or through their work in research and policy'.

Specialist Service

It's been a busy year in Specialist Services. Some areas have been decommissioned and others subject to investment. The issues faced are as diverse as the types of service we offer. A willingness to adapt has been important in continuing to deliver high quality services.

Both Police Custody and Dental services were subject to competitive tendering processes this year.

In January 2018 we were delighted to be awarded the new regional police custody contract for four years, with the possibility of further extension. The new service model builds on the success of the last four years and allows for further quality improvements. It will also see additional investment into frontline staffing.

The detail of the region's Community Dental Service is still being worked through, in line with this; the commissioner has withdrawn its current tender specifications. Our service is introducing planned changes in response to the original plans. We continue to work closely with commissioners to influence future developments.

In other news, new colleagues were welcomed into the Substance Misuse Service at Wetherby Young Offenders Institute (YOI); having transferred into Leeds Community Healthcare from another provider. The move enhances our existing partnership with South West Yorkshire Partnership Trust (SWYPT) and supports the delivery of a holistic approach to managing the physical, mental health and substance misuse needs of young people in this setting.

In year we did say goodbye to the Expert Patient Programme; a view was taken to look again at the way patients are supported through education and self-management. Whilst disappointing to lose an established service, it has presented new opportunities for the future. We also no longer provide the Healthy Living Service, which we lost in a competitive tendering process in October 2017. The

service and its staff were transferred to a private provider and we supported colleagues through this process.

As part of adapting to change, we're always looking for opportunities for growth. A number of services have been involved in scoping out new and innovative opportunities that align to the Trust's corporate goal; to have a role in delivering New Models of Care and Integrated healthcare.

Developments include:

- Working closely with commissioners and Primary Care to introduce new ways of working, including extended roles for our Musculoskeletal (MSK) practitioners. We're evaluating existing pilot projects to determine a future service model for the city.

- Investment in Diabetes care, in particular Foot Protection in the Podiatry service and a tailor made education programme for people with Type 2 Diabetes in our Diabetes service.

Design note: Use the thumbnails from our structured adverts and the info pack.

- Funding to introduce a 'Virtual Ward' for people with respiratory conditions. This will see us working together with health and social care partners to support people who have complex medical and social care needs as a result of their condition, particularly those at risk of an avoidable emergency hospital stay, or whose length of stay could be reduced.

- Public Health investment up until March 2018 for our Tuberculosis (TB) service. This is to deliver a screening programme for eligible people aged 16-35 as part of the National TB Strategy.

- NHS England (NHSE) investment in Wetherby YOI to introduce a therapeutic approach called 'Secure Stairs'.

- Working with Leeds Teaching Hospitals NHS Trust (LTHT) a number of our services are looking at how we can deliver more 'joined up' healthcare. The services involved include:

    - Community Intravenous Antibiotics (CIVAS)
    - Neurology
    - Long Term Conditions
    - Community Gynaecology.

  We're looking again at some of our clinical pathways in these areas, to see how we can break down barriers and deliver services in the best way possible for patients. This provides exciting opportunities for working together, enhancing skills and following patients through their care journey.

- 1 year additional funding for our Gypsy Traveller Nurse post. We'll be looking closely at the good work we are doing with this hard to reach community to see how we could use this learning to work with other groups of people.

Next Steps?

There has been a shift in approach from some of our commissioners with a move away from competitive tendering in support of service redesign through collaboration. This will provide the focus for much of our work in the coming year.

Design note: Breakout box

We're proud of…

… Caroline Senior from our Long Term Conditions Team and the healthcare team at Wetherby Young Offenders Institute (WYOI) health team, both were shortlisted for national awards.

…Our new portable therapeutic space known as 'Seeds'. Based at Wetherby Young Offenders Institution, the space is used for 1:1 work, supervision, time out and private discussions.

Design note: Include the 'Seeds' Pod picture.

…Dr Christine Comer, from our musculoskeletal service. Christine was awarded a Fellowship and NIHR Clinical Lectureship secondment for a research study into community based rehabilitation and improving care pathways for people with spinal stenosis.

…our Community Stroke Rehabilitation team. They transitioned from a 10-week service to six-week service in under two months to help reduce hospital bed days and provide higher intensity rehabilitation.

…Mark Simpson, Project Support Officer and Admin Lead. Mark's positive attitude and relentless commitment makes 'the magic happen' in our Nutrition and Dietetics team.

…Our Police Custody care team. They have incredibly challenging roles in very complex environments but always offer a personalised, patient-centred, holistic assessment to all individuals referred through to the service by police.

…Alyson Cawthorne, Clinical Lead Dietitian for the Diabetes service. Alyson has developed and put in place a tailor made structured education programme for people with Type 2 Diabetes.

…Our Leeds Improving Access to Psychological Therapies team. They have developed an online self-referral tool, to improve access to the service and increase the number of people receiving support in a timely manner.

You can find out more about our Trust services here:
http://www.leedscommunityhealthcare.nhs.uk

Goal 4: Ensure Services are sustainable (Quality, Efficiency and Value for Money)

Quality - Involving people in our plans

Our commitment and approach to genuine and meaningful involvement of patients, carers and the public is one way we aim to provide quality services that are fit for the people who need them now, and in the future.

In 2017-18, some of the ways we have involved and engaged patients, carers and the public in our work included:

- For the first time, we joined up with our partners across Leeds, including Healthwatch Leeds, Leeds City Council and other NHS organisations to try out a new method of collaborative engagement. At the event we sought people's views, listened and made changes based on people's feedback to our new Patient Experience Pledge.
- Developing a new educational programme for Type 2 Diabetics, seeking feedback and incorporating suggestions.
- Involving people in judging the Trust's staff 'Thank You' awards based on our 'How we work' behaviours.

- Asking people for their feedback about changing the term ‘members’ to ‘Friends of LCH’ to describe people’s relationship with us and how people can continue to be involved in the work of LCH.
- Providing opportunities for people to share their direct experience of our services at Trust Board.
- Sharing learning with new staff about what good involvement is like for patients, carers and the public, through our corporate induction programme. We also provide opportunities for people to attend corporate induction and share their own experience of LCH.
- Inviting patients and the public, supported by a training package, to take part in Safe Clean Care Project and PLACE (Patient Led Assessment of Care Environments) to continue to make a practical differences in our health centres and inpatient units.
- Developing a new Friends and Family feedback form for children and young people.
  Design Note: Include the ‘before and after’ shots of the feedback form (from Your Health)
- Having information about carers’ support available in our health centres.
- Launching a new parent group for Child and Adolescent Mental Health Services.
- Developing five easy read documents about the MSK service and common conditions the team supports/treats.
- Redesigning induction information for the young people of Kepple Unit at Wetherby YOI to make it more accessible.

Spotlight on CAMHS Involvement: Young people from Leeds CAMHS & West Yorkshire Playhouse help tackle Mental Health stigma

A moving play which helped to tackle young people’s mental health was given added authenticity by patients from Leeds Child and Adolescent Mental Health Service (CAMHS). Zoetrope opened at West Yorkshire Playhouse in November 2017 and followed the journey of seven very different youngsters as they navigate their way through mental health difficulties.

In preparation for their performance, Zoetrope’s cast had discussions with young people from Leeds Community Healthcare’s CAMHS service. CAMHS provides services for young people under 18 when mental health issues get in the way of daily life.

CAMHS young people and staff met the cast, read through scripts, and developed an understanding of what goes into putting on a production, as well as sharing their own insights and experiences.

CAMHS staff also run a stall on show nights with information about CAMHS, additional support services available in Leeds, and ways to maintain good mental health.

Design note: Include the photography from Zoetrope

Efficiency - meeting our legal obligations

We recognise the legal obligations we have as a provider of NHS funded healthcare. We take care to uphold these responsibilities in order to work as efficiently as possible with our partners and within our local community.

Here are some examples of how we do this:

Emergency preparedness and resilience

We continue to fulfil our requirements set out in the Civil Contingencies Act 2004. The requirements ensure that we are able to respond in the best way possible to any form of disruption to normal service or in the case of a major incident.

- Our major incident plan is regularly updated to ensure it is fit for purpose
- We have a dedicated and trained emergency management and on-call team who lead our response to a significant event (This plan and the team are regularly tested through desk-top, situation-based training sessions and communications tests)
- Members of the emergency team, take part in regular multi-agency exercises and events to strengthen and reinforce our ability to contribute as part of a wider multi-agency response to a major incident.
- All our services have business continuity plans in place to protect against the impact a wide range of emergency situations, which may affect normal service delivery.
- We have developed a number of Operational Pressures Escalation Levels (OPEL) plans. These detail the triggers which would prompt escalation both internally and across the local health economy, and the associated actions required to mitigate and manage an incident. These OPEL plans have been developed in conjunction with and are aligned to the OPEL plans of our partner organisations.
- We continue to participate in local, regional and national exercises and events and work closely with partners in key areas to make sure our plans work well within the wider health economy.
- As an active member of the Local Health Resilience Partnership we take part in a number of associated forums and groups along with more local planning-based task groups.

What next?

In 2018/19 we will continue the development of our escalation plans, we will review the plans we have in place for severe weather situations. As part of this review, we aim to introduce Personal Business Continuity Plans for every member of staff. This will make sure that they are personally prepared for disruptive events. The Trust will also prepare for and plan to manage the impact of major regional events, for example the Tour de Yorkshire and World Triathlon.

Health and Safety

We are committed to maintaining an environment where the health and safety of staff, patients, visitors, contractors and the public is assured. This is in accordance with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999)

We have a Trust Board approved Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes.

Health and Safety in the Trust is overseen by the Health and Safety Group, which meets quarterly and is chaired by the Executive Director of Finance and Resources, with membership including staff-side representatives.

The following staff work together to ensure safety standards are met, by conducting a programme of inspections and assessments of all Trust owned or occupied buildings, providing suitable training, and offering advice and support to staff:

- Health and Safety Officer
- Risk Manager
- Security Officer
- Infection Prevention and Control Team
- Estates Team

Reactive monitoring of health and safety data, in particular RIDDOR reports following serious incidents, shows a declining number of serious health and safety incidents occurring and reported to the Health and Safety Executive (HSE) in 2017/18. There were eight events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. The Trust has continued to raise the profile of safety management during the year, and has received reports on progress at the Health and Safety Group. In 2017/18, the HSE did not issue Leeds Community Healthcare NHS Trust with any statutory enforcement notices that require employers to take immediate action to improve health and safety risks.

Fraud

The Trust has a zero tolerance to fraud. We work hard to prevent, deter, detect and investigate fraud. Our counter fraud work is undertaken by a counter fraud specialist from our Internal Audit team and is overseen by the Executive Director of Finance and Resources. Our counter fraud work complies with that required of providers of NHS services.

Disclosure of personal data related incidents

- Incidents calculated to Level 2 or above ***must*** be reported to the Information Commissioner's Office (ICO), through the Health and Social Care Information Centre.
- Criteria for reporting incidents externally to the Trust (Serious Incidents Requiring Investigation – SIRI) were updated in 2015 to include cyber security.

Three incidents have been reported to the Information Commissioner's Office (ICO) under the mandatory reporting requirements. Four incidents were regarding loss of person identifiable information and one regarding inappropriate access of information.

A fact-find has been undertaken in the wake of each incident and process improvements have been actioned, where appropriate, to prevent recurrence.

We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken at source. Low level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support Information Governance (IG) training through the national e-learning programme and ensure staff takes part in annual Information Governance training.

The Trust has a highly developed IG function and framework. It maintains effective links with the Trust's clinical teams through directorate and clinician representative delegates at the Information Governance Group meetings. The Trust's Senior Information Risk Owner (SIRO) (Executive Director of Finance and Resources) and Caldicott Guardian (Executive Medical Director) are members of this group. The group is a sub-group of the Audit Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. The group monitors IG breach incidents, maintaining oversight of breaches, as well as triggering appropriate responses to clusters of low-level incidents.

Risks to data security are managed by ensuring that all staff with access to patient-identifiable data have the requisite access permissions and have completed their compulsory information governance training. All IT equipment is fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' as at 31 March 2017, achieving Level 2 or higher for all IG requirements.

Sustainability Report

As an NHS organisation, and as a spender of public funds, we need to work in a way that has a positive effect on the communities we serve. Sustainability means:

- ✓ Spending public money well
- ✓ Smart and efficient use of natural resources
- ✓ Building healthy, resilient communities.

By making the most of social, environmental and economic assets we can improve health, both now and in the future, even with the rising cost of natural resources. Showing that we consider the social and environmental impact our services have means that we meet the legal requirements set out in the Public Services (Social Value) Act (2012).

We have a Sustainable Development Management Plan (SDMP), the mission statement for this plan is:

" Our Sustainable Development Plan will help us to go the extra mile and deliver quality outcomes such as:

- *Listening*
- *Taking diversity into account*
- *Service efficiencies*
- *Giving back time to staff and patients*
- *Gathering and making best use of feedback from across the board*
- *Improving conditions that surround patients and not just their healthcare need.*

We will do this by working and supporting development across the sustainability spectrum."

The board approved our SDMP so our plans for a sustainable future are well known within the organisation and clearly laid out. This year we are starting to increase promotion of the need and opportunities to recycle or reduce our waste volumes

Performance

Organisation

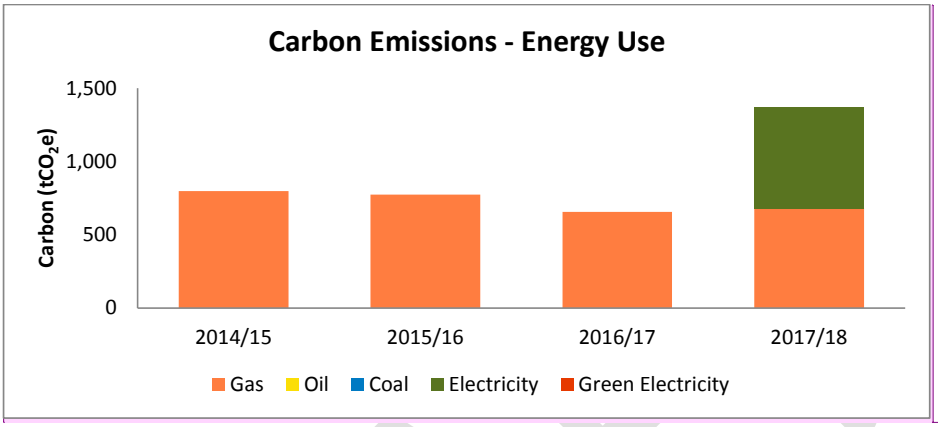
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Here's how both the organisation and its performance on sustainability has changed over time.

	2014/15	2015/16	2016/17	2017/18
Floor Space (m^2)	37,508	39,504	40,558	37,454
Number of Staff	2,497	2,717	2,492	2,480

Energy

Energy use has shown a small reduction, due to less electricity use. Gas use is dominated by weather conditions so the much colder winter this year has increased gas consumption. Energy control systems are in place in all buildings. Currently our

electricity comes from a mix of generating fuel of which renewables are 40%. In previous years this was 100% but changes in the regulatory regime required us to pay more for this type of supply and the financial position of the trust did not permit this.



Comment [JM1]: Graph will be adjusted to reflect previous electricity figures in the final design layout

Travel

Every action counts. We are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel, to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

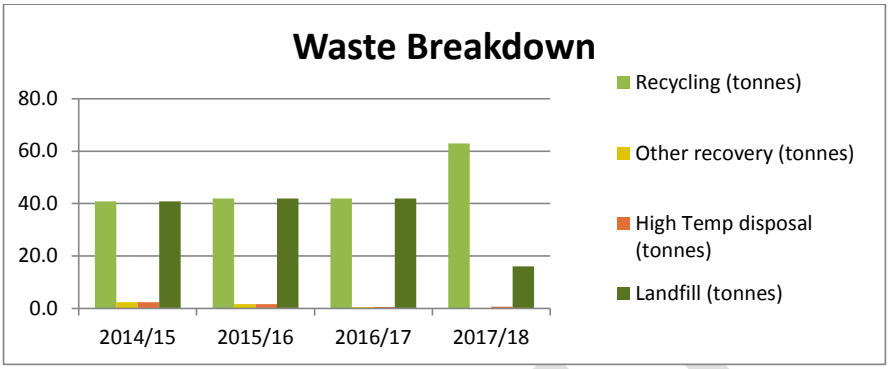
Category	Mode	2014/15	2015/16	2016/17	2017/18
Staff commute	miles	2,398,662	2,609,998	2,394,812	2,382,332
	tCO_2e	881	944	866	849
Business travel and fleet	miles	3,647,112	3,043,042	3,472,501	3,647,106
	tCO_2e	1,340	1,100	1,255	1,247
Total cost of business travel	£	133,045	138,000	142,791	145,000

*Staff commute is a calculated result using National travel Survey data

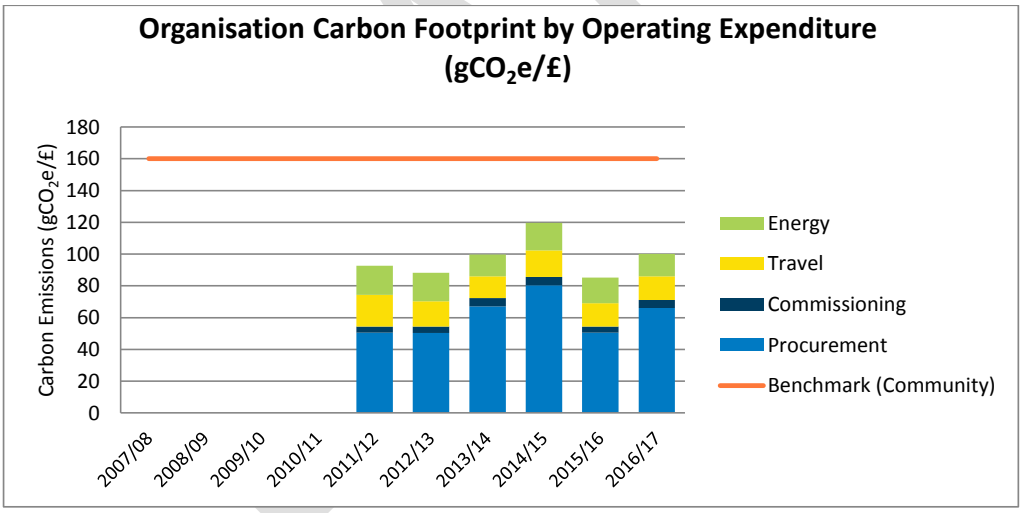
Waste

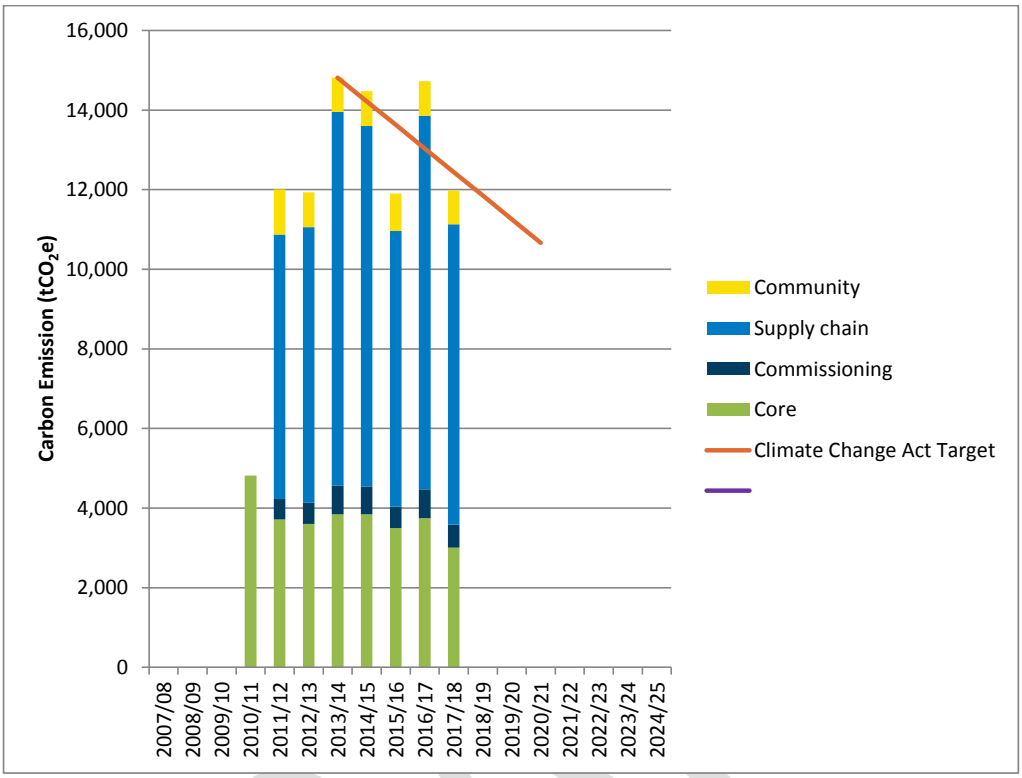
Comment [JM2]: Awaiting updated figures from contractors. Figures appear as an estimate at present.

Waste volumes remain fairly consistent however our main general waste contractor now disposes of waste by burning not landfill hence the change on the chart below.



Overall summary of carbon





Value for Money - Financial performance summary

This is the seventh Annual Report and Accounts of Leeds Community Healthcare NHS Trust and the seventh report on our financial performance. There has been a great deal of consistency about the Trust's financial performance in that, in each and every year, the Trust has achieved its financial targets. This is not achieved by luck, but by the hard work of many, many staff; balancing their desire to continue to provide high quality care within a finite budget that requires further efficiency savings every year.

Most, if not all, NHS organisations continue to face a challenging financial environment. Many will have challenges that are specific to the services they provide or their particular circumstances. In Leeds Community Healthcare a significant proportion of the services that we provide are subject to competitive tendering. The Trust recognises that competitive tendering is one of the options open to our commissioners and, where we believe that we can deliver high quality services within the money available, we will bid to retain those services. However, there is a cost to competitive tendering, not just the cost of bidding but in the

uncertainty it creates for our staff who work in the services subject to tender and the effect on them personally when a service moves to a different provider. During 2017/18 we lost a small number of services, saw a significant tender for Community Dental services aborted for the second time but we were delighted to retain the police custody service across Yorkshire and Humberside. This will put that service on a more secure financial footing from 2018/19.

Target	Target	Performance	Achieved
Planned surplus on income & expenditure	£3,034k	£4,655k	☑
Remain within External Finance Limit	(£2,941k)	(£4,140k)	☑
Remain within Capital Resource Limit	£1,816k	£1,060k	☑
Capital Cost Absorption Rate	3.50%	3.50%	☑
Agency control total	£7,386k	£6,101k	☑
Use of Resources	2	1	☑
Better Payment Practice Code:			
Non NHS invoices (number & value)	95% & 95%	96% & 97%	☑☑
NHS invoices (number & value)	95% & 95%	98% & 99%	☑☑

You may be surprised to see a target income and expenditure surplus of just over £3m and further surprised to see the Trust exceeding that by some £1.6m. The planned surplus of £3m for 2017/18 was required to achieve the "control total" set for the Trust by NHS Improvement. The additional £1.6m surplus resulted from:

- £1.3m as part of a general distribution of the national "Incentive Strategic Transformation Fund (STF)
- £150k additional surplus resulting from underspending a risk reserve held under NHS Improvement rules until the 4th quarter
- £150k matching this sum as a 'bonus' from the STF

The additional funds received from the STF had to be used to increase the Trust's surplus; they do increase the Trust's cash balance which is already healthy and may, in due course, be available for investment in capital assets

The Trust's capital investment strategy continues to be one of aiming to invest all its internally generated capital resources. During 2017/18 the Trust spent just over

£1.4m on communication aids for Speech and Language Therapy patients, the continuing roll-out of our Electronic Patient Record and building refurbishments.

The Trust was delighted to be allocated £13m of capital resources to develop a new in-patient facility for children and young people with mental health needs. Our plans for 2018/19 include the preparation work with a start date for construction early in the new calendar year.

In 2018/19 the Trust expects to deliver a control total of £2.5m agreed with NHS Improvement. Our cost improvement plans for the year have significantly protected front line services but there remain a number of risks, principally around the level of national funding for the 2018/19 pay award and the financial consequences of commissioning decisions by NHS Leeds CCG. This Annual Report will be published nearly half way through the financial year by when we will know the extent to which these risks have materialised. We are proud of our reputation for providing high quality services within our financial resources; we will continue to do all we can to maintain both.

Accountability report
Corporate governance

The Trust Board - What we do and how we do it

Along with all NHS trusts across the country, we have a Board of Directors to guide our work. The purpose of our Board is to govern effectively, and to build patient, public and stakeholder confidence that health and healthcare is in safe hands.

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services
- Accessible and responsive health services
- Public money spent in a way that is fair, efficient, effective and economic
- Being a good employer
- Patient and the public engagement in shaping health services

The Board plays a key role in:

- Shaping the strategy, vision and purpose of the Trust.
- Holding the organisation to account for the delivery of strategy
- Ensuring value for money
- Working to shape a positive culture

The Trust Board has both Executive and Non-Executive Directors. It is a unitary Board, which means that both Executive and Non-Executive Directors share the same liabilities and joint responsibility for every decision of the Board. Led by an independent chair and made up of both executive and independent non-executive members, the Board has collective responsibility for the performance of our organisation.

The Trust's Chair and Chief Executive have led these functions throughout 2017/18.

Here are the people on our Board of Directors:

Design note: Insert Board structure with photos

The Director of Workforce is a non-voting member of the Board.

Changes to the Board

Elaine Taylor-Whilde stepped down as non-executive director during 2017/18 and a replacement non-executive director, Professor Ian Lewis was appointed. Professor Lewis brings considerable clinical and senior management experience, which has already been utilised in chairing the Quality Committee.

Following the secondment of Sue Ellis, Director of Workforce to another NHS post in September 2017, the post of Director of Workforce was being covered by Ann Hobson, Deputy Director of Workforce until the substantive post was filled. The Trust has now successfully recruited a job-sharing role of Director of Workforce, Organisational Development and System Development. Jenny Allen and Laura Smith will be joining the Trust's Management Team on 4 June 2018..

All directors have made a declaration that they comply with the 'fit and proper person test' that was introduced from November 2014, with the exception of one executive director who is currently on temporary leave of absence for health reasons.

Board members have an annual appraisal, which is a thorough review of the assessment of their performance, reflecting on their contribution to the Trust during the year and setting objectives for the coming year.

The Board has continued with its development programme during the year. It has a programme of workshops to support Board members' development, covering such topics as quality improvement, new ways of working, stakeholder engagement and system planning. Both executives and non-executives attend training days and networking events to improve their knowledge base and remain up to date with current NHS matters.

Directors' Interests

Our Director's declare interests that they have in associated businesses or areas of work. These are shown in the following table:

Leeds Community Healthcare NHS Trust
Director's declarations of interests for disclosure 2017/18

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: £100 up to and including 7 November 2017. In excess of £25 from 8 November 2017
Neil Franklin	None	None	None	Board member (acting in an advisory capacity only), Donisthorpe Hall Care Home	Donisthorpe Hall, Care Home	None	None	
Thea Stein	None	None	None	CQC Executive Reviewer	None	None	None	None
Jane Madeley	None	None	None	Chief Financial Officer , University of Leeds	None	None	Any contracts between the University of Leeds, Leeds Faculty of Medicine and Health, Leeds Academic Health Partnership and Leeds Community Healthcare NHS Trust	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: £100 up to and including 7 November 2017. In excess of £25 from 8 November 2017
Tony Dearden	None	None	None	Fee paid Medical Member of First Tier Tribunal (Health, Education and Social Care Chamber), i.e. mental health tribunals. Fellow, Royal College of Psychiatrists.	None	None	None	None
Brodie Clark	None	None	None	Non-executive Director Compass	Compass (services for drug and alcohol misuse)	None	None	None
Richard Gladman	None	None	None	Programme Director, Health & Social Care Information Centre (NHS Digital)	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: £100 up to and including 7 November 2017. In excess of £25 from 8 November 2017
Elaine Taylor-Whilde Until 30 June 2017	CEO, Nine Health Global &Nine Health UK Ltd	Nine Health CIC	None	CEO, Nine Health CIC	Nine Health CIC	None	None	None
Ian Lewis	None	None	None	Trustee: Bone Cancer Research Trust	Occasional teaching/ facilitating for Medical Mediation Foundation	None	None	None
Bryan Machin	None	None	None	None	None	None	None	None
Amanda Thomas	None	None	None	None	None	None	Child Protection Trust Fund co-manager	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: £100 up to and including 7 November 2017. In excess of £25 from 8 November 2017
Phil Ayres- From January 2018	None	None	None	Employed by Leeds Teaching Hospitals NHS Trust	None	None	None	None
Sam Prince	None	None	None	None	None	None	None	None
Marcia Perry	None	None	None	None	None	None	None	None
Sue Ellis* Until 2 October 2017	None	None	None	Governor, Greenhead College, Huddersfield (from 2 October 2015) Seconded fulltime as Programme Director for Health and Social Care Academy, hosted by Leeds Teaching Hospitals from 3/10/2017	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: £100 up to and including 7 November 2017. In excess of £25 from 8 November 2017
Ann Hobson* From 3 October 2017	None	None	None	Husband works for West Yorkshire Police – Leeds Community Healthcare provides health input into West Yorkshire Police Custody Suites	None	None	None	None

***** Non-voting Board member

Board meetings and business in 2017/18

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally six times during the year. At these meetings, the Board takes strategic decisions and monitors the operational performance of the Trust. Any member of the public is welcome to attend the formal meetings; the dates are advertised on the Trust's website. Board meeting agendas, papers, minutes and future dates are posted on the Trust's website. A briefing document is provided to staff following each Board meeting, which provides information from the main agenda items of the meeting.

The Board has also met informally on a further six occasions. These events have taken the form of strategic workshops and have involved a wider group of senior leaders.

In addition, an annual general meeting was held in September 2017.

The quality of care is at the heart of all that the Trust does; the over-arching approach to quality within the Trust is captured within the quality strategy, which is being revised for 2018-2021. The strategy describes an overarching quality objective to strengthen the approach to quality improvement with a focus on understanding data in order to give the necessary assurances on the quality of services. Using this approach the Trust will focus on four priority areas:

- Prevention, proactive care and self-management
- Patient experience and engagement
- New models of care
- Workforce

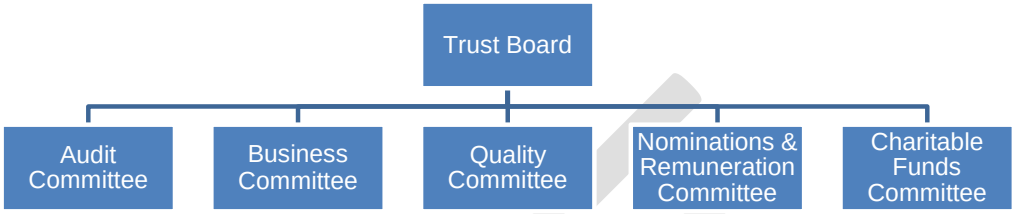
All actions to ensure the Trust provides high quality services are overseen closely by the Board.

The Board receives regular updates on strategic service developments. For example:

- Enhancing integration across primary and secondary health and social care
- Rolling out new ways of working

Our Board receives regular integrated performance reports (the report brings together quality and financial information in one document). Information in the report is aligned to the Care Quality Commission's (CQC) five domains (safe, caring, effective, responsive and well-led).This is the main way the Board assesses that we meet all national and local standards and targets for the services we provide.

The Board's committees (decision making groups)
The Trust has five committees that make sure we carry out our duties effectively, efficiently and economically. These are shown in the organisation chart below.



Details of the functions of each committee can be found in our Annual Governance Statement 2017/18.

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Comment [JM3]: Blue font represents mandated wording and cannot be changed.

Signed.....Chief Executive

Date.....

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

.....Date.....Chief Executive

.....Date.....Finance Director

Leeds Community Healthcare NHS Trust
Annual Governance Statement 2017/18

Scope of responsibility

'As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.'

Thea Stein

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Community Healthcare Trust NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust recognises that it is operating in a healthcare environment where patient safety, quality of care and service sustainability are paramount and are of mutual benefit to stakeholders and the organisation alike. The Trust manages clinical risks (i.e. risks to individual patients through clinical activity) and financial and business risks (i.e. risks that threaten the achievement of statutory financial duties or the safeguarding of the Trust's assets) in order to deliver its objectives in a controlled manner. Subject to controls and assurances being in place, and in line with the Trust's risk appetite statement, the Trust accepts manageable risks, but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Risk management is embedded within the culture of the organisation from risk assessment in clinical practice to the consideration of risk underpinning the Board's decisions. Risks are identified and aligned to strategic objectives. The level at which risk is escalated is clearly set out in the Risk Management Policy and Procedure.

The Trust employs a qualified risk manager who delivers risk management training, coordinated the risk register and the board assurance framework and provides support and direction in all risk management related matters.

Members of staff receive information and are briefed on risk management procedures as part of the induction process. Managers are trained in risk management procedures both as part of the induction process and as part of ongoing training, coaching and support. All training includes the Trust's risk appetite and how this should be applied in decision-making processes.

The Trust has a quarterly risk management newsletter to share lessons that can be learned from incidents and complaints, the latest information about risk management, training courses available and examples of good practice across the Trust. A 'lessons learned' portal has recently been developed on the Trust's intranet, for managers to share information about incidents and improvement.

The Trust has recently completed a risk management 'health check', which surveyed service managers and clinical leads to check their knowledge of risk management policy and procedure. Overall, the response was positive. It was found that managers are generally aware of and proficient in risk management. Where scope for improvement has been identified, actions to remedy these have now been put in place.

The risk and control framework

The Trust's risk management policy: defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The risk management procedure*:* supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk. The Trust has systems in place that contribute to the identification of risk from a number of sources; the following are examples:

- Review of performance and working practice
- Clinical practice

- Legislation, national policy and guidance
- Risk assessments
- Incident reports
- Complaints
- Claims
- Audit and work place surveys
- Patient satisfaction surveys
- External/internal audits
- Regulators' inspections and reports

Any of the above can inform the risk assessment process and therefore the population of the Trust's risk register. Risks are identified in a proactive way, for example: changes or introduction of new processes, new equipment, different ways of working etc will initiate a risk assessment. In addition, individual staff may identify risks whilst carrying out their duties or risks may be identified through discussions in team meetings etc.

The risk management policy and procedure is supported by content contained in the Trust intranet in a bespoke risk management webpage, and is available to all directors, SMT, service managers, clinical leads and staff-side representatives.

The risk register: is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The electronic risk management system used by this Trust to record and monitor risks is 'Datix'. The risk register contains in summary: a description of the risk, the risk owner, any controls in currently in place, actions to be completed, and the initial, current and target risk scores. Risk register extracts from Datix are frequently drawn to allow for scrutiny of risk by appropriate managers, committees and the Board.

The Trust's risk appetite: is aligned with its four strategic aims. Trust Board determines its appetite for risk and the senior management team review the trust's risk appetite on an annual basis. The risk appetite statement is appended to the risk management policy and procedure, which is on the Trust's internal website.

Data security risk: is managed through a system of general managers and heads of service that act as information asset owners and work with the Senior Information Risk Owner to manage data security and other information related risks.

In 2017, the Trust took part in the annual national digital maturity (DMI) review. Areas demonstrating the greatest progress since the 2016 are those that the Trust has made specific investments in, namely EPR and business intelligence. The continued delivery of the Trust's digital strategy will bring about a number of improvements and continues to make positive progress towards digital maturity.

Governance structures and accountability

Trust Board (Chair: Neil Franklin)

The Board leads the Trust by undertaking three main roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the wider Trust

The Board consists of six non-executive directors (including the Chair), and five executive directors. In addition, there is one non-voting member of the Board.

There is a clear division of responsibilities between the Chair and Chief Executive. The Trust's Chair and Chief Executive have discharged their leadership functions throughout the whole of 2017/18.

The Director of Workforce is a non-voting member of the Board.

The Board has met on thirteen occasions in 2017/18; this has comprised six formal meetings held in public, six informal meetings or strategic workshops plus an annual general meeting. Attendance at Board meetings has been good and all meetings have been quorate.

The quality of services remains the Trust's first priority and, to this end, the Board's agenda features reports reflecting key quality matters. Information presented to the Board provides essential assurance. Board meetings have received papers on the Trust's quality strategy, patient experience topics and the maintenance of safe staffing levels. The Board's non-executive directors conduct regular visits to frontline services.

The Board has standing orders, a scheme of reservation and delegation of powers and standing financial instructions. These provide a governance framework that enables the organisation to demonstrate it is well governed and that it meets requirements of corporate governance codes of practice.

The Board has an annual work plan, which demonstrates the scheduling of required and discretionary business. The five Board committees all have terms of reference and work plans all of which have been reviewed during 2017/18.

The Trust's Board receives a performance brief and a suite of reports aligned to the five Care Quality Commission (CQC) domains. This is the primary mechanism for assessing compliance with national and local targets. The performance brief brings quality and financial information together in one report.

The Trust's Board receives regular updates on strategic service developments, for example work to enhance integration across primary and secondary health care and social care and the introduction of new ways of working.

The Board receives and considers extracts from the risk register and the board assurance framework at each meeting to gain assurance as to the effective management of risk in the organisation. Through these arrangements, the Board receives timely information about existing and potential risks to the Trust.

The Board also receives minutes and assurance reports from each of its committees at Board meetings.

The Board wishes to assure itself that it operates effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance, in doing so, it is mindful of the best practice contained within codes of governance.

The Trust Board and committees undertake an annual self-assessment against elements of the NHS Improvement Well-Led Framework and has drawn out a number of priorities to enhance the effectiveness of elements of the Trust's governance. The results being reported to the Board and are contained in committees' annual reports. The committees' chairs' also meet collectively to discuss committees' effectiveness.

The Trust has a needs-based Board development programme. A feature of which is a series of Board workshops taking place every two months (six events in 2017/18); senior leaders from corporate services and business units (including clinical leads) also participate in these sessions.

The individual performance of all Board members is reviewed through a formal appraisal process and any individual development needs are identified and supported.

The Trust's Board has appointed five committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically. These are detailed below.

Audit Committee (Chair: Jane Madeley)

The Committee comprises three non-executive directors. The Chair of the Committee is a qualified accountant and is a Chief Financial Officer in the higher education sector. The Executive Director of Finance and Resources, the Company Secretary, the Internal Auditor and the External Auditor attend on a routine basis. The Audit Committee met formally six times during 2017/18.

The Audit Committee provides an overarching governance role and reviews the work of the other committees, whose work can provide relevant assurance to the Audit Committee's own scope of work.

During the year, the Committee has received regular reports on progress from internal audit, external audit, the local counter fraud specialist, the security management service and from information governance specialists.

The Committee has considered a range of financial control reports and a number of governance papers, and has oversight of the board assurance framework, which it reviewed twice in full during the year.

The Committee has pursued evidence of compliance with data security requirements and received regular reports concerning data security, including information about the status of serious information governance incidents reported to the Information Commissioner's Office (ICO).

The chair of each of the Board's committees produced an annual report, which provides assurance to the Audit Committee on how each committee has met its terms of reference during the year. The committees also undertook a self-assessment exercise, which was reviewed by the Audit Committee. The committees' chairs also met to discuss the outcome.

Quality Committee (Chair: Doctor Tony Dearden until December 2017, Professor Ian Lewis from January 2018)

The Quality Committee's membership comprises the Trust's Chair, two non-executive directors, the Chief Executive and two executive directors; a number of other senior officers attend each meeting. The Committee met on 10 occasions in 2017/18.

The Committee provides assurance to the Board that high standards of care are provided by the Trust and that adequate and appropriate quality governance structures, processes and controls are in place to:

- Promote quality, in particular safety and excellence in patient care
- Identify, prioritise and manage clinical risk and assure the Board that risks and issues are being managed in a controlled and timely manner

- Ensure effective evidence-based clinical practice
- Produce the annual Quality Account and monitor progress

The Committee exercises these functions in the context of the Trust's quality strategy. The strategy provides an overarching framework for quality within the Trust and sets out a programme of work to achieve four key objectives and seven action areas focused on patient safety, clinical effectiveness and patient experience. The Committee has received an update on a quarterly basis and has sought assurance about the implementation of specific actions. The Committee has recently received and reviewed the new quality strategy for 2018-2021.

Within that strategic framework, the Quality Committee and the Board monitors serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's incident and serious incident management policy.

Business Committee (Chair: Brodie Clark)

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives; other senior officers attend as required. The Business Committee held 10 meetings in 2017/18.

The Committee provides assurance to the Board on the financial and performance management processes within the organisation, including monitoring the delivery of the Trust's business plan and oversight of significant projects.

The Committee oversees business and commercial developments and makes investment decisions in line with the scheme of delegation and the Trust's investment policy and ensures that the Board has a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

The Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance. There has been consideration of recruitment and retention initiatives, sickness absence management and leadership approaches.

The committee has assumed an extended role in terms of oversight of the Trust's main projects. At each meeting, the Committee receives an in-depth report on one aspect of the Trust's business or one area of project work for example the review of patient administration services across the Trust, which aims to provide a modern and consistent service that makes best use of digital approaches.

Nominations and Remuneration Committee (Chair: Neil Franklin)

The Nominations and Remuneration Committee's membership comprises the Chair and two further non-executive directors; the Committee is supported by the Director of Workforce. The Committee has met three times in 2017/18.

The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, executive directors, directors and any senior managers not covered by national Agenda for Change terms and conditions of employment.

Charitable Funds Committee (Chair: Brodie Clark)

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director; the Committee is supported by the Executive Director of Nursing. The Committee has held three meetings during 2017/18.

The purpose of the committee is to give assurance to the Board that the Trust's charitable activities are discharged within the law and regulations set by the Charity Commissioners for England and Wales. The Committee oversees charitable activities, approves charitable funds expenditure, agrees an investment policy for charitable funds and monitors investments on a regular basis.

Principal risks

There are seventeen strategic risks aligned to the Trust's four strategic goals, which are grouped into four strategic risk 'clusters':

- Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
- Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
- Failure to engage and empower the Trust's workforce and the ability to recruit, retain and develop staff
- Failure to maintain a viable and sustainable organisation

The Board Assurance Framework (BAF) records: risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans have been identified and the BAF was revised during 2017, in line with the Trust's annual plan. These risks are assigned to a lead executive to manage. Each of these strategic risks is also assigned to one of the Board's committees for oversight and scrutiny.

The BAF was reviewed in 2017/18 by the Trust's internal auditors. The internal auditors have confirmed that the BAF will support the Trust's overall risk management framework.

Scrutiny of risks

The Risk Review Group meets quarterly to review new risks that have been added to the risk register. They also review escalated and deescalated risks and risks that have recently been closed. The group acts as a moderator for risk grading, ensuring appropriate ownership of the risk and ensuring that effective management of the risk is being recorded. The group also maintains an oversight of the practical application of the risk management procedure.

The Board receives a significant risks and risk assurance report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures. It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The report also includes the BAF summary advising the Board of the current assurance level determined for each of the Trust's strategic risks. The Senior Management Team reviews the significant risks and risk assurance report on a monthly basis. The Quality Committee reviews in more detail the clinical and operational risks and the Business Committee reviews non-clinical risks, rated as high.

Assurance of risk mitigation is provided to the Board through the Senior Management Team, and through the Quality and Business Committees in relation to clinical and non-clinical risks. The Audit Committee assures the risk management process.

Together, these mechanisms allow for the appropriate identification, monitoring, control and mitigation of risks, which may have an impact on the Trust's objectives.

Incident reporting

The Trust has a strong, open incident reporting culture and is therefore a high reporter of incidents when compared to similar organisations. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and training and regular communications. Learning from incidents is shared with staff through the Trust's quarterly risk management newsletter, at staff forums and new to 2017 is a learning resource on the Trust's internal website for all staff to access, which has been developed to share anonymised, learning from incidents across the organisation. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Serious incidents are reported and managed in accordance with the Trust's incident and serious incident policy. The majority of managers have had serious

incident investigation training and the Trust has a good record of reporting incidents in a timely way to NHS Improvement and to commissioners.

CQC compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust received a CQC inspection in the fourth quarter of 2016/17 and the report arising from the inspection was received by the Trust in mid-2017. The Trust received an overall rating of 'Good'. The CQC described the Trust as having 'stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these. Leaders were visible and accessible'. Following receipt of the CQC report, a quality improvement plan was produced and is monitored by the Quality Committee at each meeting.

NHS pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Carbon reduction delivery plans

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that plan is adhered to. The Trust has consistently met the financial targets set by regulators. The Business Committee also receives an annual report on the Trust's reference costs, which are an indicator of the Trust's efficiency in delivering its services. Over time the Trust's overall reference cost have fallen from a maximum of 111 in 2011/12 to 97 (including IAPT) in 2016/17.

As part of the internal audit cycle, the auditors, TIAA, review the Trust's approach to delivering cost improvement targets; the last report was completed in 2017/18.

The Audit Committee reviews all internal audit reports and monitors the Trust's implementation of any recommendations. Annually the Trust's external auditors are required to provide a Value for Money conclusion. In the last report available, for 2016/17 the auditors concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. The effectiveness of the Trust's services are assessed monthly by the Trust's Quality Committee and bi-monthly by the Board.

Information governance

The Trust recognises that information is an important asset, supporting both clinical and management needs and is fully committed to ensuring that personal information is protected and used appropriately. The Trust has submitted a self-assessed score of level two for the information governance toolkit.

The Trust's information governance group develops relevant policies and strategies to control data security and other information related risks. As a community trust, sharing information has been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced the risk of data loss through the use of mobile devices. The Trust has been reviewing and revising its information governance policies and procedures to ensure compliance with the General Data Protection Regulation (in force from May 2018).

In recognition of the importance of data security, the Trust has a target of 95% of staff compliance with information governance training. Training compliance is fully monitored, and attendance is enforced where necessary.

Three incidents were reported to the Information Commissioner's Office (ICO) by the Trust during 2017/18:

Case 1 - Loss of nine staff files containing personal information. Trust reported loss to the ICO. Outcome from ICO was no further action required.

Case 2 – As part of a service tender process, a list containing details of 4000 Trust staff was sent to the service's commissioner, when only the details of staff potentially affected involved in the tender process should have been sent. Outcome from ICO was no further action required.

Case 3 – A member of staff using a system managed by another NHS trust to access a patient's notes without a legitimate reason and without consent. They shared the information with a person known to the patient. The member of staff no

longer works for the Trust. A complaint was made to the ICO, who are considering their response.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

LCH ensures that the Quality Accounts are collaborative and that services understand the potential reach and impact of the Quality Accounts.

The Trust found ways of engaging with more service users to get their input and stories to demonstrate successes and failures in context, to provide a balanced view. In particular, focus was on engagement with patients who are elderly and infirm and often housebound. The Trust strives to make the Quality Account accessible and relevant to all the communities it serves.

The Quality Account priorities have been developed in conjunction with the services and disseminated to senior managers to ensure that the priorities are aligned to both the Quality Strategy and the Trust's business objectives.

Data accuracy

The Trust reports monthly on its performance against national key performance indicators in line with NHS Improvement's Single Oversight Framework and other indicators as contained within contracts with commissioners.

The Trust works to evidence good standards of data quality and accuracy in its performance reporting and is confident that key national indicators eg waiting times are accurate.

In order to ensure that data provided for elective waiting times is accurate, a weekly report is downloaded by the Business Intelligence Team, which identifies any potential patient breaches. This report is reviewed and validated in the consultant-led services, where explanations are provided against any patients who are listed on the report with a waiting time over 17 weeks. The validator is required to update the patient record where an error has been made. The updated validations form the basis for the figures submitted to NHS Improvement and NHS England.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework. I have

drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of internal auditors, the comments made by external auditors in the ISA260 report, the continuing engagement of the Audit Committee, managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. The Audit Committee undertakes a role in terms of providing assurance to the Chief Executive.

Internal audit

TIAA Limited has been the provider of internal audit services since 1 April 2015. This contract was recently reviewed and has been renewed. TIAA carried out 22 reviews in 2017/18, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review, an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. The Head of Internal Audit has provided an overall opinion which concludes that, based on the work undertaken in 2017/18, reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives. No emerging risks have been identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

In areas reviewed by internal audit where it was assessed that the effectiveness of internal control arrangements provided less than 'substantial' assurance, recommendations were made to further strengthen the control environment. There were three areas reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited' assurance. Resultant management actions, which are monitored by the Audit Committee, have been completed or are being progressed in a satisfactory manner.

The Board commissioned an internal audit of Board and Committee effectiveness during 2017/18. The audit assessment provided reasonable assurance having found no material concerns, but outlined opportunities to advance governance arrangements.

Clinical audit

Clinical audit is vital to the quality and effectiveness of clinical services and is a fundamental part of the quality improvement process. It plays a pivotal role in providing assurances about the quality of services. Findings from clinical audit are used to ensure that action is taken to protect patients from risks associated with unsafe care, treatment and support.

Clinical audit is managed at service level with the support of the quality and professional development directorate. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the course of the year. The 2017/18 programme comprised of 33 mandatory audits, 40 recommended audits and a further 44 audits which had been determined locally.

NHS Improvement oversight

NHS Improvement has assigned the Trust a segment rating of '2'; this indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

The Trust works with a range of regulators including the CQC, HM Inspectorate of Prisons, and Ofsted. The Trust is fully compliant with the registration requirements of the CQC. During late 2016/17, the Trust was involved in an inspection by the CQC, which particularly focused on inpatient care, adult services, sexual health services and a Trust-wide review of the well-led domain and has since received an overall rating of 'Good'.

Conclusion

During 2017/18, no significant control issues have been identified by the Trust's systems of internal control.

The Trust is a well-established health care provider that has built a system of internal control based on sound foundations. The Trust has a strong safety culture and sees quality of care as the primary objective. Ongoing scrutiny enhances learning and strengthens governance.

The annual governance statement shows that the Trust has the necessary control arrangements in place to manage risks and take action when incidents occur.

Strong financial control and the achievement of statutory financial duties support the view that, clinically and financially, the Trust has effective and improving systems in place.

Signed……..

Chief Executive Date: xx May 2018

Remuneration and staff report

Policy on senior managers' contracts

The table below provides details on the contracts for each senior manager who has been employed during the year. The contracts do not make any specific provisions for compensation for early termination in addition to the notice periods.

Name and Title	Contract date	Date of Expiry	Notice period
Susan Ellis Director of Workforce Ann Hobson Interim Director of Workforce	23 January 2012 1 October 2017	External secondment from 2 October 2017 No end date	6 months 3 months
Bryan Machin Executive Director of Finance and Resources	9 May 2011	No end date	6 months
Marcia Perry Executive (Nurse) Director of Quality from 10/08/05	10 August 2015	No end date	6 months
Samantha Prince Executive Director of Operations	4 July 2011	No end date	6 months
Thea Stein Chief Executive	1 October 2014	No end date	6 months
Dr Amanda Thomas Executive Medical Director D Phil Ayres Interim Medical Director	5 September 2011 Internal secondment from LTHT 1 January 2018 and then employed by LCH from 9 April 2018	No end date 31 May 2018	6 months

Payments to past senior managers (subject to audit)

We have not made any awards to past senior managers in addition to the remuneration disclosed later in this report

The Trust can confirm:

- There were no performance related payments made to senior managers in 2017/18.
- There were no senior managers service contracts awarded during 2017/18.
- There were no payments to past senior managers during 2017/18.
- There were no payments for loss of office during 2017/18.

There was no senior off-payroll engagement during 2017/18.

Number of individuals that have been deemed 'Board members, and / or senior officers with significant financial responsibility' during the financial year. This figure includes off payroll and on-payroll engagement	15

Senior Manager Remuneration Report (subject to audit)

	2017 / 18						2016 / 17					
Name and title	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s
Dr Phil Ayers - Interim Executive Medical Director	35 - 40					35 - 40						
Brodie Clark – Non-Executive Director	5 - 10	0.7				5 - 10	5 - 10	0.8				5 - 10
Dr Tony Dearden – Non-Executive Director	5 - 10	0.4				5 - 10	5 - 10	0.5				5 - 10
Susan Ellis – Director of Workforce (until 01/10/2017)	45 - 50				7.5 - 10	50 - 55	90 - 95				30 - 32.5	120 - 125
Neil Franklin – Chair	20 - 25	0.4				20 - 25	20 - 25	0.6				20 - 25
Emma Fraser – Director of Strategy and Planning (until 31/07/2016)							15 - 20		0 - 5		0 - 2.5	20 - 25

Richard Gladman - Non-Executive Director (from 01/04/2016)	5 - 10					5 - 10	5 - 10					5 - 10
Ann Hobson - Interim Director of Workforce (from 02/10/2017)	40 - 45					40 - 45						
Ian Lewis - Non-Executive Director (from 01/07/2017)	0 - 5					0 - 5						
Bryan Machin – Executive Director of Finance and Resources	115 - 120	0.1				115 - 120	110 - 115	0.1			52.5 - 55	165 - 170
Jane Madeley – Non-Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Paul Morrin – Director of Integration, Adult Health and Social Care (until 01/06/2016)							10 - 15		0 - 5		0 - 2.5	15 - 20
Marcia Perry - Executive (Nurse) Director of Quality	90 - 95	0.1			5 - 7.5	95 - 100	90 - 95	0.1			42.5-45	135-140
Samantha Prince – Executive Director of Operations	95 - 100	0.1			15 - 17.5	110 - 115	95 - 100	0.1			30 - 32.5	125 - 130
Thea Stein – Chief Executive	140 - 145	0.1				140 - 145	140 - 145	0.1				140 - 145
Elaine Taylor-Whilde - Non-Executive Director (from 01/04/16 until 30/06/2017)	0 - 5					0 - 5	5 - 10	1.0				5 - 10
Dr Amanda Thomas – Executive Medical Director	95 - 100		60 - 65			155 - 160	95 - 100		75 - 80			170 - 175

Pension details for senior managers (subject to audit)

	2017/18						
Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2018 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000
Dr Phil Ayers - Interim Executive Medical Director	0	0	0	0	0	0	0
Susan Ellis - Director of Workforce (to 01/10/2017)	0 - 2.5	0 - 2.5	40 - 45	130 - 135	956	34	1,039
Emma Fraser - Director of Strategy and Planning (to 31/07/16)	0	0	0	0	214	0	0
Ann Hobson - Interim Director of Workforce (from 02/10/2017)			25 - 30	75 - 80			527
Bryan Machin - Executive Director of Finance and Resources*	0	0	0	0	873	0	0
Marcia Perry - Executive (Nurse) Director of Quality	0 - 2.5	0 - 2.5	35 - 40	105 -110	588	43	649
Samantha Prince - Executive Director of Operations	0 - 2.5	0	35 - 40	90 - 95	558	36	613
Paul Morrin - Director of Integration, Adult Health and Social Care (to 1/06/16)*	0	0	0	0	0	0	0
Thea Stein - Chief Executive*	0	0	0	0	0	0	0
Dr Amanda Thomas - Executive Medical Director*	0	0	0	0	0	0	0

* Individual ceased to be a member of the scheme before the start of the financial year

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with Statutory Instrument number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Fair pay disclosures (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director for the Trust in the financial year 2017/18 was £159,144 (2016/17, £173,181). This was 5.5 (2016/17, 6.1) times the median remuneration of the workforce, which was £28,746 (2016/17 £28,211). The multiple is the less than last year as the highest paid director has reduced the number of clinical sessions undertaken.

In 2017/18 total remuneration ranged from £16,523 to £170,527, (2016/17, £15,251 to £173,181). Two medical staff employees were paid more than the highest paid director.

Total remuneration includes salary, non-consolidated performance related pay, clinical excellence awards and on-call payments and benefits-in-kind. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

Staff costs and numbers including senior officers (subject to audit)

Staff costs	2017/18 Permanent £k	2017/18 Other £k	2017/18 Total £k	2016/17 Total £k
Salaries and wages	77,108	2,584	79,692	79,478
Social security costs	7,353	0	7,353	7,586
Apprenticeship levy	373	0	373	0
Employer's contributions to NHS pensions	9,991	0	9,991	10,186
Pension cost - other	13	0	13	15
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	265	0	265	702
Temporary staff	0	6,226	6,226	8,377
Total gross staff costs (including seconded out)	**95,103**	**8,810**	**103,913**	**106,344**
Of which:				
Costs capitalised as part of assets	157	125	282	275

Average staff numbers in post by occupation groupings.

Average number of employees (WTE basis)	2017/18 Permanent Number	2017/18 Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	53	28	81	84
Administration and estates *	628	83	711	742
Healthcare assistants and other support staff	466	40	506	540
Nursing, midwifery and health visiting staff *	877	46	923	957
Nursing, midwifery and health visiting learners	3	0	3	9
Scientific, therapeutic and technical staff	429	31	460	470
Healthcare science staff	1	0	1	1
Other	28	1	29	27
Total average numbers	**2,485**	**229**	**2,714**	**2,830**
Of which:				
Number of employees (WTE) engaged on capital projects	4	2	6	5

* The 2016/17 average staff numbers for administration and estates have been by increased by 23 to reflect a classification change for some staff that had previously been reported as qualified nurses. These have leadership roles within adult services and have been re-classified as managers in 2017/18. The adjustment has been made to facilitate comparisons between the two years.

On average there was 116 whole time equivalent less staff in post in 2017/18; 89 of these posts relate to services such as Family Nurse Partnership, Healthy Living,

York Street, South Leeds Independence Centre, Community Intermediate Care Unit and Neonatal Hearing that the Trust has ceased to provide in 2017/18.

Expenditure on consultancy

The Trust had no expenditure on consultancy services during 2017/18.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2018	21
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	5
For between three and four years at the time of reporting	15
For four or more years at the time of reporting	0

All of the existing engagements have contractual clauses to request assurance on tax status.

For all new off-payroll engagements or those that reached six months in durations between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the year	0

Exit Packages

The figures reported here relate to exit packages agreed in year. The actual date of departure might be in a subsequent period, and the expense in relation to departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost expenditure in the accounts.

Exit Package cost band (including any special payment element)	Total number of compulsory redundancies	Total cost of compulsory redundancies	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s
Less than £10,000	4	24,541	0	0
£10,000 - £25,000	0	0	0	0
£25,001 - £50,000	1	30,000	0	0
Totals	**5**	**54,541**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirements are met by the NHS Pensions Scheme and are not included in the table. There were no other departures during 2017/18.

Staff Sickness

The table below illustrates a total number of days lost through sickness absence across the calendar year. These figures are supplied to the Trust by the Department of Health. This is to make sure a standard approach is taken and so that figures can be compared across NHS organisations.

	Calendar Year	
	2017	2016
Total days lost	32,038	34,140
Total staff years	2,485	2,634
Average working days lost	13	13

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Financial Statements (Full accounts and notes to be appended after Audit)

Agenda item 7b

Leeds Community Healthcare NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	142,243	141,955
Other operating income	4	7,283	6,699
Operating expenses	6, 8	(144,623)	(144,597)
Operating surplus / (deficit) from continuing operations		**4,903**	**4,057**
Finance income	11	70	43
Finance expenses	12	-	-
PDC dividends payable		(488)	(706)
Net finance costs		**(418)**	**(663)**
Other gains / (losses)	13	(46)	(48)
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**4,439**	**3,346**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**-**	**-**
Surplus / (deficit) for the year		**4,439**	**3,346**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(574)	-
Revaluations	18	3,428	-
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset		-	-
Other reserve movements		43	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available for sale financial investments	13	-	-
Recycling gains / (losses) on available for sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	-
Total comprehensive income / (expense) for the period		**7,336**	**3,346**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	53	76
Property, plant and equipment	16	29,310	27,144
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Trade and other receivables	24	-	-
Other assets	25	-	-
Total non-current assets		**29,363**	**27,220**
Current assets			
Inventories	23	-	-
Trade and other receivables	24	8,849	6,209
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets held for sale / assets in disposal groups	26	-	165
Cash and cash equivalents	27	23,244	19,104
Total current assets		**32,093**	**25,478**
Current liabilities			
Trade and other payables	28	(11,029)	(9,757)
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	(1,361)	(1,398)
Other liabilities	30	(1,042)	(855)
Liabilities in disposal groups	26.1	-	-
Total current liabilities		**(13,432)**	**(12,010)**
Total assets less current liabilities		**48,024**	**40,688**
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	-	-
Other liabilities	30	-	-
Total non-current liabilities		**-**	**-**
Total assets employed		**48,024**	**40,688**
Financed by			
Public dividend capital		256	256
Revaluation reserve		12,032	9,496
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		35,736	30,936
Total taxpayers' equity		**48,024**	**40,688**

The notes on pages 7 to 48 form part of these accounts.

Name

Position

Date **25 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**
Surplus / (deficit) for the year	-	-	-	-	-	4,439	**4,439**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(574)	-	-	-	-	**(574)**
Revaluations	-	3,428	-	-	-	-	**3,428**
Transfer to retained earnings on disposal of assets	-	(361)	-	-	-	361	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Recycling gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Foreign exchange gains / (losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability / asset	-	-	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	43	-	-	-	-	**43**
Taxpayers' equity at 31 March 2018	**256**	**12,032**	**-**	**-**	**-**	**35,736**	**48,024**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**256**	**9,525**	**-**	**-**	**-**	**27,561**	**37,342**
Surplus / (deficit) for the year	-	-	-	-	-	3,346	**3,346**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	(29)	-	-	-	29	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Recycling gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Foreign exchange gains / (losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability / asset	-	-	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Other reserves
The Trust does not hold an available for sale investment reserve, a merger reserve or any other reserves.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,903	4,057
Non-cash income and expense:			
Depreciation and amortisation	6.1	1,724	1,565
Net impairments	7	212	-
Income recognised in respect of capital donations	4	-	-
Amortisation of PFI deferred credit		-	-
Non-cash movements in on SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(2,331)	(91)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilities		1,637	(3,492)
Increase / (decrease) in provisions		(37)	(29)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		52	-
Net cash generated from / (used in) operating activities		**6,160**	**2,010**
Cash flows from investing activities			
Interest received		70	43
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(1)	(46)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(1,628)	(1,338)
Sales of property, plant, equipment and investment property		348	36
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions / disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(1,211)**	**(1,305)**
Cash flows from financing activities			
Public dividend capital received		-	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		(809)	(675)
Financing cash flows of discontinued operations		-	-
Cash flows from / used in other financing activities		-	-
Net cash generated from / (used in) financing activities		**(809)**	**(675)**
Increase / (decrease) in cash and cash equivalents		**4,140**	**30**
Cash and cash equivalents at 1 April - brought forward		**19,104**	**19,074**
Cash and cash equivalents transferred under absorption accounting	41	**-**	**-**
Unrealised gains / (losses) on foreign exchange		**-**	**-**
Cash and cash equivalents at 31 March	27.1	**23,244**	**19,104**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The going concern concept was reviewed by the Trust's Audit Committee at its meeting on 16 March 2018.

In considering whether the Trust is a going concern the following areas were reviewed:

The Trust’s financial monitoring throughout 2017/18 provides evidence that financial duties and targets will be met or exceeded. The Trust will achieve the control total set by NHS Improvement. Historically, the Trust has achieved all its financial duties.

The Trust’s financial performance is monitored externally by NHS Improvement through monthly reporting and regular meetings. Internally, the Trust’s financial performance has been monitored monthly by the Senior Management Team and the Business Committee and by the Board at each meeting.

The Trust has reported a use of resources risk rating of 1 since it was introduced in October 2016. A rating of 1 represents the lowest risk rating for provider organisations.

The Trust’s draft financial plan for 2018/19 demonstrates delivery of the Board approved surplus; for 2017/18 the Trust will achieve the NHS Improvement control total, for 2018/19 the plans demonstrate achievement of the control total surplus.

The Trust has low levels of outstanding debt; the majority of the contract income is paid in month.

The Trust’s liquidity remains very strong with £23.2m in the bank at the year end. The financial plan demonstrates the Trust has sufficient cash resources to meet its operational and capital investment commitments for 2018/19.

The Board of Directors is a stable and experienced team. The vacant Director of Workforce has been covered on an interim basis whilst substantive recruitment is undertaken and arrangements are in place for an experienced local consultant to temporarily cover the Medical Director role. A new Non-Executive Director was appointed in year to strengthen clinical input into the Board decision making.

The Board has considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

With the introduction of IFRS 16 the Trust has the responsibility for ensuring the carrying value of its fixed assets reported in the Statement of Financial Position is up to date. The Trust has taken advice from the District Valuers Office, an independent expert body, on the movement in building and land values since the last full valuation was undertaken in 2014/15. The movement in the value was greater than the Trust's threshold of 10%; therefore a full revaluation of the land and buildings has been undertaken during 2017/18. This resulted in asset values increasing by £2,642k, write back of depreciation of £1,454k and a net impairment of £212k.

Note 1.2.1 Sources of estimation uncertainty
An estimate of the redundancy costs has been made and included in the Trust's expenditure for 2017/18 as required under IAS 37. The estimated value of redundancies provided for is £1,028k.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The Trust provides sexual health services under a joint operation with Leeds Teaching Hospitals NHS Trust. As lead provider the contract income flows to the Trust, and Leeds Teaching Hospitals NHS Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to Leeds Teaching Hospitals NHS Trust.

The Trust provides forensic child and adolescent mental and physical health services under a joint operation with South West Yorkshire Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust, and South West Yorkshire Partnership NHS Foundation Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to South West Yorkshire Partnership NHS Foundation Trust.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Income from Clinical Commissioning Groups totalled £104,059k or 70% of the total income received by the Trust. £28,444k or 19% of the Trust's income was from Local Authorities. All income is reported under a single operating segment.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust operates an alternative mandatory scheme, National Employment Savings Trust, for employees who do not qualify for or choose not to become a member of the NHS Pension Scheme.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has a cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are subsequently measured at their current value in existing use. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the Trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
• the sale must be highly probable ie:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
The Trust has no Private Finance Initiative or Local Improvement Finance Trust transactions.

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	87
Dwellings	-	-
Plant & machinery	5	10
Transport equipment	-	-
Information technology	5	5
Furniture & fittings	10	10

Where material refurbishment schemes have taken place the asset lives have been reviewed and amended as appropriate.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	5	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

The Trust has no inventories.

Note 1.10 Investment properties

The Trust has no investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment Scheme (CRC)

The Trust does not contribute to the Carbon Reduction Commitment Scheme.

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets and financial liabilities at fair value through income and expenditure are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The Trust has made provision for the impairment of non-NHS receivables in excess of 90 days overdue. The Trust regularly reviews aged debts and makes referrals to a debt collection agency. Where advice from the collection agency indicates recovery is unlikely the debt is written off. Where a payment schedule is in place these debts are recovered over a longer time period.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance expenses in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 33.1 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
(iii) any PDC dividend balance receivable or payable; and
(iv) sustainability and transformation funding.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

Health service bodies are generally exempt from corporation tax, as they are either part of the Department of Health and Social Care or have specific exemption provided by sections 985 and 986 of the Corporation Tax Act 2010 (CTA 2010). Having reviewed these sections the Trust is satisfied it fulfils the definition of a health service body. The Trust has been established under section 25 of the National Health Service Act 2006 (as amended in 2012). This legislation states NHS trusts have been established to provide goods and services for the purposes of the health service. This is further defined as:
- the provision of goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
- the promotion and protection of public health.

Since the Trust only carries out services as described above, it has established no wholly or partially owned subsidiaries, and is therefore a health service body as defined by the Corporation Tax Act 2010, the Trust is exempt from corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at fair value through income and expenditure) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets / liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 9 *Financial Instruments*
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 *Regulatory Deferral Accounts*
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 15 *Revenue from Contracts with Customers*
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 *Leases*
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 *Insurance Contracts*
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22 *Foreign Currency Transactions and Advance Consideration*
Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 *Uncertainty over Income Tax Treatments*
Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

All activity at Leeds Community Healthcare NHS Trust is healthcare related and the majority of the Trust's revenue is received from within UK government departments.

The main proportion of operating expenses are payroll related and are for the staff directly involved in the provision of healthcare and the indirect and overhead costs associated with that provision. It is deemed that the business activities that earn revenues for the Trust, and in turn incur the expenses, are therefore one broad provision on which it is deemed appropriate to identify as only one segment, namely healthcare.

Monthly operating results are published for assessment and review by the Trust's Chief Operating Decision Maker, which is the overall Trust Board that includes Executive and Non-Executive Directors. The financial position of the Trust to date, the Trust's Statement of Financial Position and Cash Flow and projections of future performance are assessed as a whole Trust rather than individual component parts that make up the sum total. In addition, all reporting of the position of the Trust is presented on a whole Trust basis that again implies a single operating segment under IFRS 8. As all decisions affecting the Trust's future direction and viability are made based on the overall total presented to Board, the Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Other NHS clinical income	692	-
Mental health services		
Block contract income	1,621	1,574
Community services		
Community services income from CCGs and NHS England	109,827	109,827
Income from other sources (eg local authorities)	29,822	30,537
All services		
Private patient income	-	17
Other clinical income	281	-
Total income from activities	**142,243**	**141,955**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	8,079	7,997
Clinical Commissioning Groups	104,059	103,404
Department of Health and Social Care	-	-
Other NHS providers	281	2
NHS other	-	-
Local authorities	28,444	28,927
Non-NHS: private patients	-	17
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme	-	-
Non-NHS: other	1,380	1,608
Total income from activities	**142,243**	**141,955**
Of which:		
Related to continuing operations	142,243	141,955
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust has no overseas visitor income.

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	371	385
Education and training	1,551	1,500
Receipt of capital grants and donations	-	-
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	121	183
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	2,417	1,350
Rental revenue from operating leases	479	434
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	722	840
Other income*	1,622	2,007
Total other operating income	**7,283**	**6,699**
Of which:		
Related to continuing operations	7,283	6,699
Related to discontinued operations	-	-

*Other non-clincial income totalled £1,622k; of which £761k was rental income and £376k lease car income.

Note 5 Fees and charges

The Trust received no income in respect of fees and charges.

Note 6 Expenses

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	1,345	627
Purchase of social care	-	-
Staff and Executive Directors costs	103,631	106,069
Remuneration of Non-Executive Directors	54	56
Supplies and services - clinical *	9,983	10,277
Supplies and services - general	3,537	2,435
Drug costs *	875	1,294
Inventories written down	-	-
Consultancy costs	-	25
Establishment	3,346	2,885
Premises *	12,259	11,477
Transport (including patient travel) *	1,777	1,918
Depreciation on property, plant and equipment	1,700	1,541
Amortisation on intangible assets	24	24
Net impairments	212	-
Increase / (decrease) in provision for impairment of receivables	(6)	51
Increase / (decrease) in other provisions	(28)	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services - statutory audit	47	52
other auditor remuneration (external auditor only)	-	13
Internal audit costs	94	92
Clinical negligence	371	265
Legal fees	84	248
Insurance	129	133
Research and development	12	58
Education and training	519	631
Rentals under operating leases *	2,244	2,414
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on SoFP IFRIC 12 schemes	-	-
Charges to operating expenditure for off SoFP IFRIC 12 schemes	-	-
Car parking and security *	260	226
Hospitality *	-	-
Losses, ex-gratia and special payments *	27	85
Grossing up consortium arrangements	-	-
Other services, eg external payroll *	812	835
Other **	1,315	866
Total	**144,623**	**144,597**
Of which:		
Related to continuing operations	144,623	144,597
Related to discontinued operations	-	-

* The prior year figures for these items of expenditure have been restated to reflect the additional detail in 2017/18 and to provide accurate comparative information. Operating costs for 2016/17 overall remain the same as reported last year.

** £981k of other expenditure relates to external recharges in respect of partnerships with Leeds Teaching Hospitals NHS Trust and South West Yorkshire Partnership NHS Foundation Trust.

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	13
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**13**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	212	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**212**	**-**
Impairments charged to the revaluation reserve	574	-
Total net impairments	**786**	**-**

Due to the movement in property values the Trust commissioned an asset valuation from the District Valuer as at 31 March 2018. This has resulted in impairments of £241k and the reversal of prior year impairments of £29k.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	79,692	81,316
Social security costs	7,353	7,586
Apprenticeship levy	373	-
Employer's contributions to NHS pensions	9,991	10,186
Pension cost - other	13	15
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	265	702
Temporary staff (including agency)	6,226	6,539
Total gross staff costs	**103,913**	**106,344**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**103,913**	**106,344**
Of which		
Costs capitalised as part of assets	282	275

Note 8.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£197k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Other pension costs

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish to join the NHS Pension Scheme this is the Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP). The Trust has expensed £15k during the year in respect of contributions for employees under the NEST scheme.

Note 10 Operating leases

Note 10.1 Leeds Community Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Leeds Community Healthcare NHS Trust is the lessor.

Leasing arrangements where the Trust is a lessor relate to the sub-letting of health centres and clinics, where the lessee is generally a GP practice or other healthcare provider.

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	479	434
Contingent rent	-	-
Other	-	-
Total	**479**	**434**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year	453	430
- later than one year and not later than five years	1,118	1,169
- later than five years	65	80
Total	**1,636**	**1,679**

Note 10.2 Leeds Community Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Leeds Community Healthcare NHS Trust is the lessee.

The Trust has leases in respect of accommodation, vehicles and photocopiers.

The Trust has no contingent rents.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	2,244	2,414
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,244**	**2,414**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year	2,080	2,112
- later than one year and not later than five years	4,490	4,634
- later than five years	725	1,444
Total	**7,295**	**8,190**
Future minimum sublease payments to be received	-	(115)

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	70	43
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**70**	**43**

Note 12 Financing costs

Note 12.1 Finance expenditure

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**-**	**-**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**-**	**-**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015
The Trust incurred no interest payments in respect of the late payment of commercial debt.

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	193	-
Losses on disposal of assets	(239)	(48)
Total gains / (losses) on disposal of assets	(46)	(48)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available for sale financial investments	-	-
Total other gains / (losses)	**(46)**	**(48)**

Garforth Clinic was sold in September 2017 for £362k; the carrying value was £165k. After selling costs of £4k the Trust achieved a profit on disposal of £193k. Other assets disposed of during the year relate to write offs of equipment no longer in use and were not saleable.

Note 14 Discontinued operations

The Trust has no discontinued operations.

Note 15 Intangible assets

Note 15.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**258**	**258**
Transfers by absorption	-	**-**
Additions	1	**1**
Impairments	-	**-**
Reversals of impairments	-	**-**
Revaluations	-	**-**
Reclassifications	-	**-**
Transfers to / from assets held for sale	-	**-**
Disposals / de-recognition	-	**-**
Gross cost at 31 March 2018	**259**	**259**
Amortisation at 1 April 2017 - brought forward	**182**	**182**
Transfers by absorption	**-**	**-**
Provided during the year	24	**24**
Impairments	**-**	**-**
Reversals of impairments	**-**	**-**
Revaluations	**-**	**-**
Reclassifications	**-**	**-**
Transfers to / from assets held for sale	**-**	**-**
Disposals / de-recognition	**-**	**-**
Amortisation at 31 March 2018	**206**	**206**
Net book value at 31 March 2018	**53**	**53**
Net book value at 1 April 2017	**76**	**76**

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**212**	**212**
Transfers by absorption	-	**-**
Additions	46	**46**
Impairments	-	**-**
Reversals of impairments	-	**-**
Revaluations	-	**-**
Reclassifications	-	**-**
Transfers to / from assets held for sale	-	**-**
Disposals / de-recognition	-	**-**
Valuation / gross cost at 31 March 2017	**258**	**258**
Amortisation at 1 April 2016 - as previously stated	**158**	**158**
Transfers by absorption	**-**	**-**
Provided during the year	**24**	**24**
Impairments	-	**-**
Reversals of impairments	-	**-**
Revaluations	-	**-**
Reclassifications	-	**-**
Transfers to / from assets held for sale	-	**-**
Disposals / de-recognition	-	**-**
Amortisation at 31 March 2017	**182**	**182**
Net book value at 31 March 2017	**76**	**76**
Net book value at 1 April 2016	**54**	**54**

Note 16 Property, plant and equipment

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**9,550**	**14,715**	**65**	**3,446**	**4,159**	**584**	**32,519**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	-	490	67	905	-	**1,462**
Impairments	(339)	(698)	-	-	-	-	**(1,037)**
Reversals of impairments	-	(85)	-	-	-	-	**(85)**
Revaluations	1,030	1,280	-	-	-	-	**2,310**
Reclassifications	-	550	(555)	-	-	5	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	(92)	-	(1,344)	(166)	-	**(1,602)**
Valuation / gross cost at 31 March 2018	**10,241**	**15,670**	**-**	**2,169**	**4,898**	**589**	**33,567**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**1,219**	**-**	**2,365**	**1,287**	**504**	**5,375**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**514**	**-**	**322**	**839**	**25**	**1,700**
Impairments	-	(222)	-	-	-	-	**(222)**
Reversals of impairments	-	(114)	-	-	-	-	**(114)**
Revaluations	-	(1,118)	-	-	-	-	**(1,118)**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	(62)	-	(1,194)	(108)	-	**(1,364)**
Accumulated depreciation at 31 March 2018	**-**	**217**	**-**	**1,493**	**2,018**	**529**	**4,257**
Net book value at 31 March 2018	**10,241**	**15,453**	**-**	**676**	**2,880**	**60**	**29,310**
Net book value at 1 April 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**9,550**	**14,605**	**33**	**3,664**	**2,868**	**596**	**31,316**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	-	142	96	1,291	-	**1,529**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	110	(110)	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	(186)	-	-	**(186)**
Disposals / de-recognition	-	-	-	(128)	-	(12)	**(140)**
Valuation / gross cost at 31 March 2017	**9,550**	**14,715**	**65**	**3,446**	**4,159**	**584**	**32,519**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**713**	**-**	**2,222**	**665**	**488**	**4,088**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**506**	**-**	**386**	**622**	**27**	**1,541**
Impairments	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	(142)	-	-	**(142)**
Disposals / de-recognition	-	-	-	(101)	-	(11)	**(112)**
Accumulated depreciation at 31 March 2017	**-**	**1,219**	**-**	**2,365**	**1,287**	**504**	**5,375**
Net book value at 31 March 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**
Net book value at 1 April 2016	**9,550**	**13,892**	**33**	**1,442**	**2,203**	**108**	**27,228**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net Book Value at 31 March 2018							
Owned - purchased	10,241	15,280	-	676	2,880	60	**29,137**
Finance leased	-	-	-	-	-	-	**-**
On SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	173	-	-	-	-	**173**
Net Book Value total at 31 March 2018	**10,241**	**15,453**	**-**	**676**	**2,880**	**60**	**29,310**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net Book Value at 31 March 2017							
Owned - purchased	9,550	13,319	65	1,081	2,872	80	**26,967**
Finance leased	-	-	-	-	-	-	**-**
On SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	177	-	-	-	-	**177**
Net Book Value total at 31 March 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**

Note 17 Donations of property, plant and equipment

The Trust has received no donations of property, plant or equipment in year.

Note 18 Revaluations of property, plant and equipment

Revaluation of property and land

- these were revalued as at 31 March 2018
- the valuation was under taken by the District Valuer
- with the exception of one property, all the Trust's buildings are specialised assets and are valued and depreciated at replacement cost. Modern equivalent assets values were used but not alternative site basis as buildings are situated in line with service requirements
- one building was valued at market value as it is not deemed to be a specialised asset
- as part of the revaluation the District Valuer updated the useful economic lives of building assets.

Revaluation of plant and equipment

- the Trust does not revalue its plant and equipment. The carrying value is depreciated annually and this is considered sufficient to ensure asset values are up to date.

Note 19.1 Investment Property

The Trust has no investment property.

Note 20 Investments in associates and joint ventures

The Trust has no investments in associates and joint ventures.

Note 21 Other investments / financial assets (non-current)

The Trust has no other investments / financial assets (non-current).

Note 22 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 23 Inventories

The Trust has no inventories.

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	4,272	4,157
Capital receivables (including accrued capital related income)	-	-
Accrued income	2,381	1,245
Provision for impaired receivables	(100)	(106)
Deposits and advances	-	-
Prepayments (non-PFI)	585	663
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	309	-
VAT receivable	1,378	220
Corporation and other taxes receivable	-	-
Other receivables	24	30
Total current trade and other receivables	**8,849**	**6,209**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	3,679	2,243
Non-current	-	-

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**106**	**70**
Transfers by absorption	-	-
Increase in provision	(6)	5
Amounts utilised	-	(15)
Unused amounts reversed	-	46
At 31 March	**100**	**106**

The Trust has made provision for the impairment of non-NHS receivables in excess of 90 days overdue.

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade & other receivables	Investments & other financial assets	Trade & other receivables	Investments & other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	-	-	-	-
30 - 60 days	-	-	-	-
60 - 90 days	13	-	-	-
90 - 180 days	24	-	52	-
Over 180 days	76	-	54	-
Total	**113**	**-**	**106**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	3,822	-	2,535	-
30 - 60 days	29	-	72	-
60 - 90 days	71	-	32	-
90 - 180 days	2	-	2	-
Over 180 days	-	-	299	-
Total	**3,924**	**-**	**2,940**	**-**

The Trust regularly reviews aged debts and makes referrals to a debt collection agency. Where advice from the collection agency indicates recovery is unlikely the debt is written off. Where a payment schedule is in place these debts are recovered over a longer time period.

Note 25 Other assets

The Trust has no other assets.

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18	2016/17
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**165**	**165**
Transfers by absorption	-	**-**
Assets classified as available for sale in the year	-	**44**
Assets sold in year	(165)	**(44)**
Impairment of assets held for sale	-	**-**
Reversal of impairment of assets held for sale	-	**-**
Assets no longer classified as held for sale, other than disposal by sale	-	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**165**

During the year the Trust sold Garforth Clinic, the non-current asset held for sale.

Note 26.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**19,104**	**19,074**
Transfers by absorption	-	-
Net change in year	4,140	30
At 31 March	**23,244**	**19,104**
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	23,240	19,100
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**23,244**	**19,104**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**23,244**	**19,104**

Note 27.2 Third party assets held by the Trust

The Trust does not hold cash and cash equivalents which relate to monies held on behalf of patients or other parties.

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	1,662	1,766
Capital payables	372	538
Accruals	5,674	4,112
Receipts in advance (including payments on account)	-	-
Social security costs	1,164	1,161
VAT payables	-	-
Other taxes payable	755	739
PDC dividend payable	-	12
Accrued interest on loans	-	-
Other payables	1,402	1,429
Total current trade and other payables	**11,029**	**9,757**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,345	1,357
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		-	

Note 29 Other financial liabilities

The Trust has no other financial liabilities.

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,042	855
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**1,042**	**855**
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 31 Borrowings

The Trust has no borrowings.

Note 32 Finance leases

The Trust has no finance leases.

Note 33 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Re-structuring	Continuing care	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2017	**-**	**372**	**-**	**-**	**-**	**818**	**208**	**1,398**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	-	-	-	-	-	-	-	**-**
Arising during the year	-	3	-	-	-	265	-	**268**
Utilised during the year	-	(11)	-	-	-	(55)	(208)	**(274)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	-	(31)	-	-	-	-	-	**(31)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2018	**-**	**333**	**-**	**-**	**-**	**1,028**	**-**	**1,361**
Expected timing of cash flows:								
- not later than one year	-	333	-	-	-	1,028	-	**1,361**
- later than one year and not later than five years	-	-	-	-	-	-	-	**-**
- later than five years	-	-	-	-	-	-	-	**-**
Total	**-**	**333**	**-**	**-**	**-**	**1,028**	**-**	**1,361**

In respect of legal claims the uncertainty as to amounts and timings relates to the time taken to determine whether or not the Trust is liable and if so, what the value of that liability will be.

In respect of redundancy and other provisions the uncertainty as to amounts and timings relates to the time taken to complete the necessary workforce processes.

Note 33.1 Clinical negligence liabilities

At 31 March 2018 £657k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2017: £361k).

Note 34 Contingent assets and liabilities

The Trust has no contingent assets or liabilities.

Note 35 Contractual capital commitments

The Trust has no capital commitments.

Note 36 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 £000
- not later than one year	876	2,100
- after one year and not later than five years	1,142	1,631
- paid thereafter	-	-
Total	**2,018**	**3,731**

Note 37 Financial instruments

Note 37.1 Financial risk management

In accordance with IFRS 7, trusts should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the Trust is exposed at the end of the reporting period. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. In addition financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations.

The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust currently has no borrowings.

The Trust may borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings would be for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care, the lender, at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
The majority of the Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The majority of the Trust's operating costs are incurred under contracts with Clincial Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit.

The Trust is not therefore exposed to significant liquidity risks.

Note 37.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non-financial assets	6,577	-	-	-	**6,577**
Other investments / financial assets	-	-	-	-	**-**
Cash & cash equivalents at bank and in hand	23,244	-	-	-	**23,244**
Total at 31 March 2018	**29,821**	**-**	**-**	**-**	**29,821**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non-financial assets	5,326	-	-	-	**5,326**
Other investments / financial assets	-	-	-	-	**-**
Cash & cash equivalents at bank and in hand	19,104	-	-	-	**19,104**
Total at 31 March 2017	**24,430**	**-**	**-**	**-**	**24,430**

Note 37.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non-financial liabilities	6,686	-	**6,686**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**6,686**	**-**	**6,686**

	Other financial liabilities	Liabilities at fair value through I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	-	-	**-**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	-	-	**-**
Trade and other payables excluding non-financial liabilities	6,500	-	**6,500**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**6,500**	**-**	**6,500**

Note 37.4 Fair values of financial assets and liabilities

The fair value of financial assets and financial liabilities for the Trust do not differ from the carrying value.

Note 37.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	6,686	6,500
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**6,686**	**6,500**

Note 38 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	2	-
Fruitless payments	2	93	-	-
Bad debts and claims abandoned	36	17	33	16
Stores losses and damage to property	1	6	9	17
Total losses	**40**	**116**	**44**	**33**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	9	3	18	51
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**9**	**3**	**18**	**51**
Total losses and special payments	**49**	**119**	**62**	**84**
Compensation payments received		-		-

Note 39 Gifts

The Trust received no gifts during the reporting period.

Note 40 Related parties

Details of related parties transactions with indivduals are as follows:

	Expenditure with Related Party £	Revenue from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
University of Leeds				
Jane Madeley (Non-Executive Director) *Chief Financial Officer, University of Leeds*	82,835	52,283	5,733	1,398
Care Quality Commission				
Dr A Thomas (Medical Director) *National professional advisor for Integrated Children's Service & Safeguarding*	202,239	10,043	-	-
Royal College of Psychiatrists Dr Tony Dearden (Non-Executive Director) *Fellow*	2,994	-	-	-
Leeds Teaching Hospitals NHS Trust				
Dr P Ayres (Interim Medical Director) *Employee*	5,658,354	785,653	456,450	261,471
NHS Digital				
Richard Gladman (Non-Executive Director) *Programme Director*	4,575	-	-	-

The Department of Health is regarded as a related party. During the year 2017/18 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department as listed below:

Barnsley Hospital NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Bridgewater Community Healthcare NHS FT
Care Quality Commission
Central Manchester University Hospitals NHS FT
Cheshire and Wirral Partnership NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Greater Manchester Mental Health NHS FT
Harrogate and District NHS Foundation Trust
Health Education England
Humber NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Manchester University NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
NHS Airedale, Wharfdale And Craven CCG
NHS Barnsley CCG
NHS Bexley CCG
NHS Blackburn with Darwen CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Bury CCG
NHS Business Services Authority
NHS Calderdale CCG
NHS Doncaster CCG
NHS East Lancashire CCG
NHS Leeds North CCG
NHS Leeds South and East CCG
NHS Leeds West CCG
NHS Lewisham CCG
NHS Resolution
NHS Liverpool CCG
NHS Milton Keynes CCG
NHS Newcastle Gateshead CCG
NHS North Cumbria CCG
NHS North of England Commissioning Support Unit
NHS North Kirklees CCG
NHS North Norfolk CCG
NHS Nottingham City CCG
NHS Sandwell and West Birmingham CCG
NHS Scarborough and Ryedale CCG
NHS Sheffield CCG
NHS Solihull CCG
NHS South Tees CCG
NHS South Tyneside CCG
NHS Vale of York CCG
NHS Wakefield CCG
NHS Waltham Forest CCG
North Tees and Hartlepool NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxford Health NHS Foundation Trust
Pennine Care NHS Foundation Trust
Rotherham Doncaster and South Humber NHS FT
Royal Free London NHS Foundation Trust

NHS East Riding of Yorkshire CCG
NHS Electronic Staff Record
NHS Enfield CCG
NHS England
NHS Fareham and Gosport CCG
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Herts Valleys CCG
NHS Heywood, Middleton & Rochdale CCG
NHS Hull CCG
Sheffield Children's NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
West Midlands Ambulance Service NHS FT
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies as listed below:

Community Health Partnerships
HM Revenue and Customs
Leeds City Council
NHS Pension Scheme
Humberside Police and Crime Commissioner and Chief Constable
West Yorkshire Police and Crime Commissioner and Chief Constable
NHS Property Services
North Yorkshire County Council
Kirklees Metropolitan Council
Valuation Office Agency
North Yorkshire Police and Crime Commissioner and Chief Constable
South Yorkshire Police and Crime Commissioner and Chief Constable

The Trust has received receipts from Leeds Community Healthcare Charitable Trust and Related Charities for which the Trust Board is Corporate Trustee. These are solely to reimburse the Trust for purchases made for the Charity as an agent.

The audited accounts of the Charity are available from the Trust's Communications Team.

Note 41 Transfers by absorption

The Trust has no transfers by absorption.

Note 42 Prior period adjustments

The Trust has no prior period adjustments.

Note 43 Events after the reporting date

With effect from 1 April 2018 the Trust will effectively become responsible for commissioning CAMHS inpatient services as part of the new models of care pilot with NHS England. The local providers of CAMHS community services; South West Yorkshire Partnership NHS FT, Bradford District Care NHS FT and the Trust will work in collaboration on this pilot. This pilot will not see a transfer of the full inpatient funding to the Trust however, any savings the Trust and its partners are able to initiate will be available to be re-invested in local services provided by the partners. Currently it is estimated the resources available for re-investment will be £0.7m.

During 2017/18 the Trust was successful in a bid to NHS England for capital funding to build a new CAMHS inpatient unit. This scheme will incur significant capital expenditure circa £13m in 2018/19 and 2019/20.

Note 44 Final period of operation as a Trust of NHS healthcare

This is not relevant to the Trust.

Note 45 Better Payment Practice Code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	18,178	30,890	20,085	32,145
Total non-NHS trade invoices paid within target	17,487	29,827	19,141	30,870
Percentage of non-NHS trade invoices paid within target	96.20%	96.56%	95.30%	96.03%
NHS Payables				
Total NHS trade invoices paid in the year	935	17,588	998	19,647
Total NHS trade invoices paid within target	918	17,483	972	19,555
Percentage of NHS trade invoices paid within target	98.18%	99.40%	97.39%	99.53%
Total All Payables				
Total trade invoices paid in the year	19,113	48,478	21,083	51,792
Total trade invoices paid within target	18,405	47,310	20,113	50,425
Percentage of trade invoices paid within target	96.30%	97.59%	95.40%	97.36%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 46 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	(4,140)	(30)
Other capital receipts	0	0
External financing requirement	**(4,140)**	**(30)**
External financing limit (EFL)	**(2,941)**	**1,336**
Under / (over) spend against EFL	**1,199**	**1,366**

Note 47 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	1,463	1,575
Less: Disposals	(403)	(72)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal of donated / granted assets	-	-
Charge against Capital Resource Limit	**1,060**	**1,503**
Capital Resource Limit	**1,816**	**2,581**
Under / (over) spend against CRL	**756**	**1,078**

Note 48 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	4,655
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	4,655

Note 49 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	2,577	1,809	1,425	2,007	2,985	3,350	4,655
Breakeven duty cumulative position	2,577	4,386	5,811	7,818	10,803	14,153	18,808
Operating income	134,978	139,906	142,863	146,668	156,367	148,654	149,526
Cumulative breakeven position as a percentage of operating income	1.91%	3.13%	4.07%	5.33%	6.91%	9.52%	12.58%

Leeds Community Healthcare
NHS Trust

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Clare Partridge
Partner
KPMG LLP
1 Sovereign Square
Sovereign Street
Leeds LS1 4DA

25 May 2018

Dear Clare

This representation letter is provided in connection with your audit of the Leeds Community Healthcare NHS Trust financial statements of Leeds Community Healthcare NHS Trust ("the Trust"), for the year ended 31 March 2018, for the purpose of expressing an opinion:

- as to whether these financial statements give a true and fair view of the state of the financial position of the Trust as at 31 March 2018 and of the Trust's income and expenditure for the financial year then ended; and
- whether the Trust's financial statements have been prepared in accordance with the Department of Health Group Accounting Manual (GAM).

These financial statements comprise the Trust Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

   i. give a true and fair view of the financial position of the Trust as at 31 March 2018 and of the Trust's income and expenditure for that financial year; and

   ii. have been prepared in accordance with the GAM 2017/18.

   The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 Events after the reporting period requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There are no uncorrected adjustments above AMPT of £100k following audit of the 2017/18 financial statements.

Information provided

6. The Board has provided you with:

- access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
- additional information that you have requested from the Board for the purpose of the audit; and
- unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

Included in the Appendix to this letter are the definitions of fraud, including misstatement arising from fraudulent financial reporting and from misappropriation of assets.

ii. The Board has disclosed to you all information in relation to:

a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:

- management;
- employees who have significant roles in internal control; or
- others where the fraud could have a material effect on the financial statements; and

b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 Related Party Disclosures. Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2018 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.

    b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

This letter was tabled and agreed at the meeting of the Board of Directors on 25 May 2018.

Yours sincerely

Thea Stein

Chief Executive, for and on behalf of the Board of Leeds Community Healthcare NHS Trust

Neil Franklin OBE

Chair

Appendix to the Board Representation Letter: Uncorrected audit differences

There are no uncorrected audit differences

KPMG

External Audit Report

Leeds Community Healthcare NHS Trust

—

25 May 2018

Content

The contacts at KPMG in connection with this report are:

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Partner

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Manager

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Important Notice

This report is presented under the terms of our audit engagement letter. This report is addressed to Leeds Community Healthcare NHS Trust (the Trust) and has been prepared for your use only. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Basis of preparation: We have prepared this External Audit Report (Report) in accordance with our engagement letter/letter of appointment dated 23 November 2016.

Purpose of this report: This Report is made to the Trust's Audit Committee in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report. This Report is subject to disclosure restrictions.

Limitations on work performed: This Report is separate from our audit opinion included in the Trust's Annual Reports and Accounts and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors reporting. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report. The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit: Our audit is not yet complete and matters communicated in this Report may change pending signature of our audit report. We will provide an updated report at the Audit Committee meeting but, at time of writing, the following work is still outstanding (note that this work will be largely undertaken on 17th and 18th May and represent to lower risk areas):

- Financial Statements audit:
  - Whole of Government Accounts work plan
  - WGA Group returns.
  - Property valuation – assumptions reasonableness test
  - Trade and Other Receivables
  - Trade and Other Payables
  - Journal Entries - sample test year end.
  - Provisions
  - Other Liabilities
  - Cashflow statement
  - Operating Leases
  - Related Party Transactions

KPMG

Summary

Section One

Summary

Value for money	
Based on the findings of our work, we anticipate concluding that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.	

Financial Statements Audit	Other Matters
We intend to issue an unqualified audit opinion on the accounts following the Board adopting them and receipt of the management representations letter. We have completed the majority our audit of the financial statements. We have highlighted on page 4 the outstanding work. Currently our key findings are: • There are no unadjusted audit differences, explained in section 2 and appendix 2. • We have agreed presentational changes to the accounts with Finance, mainly related to compliance with the Department of Health Group Manual for Accounts (GAM) 2017/18. • We are only asking for routine management representations. explained in section 2. • We have reviewed the annual report and have no matters to raise with you.	Subject to completion of the work we intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to Department of Health. We are satisfied that the Trust has addressed the recommendation raised in our 2016/17 report. We have made one recommendations as a result of our 2017/18 work. All recommendations are shown in appendix 1. In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public; and whether the public interest requires any such matter to be made the subject of an immediate report rather than at completion of the audit. There are no matters that we wish to report. We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance. There are no issues that would cause us to delay the issue of our certificate of completion of the audit.

KPMG

Financial Statements Audit

Section Two

Financial Statements Audit

We audit your financial statements by undertaking the following tasks:

Work Performed	Accounts production stage		
	Before	During	After
1. Business Understanding: review your operations	✓	✓	–
2. Controls: assess the control framework	✓	–	–
3. Prepared by Client Request (PBC): issue our prepared by client request	✓	–	–
4. Accounting standards: agree the impact of any new accounting standards	✓	✓	–
5. Accounts Production: review the accounts production process	✓	✓	✓
6. Testing: test and confirm material or significant balances and disclosures	–	✓	✓
7. Representations and opinions: seek and provide representations before issuing our opinions	✓	✓	✓

We have completed the first six stages shown above and report our key findings below:

1. Business Understanding	In our audit plan we assessed your operations to identify significant issues that might have a financial statements consequence. We confirmed this risk assessment as part of our audit work. We have provided an update on each of the risks identified later in this section.
2. Assessment of the control environment	We have assessed the effectiveness of your key financial system controls that prevent and detect material fraud and error. We found that the financial controls on which we seek to place reliance are operating effectively. We have reviewed the work undertaken by TIAA Ltd, your internal auditors, in accordance with ISA610 and used the findings to inform and planning and audit approach. We have chosen not to place reliance on their work due to the approach we adopted for the financial statements audit.
3. Prepared by client request	We produced this document to summarise the working papers and evidence we ask you to collate as part of the preparation of the financial statements. We discussed and tailored our request with the Deputy Director of Finance and Resources and this was issued as a final document to the finance team. The Clara site has been used for the first time and this has enabled effective transfer of data, and the quality of the working papers was good.
4. Accounting standards	We work with you to understand the changes to accounting standard and other technical issues. For 2017/18 there has been no changes.

Section Two

Financial Statements Audit

5. Accounts Production	We received complete draft accounts by 23 April 2018 in accordance with the Department of Health and Social Care's deadline. The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of the Department of Health and Social Care. As in previous years, we will debrief with the Finance team to share views on the final accounts audit. Hopefully this will lead to further efficiencies in the 2018/19 audit process. In particularly we would like to commend Trust finance staff who were available throughout the audit visit to answer our queries. We thank the finance team for their co-operation throughout the visit which allowed the audit to progress and complete within the allocated timeframe.
6. Testing	We have summarised the findings from our testing of significant risks and areas of judgement within the financial statements on the following pages. During the audit we identified only presentational issues which have been adjusted as they have no material effect on the financial statements.
7. Represent-ations	You are required to provide us with representations on specific matters such as your going concern assertion and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Executive Director of Finance on 16 May 2018. We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us.

We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest.

We have identified the following other matters to report:

- We have not encountered any significant difficulties during the audit;
- No significant matters arising from the audit were discussed with management; and
- We have not identified any other matters to specifically report.

Financial Statements Audit

Results of our testing on areas of high audit risk

In our External Audit Plan 2017/18, presented to you in December 2017, we identified the areas assessed as significant risks in terms of their impact on our financial statements audit opinion. We have now completed our testing of these areas and over the next pages set out:

- The results of the procedures we performed over the Valuation of Land and Buildings which was identified as significant risk within our audit plan;
- The results of our procedures to review the required risks of the fraudulent risk of revenue recognition and management override of control; and
- Our view of the level of prudence you have applied to key balances within your financial statements.

SIGNIFICANT audit risk	Account balances effected	Summary of findings
Valuation of Land and Buildings	Property Plant and Equipment, £29,310K, PY £27,144K	For the valuation of material land and building balances we have: — assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the information provided to the Trust in 2017/18, to inform its assessment of market value movements, for consistency with the requirements of the Department of Health Group Accounting Manual; — critically assessed the calculation of market value indices movements completed by the Trust, including a re-performance of this calculation to confirm that no material movement in the value of land and building assets is indicated; — agreed the data underpinning the Trust's calculation of market value movements to the RICS data obtained by the District Valuer and correlated this with our knowledge from across the region; — critically assessed the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken and the adequacy of the formal, written decision document used in the process; and — considered the adequacy of the disclosures about the key judgements and degree of estimation involved in concluding that there has been no material movement in the value of land and buildings since 31 March 2017 The overall conclusion is that the valuation of material land and buildings included in the financial statements represent a balanced valuation.

Financial Statements Audit

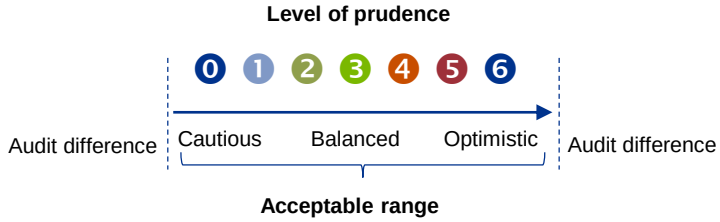
Risks that ISAs require us to assess in all cases	Why	Our findings from the audit
Fraud risk from revenue recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. As the vast majority of the Trust's income is from block contracts we plan to rebut this risk. We will however address the incentives in the NHS which include the regulatory pressure to meet agreed control totals as well as the incentive to report the delivery of specific targets which enable the Trust to secure Sustainability and Transformation funding or CQUIN monies.	Our work on NHS income and receivables and the Agreement of Balances exercise provide us with the assurance over the income received from NHS bodies. The Non-NHS income is in the main through block contract income and we have agreed this income through testing to contracts. We have agreed the recoverability of the receivables through the Agreement of Balances exercise for NHS receivables and through testing for Non-NHS receivables. We have found no issues around revenue recognition.
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, no instances of fraud were identified.

Section Two

Financial Statements Audit

Judgements in your financial statements

We always consider the level of prudence within key judgements in your financial statements. We have summarised our view below using the following range of judgement:



Assessment of subjective areas				
Asset/liability class	**Current year**	**Prior year**	**Balance (£k)**	**KPMG comment**
Property Plant and Equipment - Valuation	3	1	£29,310 (PY:£27,144)	The Trust has had a full valuation during the year and overall this has increased the value of Land and Buildings by £2,642k, this increase reflects the changes in value since the previous valuation in 2014/15.
Accruals	3	3	£5,219 (PY:£4,112)	We consider that the accruals balances disclosed are appropriate and balanced.
Provisions	3	3	£1,361 (PY £1,398)	We consider that the provisions in the financial statements are balanced.

Section Two

Financial Statements Audit

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Performance Report and AGS) and audited the relevant parts of the Remuneration Report. Based on the work performed:

- We have not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider the that the annual report and accounts taken as a whole are fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
- The part of the Remuneration Report that is required to be audited were all found to be materially accurate; and
- The AGS is consistent with the financial statements and complies with relevant guidance subject to updates as outlined within section three.

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the audit was £39,500 plus VAT (in 2017/18). This fee was in line with that highlighted within our audit plan agreed by the Audit Committee in December 2017.

We have not performed any non-audit work outside of that already disclosed to you as part of our audit planning.

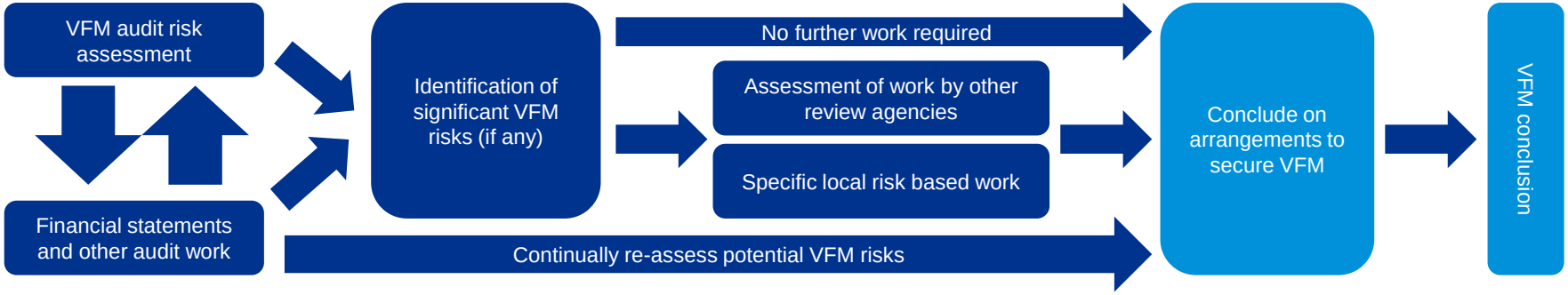
KPMG

Value for Money

Section Three

Value for Money

For 2017/18 our value for money (VFM) work follows the NAO's guidance. It is risk based and targets audit effort on the areas of greatest audit risk. Our methodology is summarised below. We identified one significant VFM risk which is reported overleaf and provide a summary below of the routine work required to issue our VFM conclusion, which is that we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018, based upon the criteria of informed decision making, sustainable resource deployment and working with partners and third parties.



AGS review	Regulatory review	Other matters considered in risk assessment
We reviewed the 2017/18 AGS and took into consideration the work of internal audit. We confirm that the AGS reflects our understanding of the Trust's operations and risk management arrangements.	We considered the outcomes of relevant regulatory reviews (NHS Improvement, CQC, etc.) in reaching our conclusion. The Trust received a CQC inspection in the fourth quarter of 2016/17 and received the report and ratings in the summer of 2017. The overall rating was Good, therefore providing us assurance that the services provided did not demonstrate significant weaknesses in the Trust's arrangements.	As part of our risk assessment we reviewed various matters, including: • core assumptions in the 2016/17 Annual Plan; • recurrent cost improvement schemes are identified and delivered; • current operational performance and commissioner relationships / contractual risks; • planned VS actual outturn; • significant one-off items affecting the outturn position; • Management's assessment of the Trust's ability to continue as a going concern; and • partnership arrangements / relationships with key third parties.

Section Three

Value for Money

Significant risk based VFM audit work

The table below sets out the detailed findings of our significant risk based VFM work. This work was completed to address the residual risks remaining after our assessment of the higher level controls in place to address the VFM risks identified in our planning and financial statements audit work.

Value for money risk	Why this risk is significant	Our audit response and findings
Governance arrangements and contract negotiation	There is a risk that the Trust will have insufficient capacity to respond to opportunities for further work and maintain existing areas of work whilst ensuring that "the day job" continues to operate effectively. The Trust will have to respond to a number of retendering requests in the next year which are time consuming	We have monitored the response that the Trust has made in respect of the various contract tendering arrangements during the year, via discussions with the Finance management. Attendance at audit committee has allowed us to understand the ongoing governance arrangements in place at the Trust which we have raised no specific concerns on. We have met with the Senior Officers of the Trust to understand, what if any impact, the tendering has had on the organisation in terms of the additional workload. Also how the risk of loss of contract would impact on the ongoing viability of the Trust. We noted that the Trust was successful in the tender for the Police Custody Healthcare contract which has secured income for 2018/19 onwards. We are satisfied that the Trust has had adequate arrangements in place during 2017/18. The tendering activity to date has not had a significant detrimental impact on the financial or governance arrangements of the Trust.

KPMG

Appendices

Appendix 1

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
1	3	Reconciliation of the Fixed Asset Register to the detailed PPE note in the Financial Statements At the time of the audit a full reconciliation between the Fixed Asset Register and the detailed PPE note in the year needed to be done. On completion of the reconciliation it was noted that the note in the draft statements included a significant change. Recommendation: Ensure that as part of 2018/19 closedown processes the Fixed Asset Register is fully reconciled to the detailed PPE note in the financial statements	**Management Response:** Agreed. Whilst the overall PPE values were correct in the draft accounts the presentation of the component parts had to be amended. A more detailed reconciliation to the fixed asset system would have enabled the detailed PPE note to be completed accurately. This will be included in the timetable for next year end and form part of the reflective session to be held with staff on the 2017/18 accounts process. **Officer:** Executive Director of Finance & Resources **Due Date:** 30 June 2018

Appendix 1

Recommendations raised and followed up

We have also follow up the recommendations from the previous years audit, in summary:

Total number of recommendations	Number of recommendations implemented	Number outstanding (repeated below):
2	2	0

Appendix 2

Audit Differences

Under UK auditing standards (ISA (UK&I) 260) we are required to provide the Audit Committee with a summary of unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those which are 'clearly trivial', which are not reflected in the financial statements. In line with ISA (UK&I) 450 we request that you correct uncorrected misstatements. However, they will have no effect on the opinion in our auditor's report, individually or in aggregate. As communicated previously with the Audit Committee, details of all adjustments greater than £[XXX]K are shown below:

Unadjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr [Name Accounts Code]	£[X.X]	-	[Explain basis of adjustment]
	Cr [Name Accounts Code]	£[X.X]	-	
2	Dr [Name Accounts Code]	-	££[X.X]	[Explain basis of adjustment]
	Cr [Name Accounts Code]	-	£[X.X]	
Total		£[X.X]	£[X.X]	

Under UK auditing standards (ISA UK&I 260) we are required to provide the Audit Committee with a summary of adjusted audit differences (including disclosures) identified during the course of our audit. The adjustments below have been included in the financial statements.

Adjusted audit differences (£m)				
No.	Detail	SOCI Dr/(cr)	SOFP Dr/(cr)	Comments
1	Dr [Name Accounts Code]	£[X.X]	-	[Explain basis of adjustment]
	Cr [Name Accounts Code]	£[X.X]	-	
2	Dr [Name Accounts Code]	-	££[X.X]	[Explain basis of adjustment]
	Cr [Name Accounts Code]	-	£[X.X]	
Total		£[X.X]	£[X.X]	

Appendix 2

Audit Differences

We are required to report any inconsistencies greater than £300,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a Trust is a sampled or non-sampled component. We have provided details of the inconsistencies that we are reporting to the NAO as follows:

Counter party	Type of balance/ transaction	Balance as per Trust (£'000)	Balance as per counter party (£'000)	Difference (£'000)	Comments on Difference
[Name body]	[Income / Expenditure / Debtor / Creditor]	£[X,XXX]	£[X,XXX]	£[X,XXX]	[State reason]
[Name body]	[Income / Expenditure / Debtor / Creditor]	£[X,XXX]	£[X,XXX]	£[X,XXX]	[State reason]
[Name body]	[Income / Expenditure / Debtor / Creditor]	£[X,XXX]	£[X,XXX]	£[X,XXX]	[State reason]
[Name body]	[Income / Expenditure / Debtor / Creditor]	£[X,XXX]	£[X,XXX]	£[X,XXX]	[State reason]

Appendix 3

Audit Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Trust for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust's financial statements.

Appendix 3

Audit Independence

- Material uncertainties related to event and conditions that may cast significant doubt on the Trust's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

New Risk identified in 2017/18

Michael Allen (MA) a KPMG Partner in our National Markets Consulting practice notified the Head of Ethics and Independence in March 2018 that his wife had been appointed Joint HR Director at Leeds Community Healthcare NHS Trust, an audit client of the firm. The role is a Board level position.

His wife will sit on the Board as Joint Director of Workforce (HR). She will not be in a position to exert significant influence over the preparation of the clients accounting records or financial statements and will not be able to exert significant influence over the client's financial position, performance or cash flows. As a Board member she may however be involved in discussions around auditor remuneration and appointment process and the approval of the financial statements.

The Audit Engagement partner, Clare Partridge ('CP') is in our National Markets Audit practice, a different independence office to MA. Both partners are based in the same physical location however they are not located close to each and work in separate areas of the building and within separate capability areas.

Independence analysis

The partners spouse will have a Board level position and as such we have checked that the partner (MA) is not a covered person for the Leeds Community Healthcare NHS Trust audit engagement. We have reviewed MA's time sheet for the past 12 months and asked both MA and the Audit engagement partner to confirm they have no mutual engagements and are not connected by way of performance management – however, as both work in the Leeds office they know each other as they operate in the same market place

Both confirmed they are not connected and the timesheet check confirmed the position. Neither partner is in a leadership or Chain of Command position. MA has confirmed he is not connected and has no performance management responsibility for any member of the audit team. MA is in a different independence office as the Audit Engagement Partner. MA is based in the same regional office as the AEP however he is not physically located in close proximity to the AEP. MA is not considered a covered person for Leeds Community Healthcare NHS Trust under the FRC definition of a covered person.

Audit Independence

This family relationship is therefore permissible under para 2.59 ES.

2.59 ES: Where a covered person, or any partner in the firm, becomes aware that a person closely associated with them, or a close family member who is not a person closely associated with them, is employed by an entity relevant to the engagement and that person is in a position to exercise influence on the accounting records or financial statements or other subject matter information or subject matter of such an engagement, that covered person or that partner shall either:

(a) in the case of a person closely associated with them being employed by the entity in such a position, be excluded from any role in which they would be a covered person; or

(b) in the case of a close family member of a covered person who is not a person closely associated with them, or, for an engagement other than an investment circular reporting engagement, any close family member of any partner in the firm who is not a person closely associated with them, report the matter to the engagement partner to take appropriate action. If it is a close family member of the engagement partner or if the engagement partner is in doubt as to the action to be taken, the engagement partner shall resolve the matter in consultation with the Ethics Partner/Function.

We have considered whether this relationship poses any potential self-interest, familiarity or intimidation threats to integrity and objectivity which may impair independence and are satisfied that it would not do so given: whilst MA and CP are known to each other their relationship is no different to that of any other two partners working in the Leeds office, he has no ability to influence the conduct and outcome of the audit and is not a covered person for the audit and given his wife's role as HR director is unlikely to have negligible (if indeed any) influence on the accounting records or financial statements. Notwithstanding these conclusions, given her personal conflict of interest we recommend that MA's spouse recuses herself from any discussions around KPMG's reappointment as auditors or KPMG's audit fee.

Conclusion

As MA is not in the same independence office as the audit engagement partner and is not considered a covered person under the FRC ES then his wife's role as HR director does not impact on our independence and objectivity as Leeds Community Healthcare NHS Trust's auditors. However we recommend the following safeguards are put in place to avoid any actual or perceived independence issues arising:

MA's spouse to ensure she formally recuses herself from any part of Board meetings where KPMG's reappointment and/or fees are discussed.

MA to ensure he does not become a covered person by virtue of providing services to the audit engagement or providing oversight or performance management for any member of the audit team.

MA to ensure that he does not deliver any non-audit services to Leeds Community Healthcare NHS Trust

CP to formally document our independence considerations with the Trust's Audit Committee/TCWG and to ensure that they concur with KPMG's conclusions in this regard.

Auditor Declaration

In relation to the audit of the financial statements of the Trust for the financial year ending 31 March 2018, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

Appendix 4

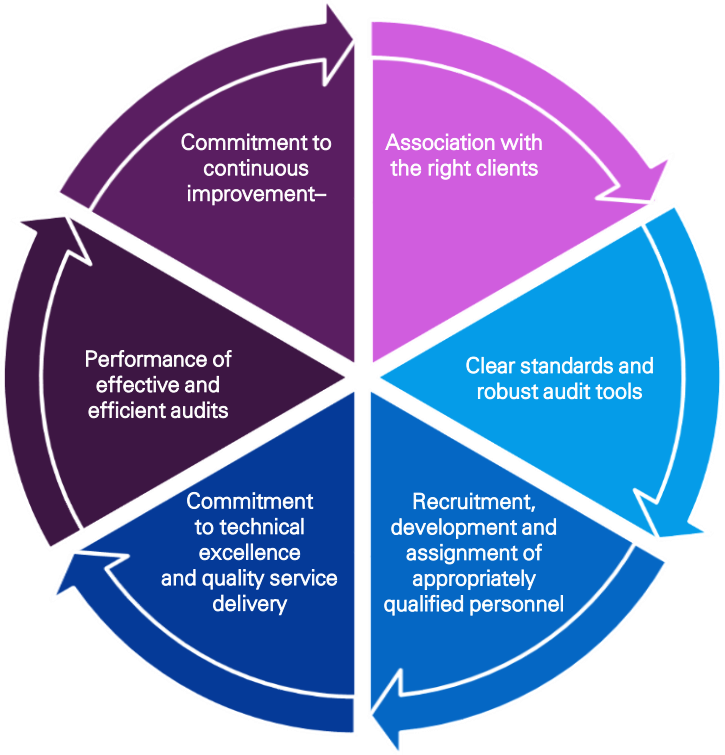
KPMG's Audit quality framework

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. To ensure that every partner and employee concentrates on the fundamental skills and behaviours required to deliver an appropriate and independent opinion, we have developed our global Audit Quality Framework

- Comprehensive effective monitoring processes
- Proactive identification of emerging risks and opportunities to improve quality and provide insights
- Obtain feedback from key stakeholders
- Evaluate and appropriately respond to feedback and findings

- Professional judgement and scepticism
- Direction, supervision and review
- Ongoing mentoring and on the job coaching
- Critical assessment of audit evidence
- Appropriately supported and documented conclusions
- Relationships built on mutual respect
- Insightful, open and honest two way communications

- Technical training and support
- Accreditation and licensing
- Access to specialist networks
- Consultation processes
- Business understanding and industry knowledge
- Capacity to deliver valued insights



- Select clients within risk tolerance
- Manage audit responses to risk
- Robust client and engagement acceptance and continuance processes
- Client portfolio management

- KPMG Audit and Risk Management Manuals
- Audit technology tools, templates and guidance
- Independence policies

- Recruitment, promotion, retention
- Development of core competencies, skills and personal qualities
- Recognition and reward for quality work
- Capacity and resource management
- Assignment of team members and specialists

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Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018/19 (8i)

Meeting Trust Board 25 May 2018	**Category of paper** *(please tick)*	
Report title – Quality Account 2017/18	**For approval**	√
Responsible director Executive Director of Nursing **Report author** Clinical Governance Manager (Interim)	**For assurance**	
Previously considered by Quality Committee 21 May 2018	**For information**	

PURPOSE OF THE REPORT

This report provides the Trust Board with the 2017/18 Quality Account for approval.

MAIN ISSUES FOR CONSIDERATION

The Quality Committee has recommended the Quality Account to the Board for approval. The account has been developed in line with national guidance given in the Department of Health Quality Account Tool Kit, the Quality Account Regulations and guidance from NHS England and NHS Improvement.

Attached is a paper copy of the Quality Account at its end stage of production.

The year-end position for the 2017/18 quality improvement priorities and progress against them has been monitored through Quality Committee over the year.

Section 2 contains statutory information as required by the Quality Account Toolkit (2011) and subsequent directives from the Department of Health and NHS England.

The priorities for quality improvement have been identified through patient, public and carer engagement, discussions with stakeholders and through a review of: performance information, feedback from the CQC and commissioners; and learning from incidents, experience and complaints. Projected outcomes and indicators have been agreed with relevant operational and corporate leads.

A combination of 11 new and refreshed priorities have been identified for 2018/19, as previously agreed by SMT and Quality Committee. These can be found in Section 3 of the Quality Account document. The priorities and progress with these will be monitored quarterly by the SMT during 2018/19 and overseen by Quality Committee.

The draft Quality Account was shared widely with all stakeholders for comment and these were received on 11 May 2018 and 16 May 2018. The Trust's response to the feedback is currently being developed and will be included in Section 4.

The glossy version of the Quality Account is currently being finalised and can be viewed via the Communications Team. This will be submitted to NHS England via NHS Choices by 30 June 2018.

RECOMMENDATIONS

- The Trust Board is recommended to approve the 2017/18 Quality Account

NHS
Leeds Community Healthcare
NHS Trust

Quality account

2017 : 2018

Contents

Introduction

We are pleased to introduce our 2017/18 Quality Account for Leeds Community Healthcare NHS Trust (LCH). This account highlights the quality improvements, developments and innovations we have achieved within our services over the last year and describes the challenges we have faced in relation to quality. The Account sets out the quality priorities we have identified for the forthcoming year, 2018/19 and how we will measure and monitor on those during the year.

Our Vision at LCH is *'To provide the best possible care to every community we serve'*.

Our engagement with patients, carers, the public and our partner organisations will be a renewed area of focus for 2018/19. Patient and public involvement and leadership at the heart of our services is fundamental to learning, in order to make our services the best they possibly can be. We continue to listen to others' experiences and feedback to shape our services for the future, to improve the quality of those services; and ensure they are really listening to people. Crucial to this is our ongoing dedication to have the right conversation with our patients and engage them in their own care through health coaching, prevention, early intervention and self-care. We work with people and want to ensure we leave them in control of their lives – asking "what's strong" rather than "what's wrong". We will work to embed this approach during 2018/19, putting the patient and carer at the heart of everything we do.

Equally, we aim to ensure our staff receive the best possible experience at LCH. Engagement with staff is ongoing as we work to address the local and national challenge of recruitment, retaining our workforce and reducing sickness levels within the organisation. The health and wellbeing of our workforce is paramount and we recognise that this is fundamental to high quality patient care. To this end we are proud to take this opportunity to celebrate our success in attaining an improved Care Quality Commission (CQC) rating of 'Good' following a CQC inspection in January 2017. This achievement demonstrates the commitment and hard work of our staff, despite the ongoing pressures and challenges they face on a daily basis; and we greatly commend them for this.

Our aspiration to be even better and become an 'Outstanding' organisation is a motivation for improving quality in 2018/19. Good leadership and management will be central to moving towards this goal, particularly as the health economy endeavours to balance limited resources and a changing population, with growing pressures on the healthcare system, particularly during the winter months. Our LEAD Programme continues to be part of developing our staff to become exemplary leaders within their teams.

Reducing incidences of avoidable harm remains a high priority for LCH. This has featured in our Quality Account quality improvement priorities for the last 3 years with a particular focus on reducing avoidable harm caused by pressure ulcers and falls. We recognise that this work must remain a high priority and our continuous quality approach is ongoing through regular scrutiny, review and reporting via our Pressure Ulcer and Falls review meetings and steering groups, our Quality Committee and our Trust Board, and to our associates at the Leeds Care Commissioning Group Partnership.

Moving into 2018/19, learning from the investigation of incidents and complaints will be an area for continuous improvement. Our Patient Safety, Experience and Governance Group will be central to scrutinising these actions and outcomes in order to provide assurance on their progress. We will endeavour to involve our patients and carers in this work to ensure the best possible outcomes and to improve the care we provide.

Outcomes and quality can only be improved through partnership working. We are positive about the development of a range of partnerships and particular our partnerships with primary care which we see as crucial as we drive new models of care in the city. As we work across the city, all partnerships continue to develop and form to create a stronger health and care network within which we can better support the needs of the community; and together improve the quality of care for the population of Leeds.

To finish where we started however – for us listening to the patient (the citizen) is the key to ensuring quality is at the heart of all that we do. This year we are recommitting to listening even harder.

This account details all of our quality improvement priorities for 2017/18. For consistency and in line with many organisations, reporting on the priorities will continue to be against the CQC domains of Safe, Effective, Caring, Responsive and Well-led.

Statement of Directors' Responsibilities in Respect of the Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the Regulations and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
- board minutes and papers for the period April 2017 to May 2018
- papers relating to quality reported to the board over the period April 2017 to May 2018
- feedback from commissioners and Healthwatch dated XX/XX/2018
- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009
- the [latest] national patient survey xx/2018
- the [latest] national staff survey 06/03/2018
- the Head of Internal Audit's annual opinion of the trust's control environment dated 23/05/2018
- CQC inspection report dated 29/08/2017
- the Quality Report presents a balanced picture of the Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed ..... Date 02 June 2018

Neil Franklin, Chair

Signed ..... Date 02 June 2018

Thea Stein, Chief Executive

Section 1

A Review of Quality in LCH

Improving Quality through the Engagement and Involvement of Patients, Carers and the Public

LCH is committed to genuine and meaningful involvement with patients, carers and the public and this is central to the way we ensure that we work to our values and behaviours.

Our Eleven

The Trust's 'Our Eleven' is made up of one vision, three values and 'seven magnificent behaviours'.

It is important that we create the working life we want. It is how we will achieve our vision –
"to provide the best possible care to every community we serve"

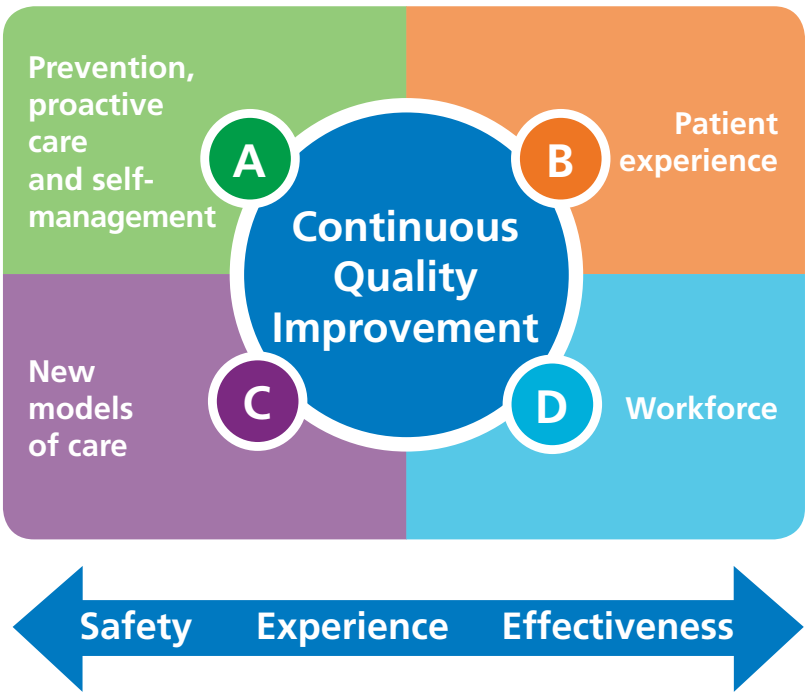
- ✓ We have simplified our Quality Account for this year and reduced the number of quality priorities set for 2018/19
- ✓ Our quality account priorities are aligned to the new quality strategy as well as organisational objectives/business priorities
- ✓ The Trust will continue to promote different ways of engaging in quality improvement in addition to the Quality Account
- ✗ We have not chosen targets that are easy to achieve
- ✗ Where quality improvement targets are continued from previous years, we will not continue to do the same thing and expect different results but will develop revised action plans and ways of working to help achieve these targets

The quality priorities we have set for 2018/19 are aligned to the four common themes outlined in the new Quality Strategy:

These priorities combined will help us meet our strategic objectives and are also in alignment with the Leeds Health and Care Plan.

The new Quality Strategy sets out the work we need to do over the next three years to support our vision and achievement of our strategic goals. It is a key enabling strategy, providing the framework for other Trust strategies that play a fundamental role in achievement of the Trust's vision.

Additional pieces of work relating to quality improvement continue to take place within individual services and are managed through services' own quality improvement plans.



We will continue to provide feedback throughout the year as well as through next year's Quality Account. This will include:

- Progress made using **"you said…we did"**
- Continuing to involve patients, carers and the public in finding solutions or improvements using **"you said…we didn't, why, and what we're doing instead"**

Engaging Staff, Patients and Public in the Quality Improvement of Patient Care - Look Forward

During 2017/18 significant improvements have been made in the way patients access a number of services and the time taken for people to receive the care they need. In addition there have been several innovative ways of working to support service users in managing their health and wellbeing.

Looking forward to 2018/19, we are adopting a more aligned and systematic approach to quality improvement, with a focus on identifying key priorities for improvement informed by what our patients are telling us, what our staff are experiencing, organisational goals and requirements of the Leeds Health and Care System. A number of Quality Improvement (QI) projects are initiated at different levels: organisational, service and team and involvement of patients will be a core part of the process. Participants in the QI work will be supported by a clear improvement methodology and will be introduced to QI tools to support this work.

We will continue to encourage new and innovative ideas from staff about care delivery such as the Dietetic passport, the 'Step-Up' App for young people with mental health conditions and the 'Let Me Show U' App which enables young people with disabilities to communicate effectively with care-givers. This work will be supported through the ongoing development of the Innovation and Research Council and Innovation huddles.

There will also be a real focus on celebrating and sharing our achievements, both within our organisation, locally and nationally. We have had great success in 2017 as Royal College of Nurses (RCN) Award winners for our integrated healthcare to children and young people in custody, and finalists for five Health Service Journal awards. We will continue to share our work through conference presentations, award submissions and internal opportunities to share knowledge, including our Innovation and Research Hub.

The Patient's Voice at Board Meetings

LCH remains committed to ensuring that discussions at Board and Board sub-committees are informed by the views of patients/carers and staff.

The Board continues to receive a patient's story at each of its public meetings. There are no formal papers for this item but a patient, family member or carer attends and 'tells their story' and there is an opportunity for Board members to ask the patient/ patient representative some further questions.

Examples of patient stories that have been presented and discussed at Board are included within this report to demonstrate how LCH works with patients and their families/carers to provide high quality, patient-centred care.

Board members continue to participate in service visits and these provide an opportunity for Board members to gain an insight into services and also to engage with service users and staff. The Quality Committee receives reports from these visits to enable lessons learnt to be shared across the Organisation.

Adult Business Unit:
Miss W - an Integrated Neighbourhood Team Approach

Miss W had a recent diagnosis of Alzheimer's Dementia and had been discharged from memory services.

She had been referred to the Memory Support Worker Service by her GP after it was acknowledged that she was failing to access other services. Memory services had previously referred her to Adult Social Care but she had refused the offer of home help however Miss W was unable to shower herself and was unable to access her heater or cooking facilities despite a keen desire to maintain her independence.

A Neighbourhood Team Senior Nurse Clinician visited Miss W with a trusted neighbour. The patient admitted she wanted support in her home, but did not want personal care from a stranger. She identified with her neighbours consent that she would accept support from her if she was assisted to do so. The clinician discussed the difference between direct payments, Carers Allowance and Attendance Allowance and the patient agreed to a re-referral to Adult Social Care for direct payments.

The patient's needs were discussed at a Neighbourhood Team meeting where it was agreed that a Community Occupational Therapist (OT) assessment would be undertaken and a Neighbourhood Team Social Worker would re-open her case to look at a claim for direct payments. Social Services were advised to do a joint visit with her trusted neighbour. A further joint visit with the mental health liaison worker was also carried out to enable an OT assessment to take place.

Miss W was known to the local neighbourhood schemes and they were able to offer her a monthly lunch club and she was also referred to a second local lunch club who could offer a weekly meal with transport. The clinician contacted a local community centre who organised taxi support for the patient to attend a weekly Chairobics session at their centre. In addition the Access Bus was able to help her attend her local shopping centre weekly.

The patient recently had a fall and was admitted to a Community Care Bed for rehabilitation. LCH notified the various services involved and again on her return home, her neighbour was able to clean and prepare her home for her return and is now awaiting the direct payments service.

Miss W is able to maintain her independence in the community with this integrated support.

Children's Business Unit: Child and Adolescent Mental Health Services (CAMHS) Patient Story

In December 2017 the CAMHS Team Manager attended the Board meeting accompanied by a former patient and her parent who had received care and support from the Service.

The young person explained that in 2016 she had spent several months as an inpatient at the Trust's unit at Little Woodhouse Hall and advised that there were both male and female inpatients ranging in age from 12-18 years old. Both the young person and her mother agreed that the prospect of admission to the unit was frightening but that the healthcare support workers, nurses and other healthcare professionals made the experience as easy as possible.

The young person added that although her journey to recovery was difficult she felt supported and empowered by staff and the other young people who provided inspiration and friendship. The young person's mother said that the staff were excellent and she felt reassured that her daughter was in a safe environment. Staff were supportive of her as a parent and always ready to listen to her concerns and offer reassuring advice.

The young person stated that she had made a number of long lasting friendships with her fellow inpatients and that, with support and careful monitoring from staff, patients frequently worked together to face their problems.

The young person explained that after she was discharged she was supported by the Tier 3 CAMHS Service for several months but unfortunately suffered a relapse requiring a further admission as an inpatient. Since there were no beds available at Little Woodhouse Hall she had to be admitted to a facility outside of the area and her mother spoke about the difficulties for her daughter and the family as a result of not being able to receive treatment close to home and in an unfamiliar environment.

The young person advised that she was now attending college full time and without the treatment and support she had received from CAMHS this would have not been possible.

A Non-Executive Director asked how important it was to have a relationship with her peers whilst an inpatient in Little Woodhouse Hall and she responded that she thought patients motivated each other to recover and supported each other to make the experience easier. Her mother advised that staff monitor friendships very carefully to ensure that they are appropriate and positive.

The Trust Chair thanked the young person and her mother for attending and speaking so eloquently and telling such a compelling story. Reflecting on this the Chair said that there were many positives but that it also highlighted areas of concern regarding the care of children and young people with complex mental health problems.

Although there were no direct changes as a result of this young person's story LCH continues to work closely and collaboratively with all young people. A participation group has recently commenced facilitated by a member of staff and the CAMHS Participation Lead.

The Service is moving to new premises which will enable them to support more than double the number of young people that we are currently able to support. This is as a direct recognition of the lack of in-patient facilities available locally resulting in too many young people being placed in beds far away from their families and local surroundings.

Specialist Business Unit:
Dietetics Patient Story

Dietitian Mark Hodgson presented a patient story to the Board on behalf of a lady who had been referred for advice regarding management of bloating in her gut. The patient was on holiday at the time of the Board and therefore unable to attend in person.

The patient described her bloating as severe, (she scored it as 9 on a scale of 0 -10 where 10 is the worst possible score) and stated that this had a profound impact on her life and mental health. She reported that her relationship had suffered and she feared her partner putting his arms around her waist as she lacked confidence in her body image, could not buy clothes like she used to and was not comfortable on holidays as the thought of looking pregnant in a bikini made her self-conscious. She stated that she was paranoid, felt guilty for eating and sick when she looked in a mirror. She started exercising obsessively, contemplated taking laxatives and thought that she was developing an eating disorder.

The patient told the dietitian that after years of suffering, she was eventually referred to LCH's Dietetics Service. She was frustrated that the referral wasn't made sooner as she felt time had been wasted attending her GP every 3 weeks for blood tests, abdominal examinations and trying various advice from her GP that did not help with her bloating. With the dietitian's advice and support, the patient followed a complex exclusion diet known as FODMAPs (Fermentable Oligosaccharides, Disaccharides, Monosaccharides and Polyols, a collection of poorly absorbed, simple and complex sugars found in fruit, vegetables, milk and wheat) to try to identify if any particular foods were aggravating her symptoms. The patient advised that she now knows what to avoid or to eat in small quantities to keep her bloating under control (she now scores her bloating at a 3 which is a significant improvement from 9 prior to her receiving this dietary advice). The patient reported that she has her confidence and normal lifestyle back and is very grateful for the help she received from the dietitian.

The patient reported that she has her confidence and normal lifestyle back and is very grateful for the help she received from the dietitian.

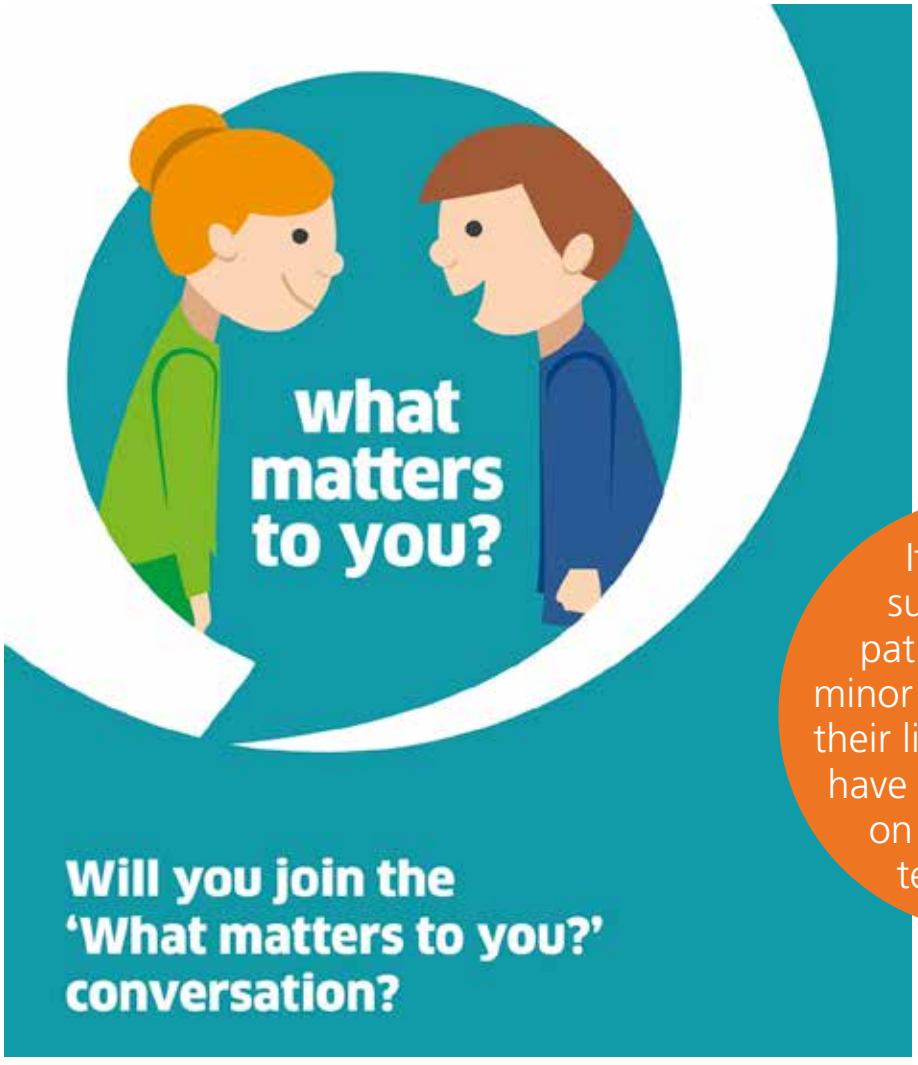
Prevention and Early Intervention and Self–care

With an ageing and increasing population that frequently presents with multiple long term conditions we need a different approach to improving health and well-being. There is strong evidence that health coaching, motivational interviewing and self-management work.

Over the last year we have worked with patients and our staff to begin to develop a culture of prevention and self-care. We have listened carefully to the patients we provide care to and firmly believe that working with and starting with the outcomes (goal setting) that a person wishes to achieve benefits the individual, the community and the NHS.

The goal setting approach can be very simple. It might seem a complicated process and challenging to do but it's fundamentally about having helpful conversations, a bit like planting a seed that with a bit of nurturing by interested and supportive clinicians can grow and empower a patient's ability to support their own health care needs.

It could be supporting a patient to make minor adjustments to their lifestyle that will have a huge impact on their longer term health. Some examples of this include eating a well-balanced diet and maintaining adequate fluid intake, stopping smoking and increasing exercise levels. Promoting healthy ageing and helping people take care of themselves also helps to reduce their risk of falls. It might be working with patients to follow pressure area prevention advice or take over the management of their medication e.g. self-administration of Insulin or Tinzaparin (an anticoagulant that helps the prevention of blood clots). For our young people work is focusing on developing accessible information and tools with children and young people in formats that they wish to use.



People have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management is a term used to include all the actions taken by people to recognise, treat and manage their own health. They might do this independently or in partnership with the healthcare system.

It could be supporting a patient to make minor adjustments to their lifestyle that will have a huge impact on their longer term health

Diabetes Structured Education
The LEEDS Programme

The aim of the LEEDS (Learning, Empowering, Enabling Diabetes Self–Management) Programme is to increase knowledge and self-management skills in people who have Type 2 Diabetes.

This might lead to an improvement in diabetes control, reduced medication requirements and a better quality of life.

The programme has been developed by Alyson Cawthorne, Lead Diabetes Dietitian, in response to the request for a bespoke programme for Leeds and has since been awarded QISMET (Quality Institute for Self-Management Education and Training) accreditation.

The LEEDS Programme is a 3 week course with each session lasting for 2 ½ hours. Topics covered include, 'what is diabetes', 'blood tests and what they mean', medications, healthy lifestyles (includes diet, alcohol, exercise, smoking) and the importance of working towards a healthy weight. Reducing the risk of longer term complications, stress management, action planning and goal setting are also included.

The Trust has recently been awarded transformation bid money to extend the programme to deliver 125 programmes per year, particularly focusing on BME (Black and Minority Ethnic) groups; men aged over 40 and deprived areas. We will also be delivering programmes out of hours (evenings and weekends) to cater for patients who are unable to attend during the day.

The programme is evaluated via patient satisfaction and their confidence in self-management of their condition and we also hope to conduct a 12 month follow up to monitor improvements in HbA1c.

Review of 2017/18 Quality Account Quality Improvement Priorities

At LCH we use the Care Quality Commission (CQC) framework and domains of Safe, Effective, Caring, Responsive and Well Led to review the quality of our services.

This section reviews the priorities we set for 2017/18 and describes our achievements during the year as well as some of the challenges the Trust has faced.

Safe

Table 1 shows the Quality Account priorities for 2017/18 relating to the CQC domain of **safe**, the progress against each priority and further work identified for 2018/19.

Quality area for action	Achievements to date	Comments
Protecting patients from harm that happens in our care (Sign up to Safety pledge) Sign up to SAFETY LISTEN LEARN ACT	**a) 10% reduction in avoidable category 3 pressure ulcers** The number of Category 3 pressure ulcers deemed to be 'avoidable' during 2017/18 was 13. This is a 35% reduction from 2016/17 and as a proportion of all category 3 pressure ulcers reported shows a figure of 10.7%. **Achieved** **b) No avoidable category 4 pressure ulcers** The Trust reported and investigated 4 Category 4 'avoidable' pressure ulcers during 2017/18 from a total of 13 that were reported. **Not achieved**	The Trust continues to work to reduce the occurrence of avoidable pressure ulcers and there is further information on work that has taken place within this report.
	c) 5% reduction in falls resulting in avoidable harm in our community inpatient units In 2017/18, 3 of the 20 (15%) inpatient falls incidents where harm was recorded were classed as 'avoidable'. In 2016/17 11 of the 45 (24.4%) falls were classed as 'avoidable' so this demonstrates an improvement although changes to inpatient provision has meant a reduction in the number of beds directly managed by the Trust. **Achieved**	The Trust continues to implement the falls prevention plan and further details regarding this are included within this report.

Quality area for action	Achievements to date	Comments
Strengthen incident management and ensure investigations are completed on time	a) **60.2%** of all low/no harm incidents (of all those that fall under the 15 day criteria) were investigated and closed within this timeframe. This demonstrates a 7.5% increase in compliance. b) **69.1%** (723) of all moderate harm and above incidents (that fall under the 30 day criteria) were investigated and closed within this timeframe, demonstrating a 15.2% increase in compliance. c) **100%** of all SI's reported individually were closed within the time limit (of all submitted reports to CCG). Combined quarterly reports to the commissioners for unstageable and Category 3 pressure ulcers have been sent on schedule. **Achieved**	Further details are included within the incident management section of the report.

Falls Group and Pressure Ulcer Management Progress in 2017/18 and a look forward

Both the Pressure Ulcer and Falls Steering Group meetings within LCH are now well established and have current work plans that are progressing.

The pressure ulcer improvement plan has been completed and a new action plan developed in light of ongoing learning.

The Trust had a pressure ulcer improvement plan which it was working on during 2017-18 and good progress has been made, with most actions either complete or on track to be completed within agreed timescales. In December 2017 a workshop was held to review progress with pressure ulcer prevention and to identify further actions required. This was particularly pertinent as there had been an increase in 'avoidable; pressure ulcers, specifically Category 4 pressure ulcers, in the second and third quarters of 2017-18. The workshop provided an opportunity to consider as a group these themes and identify further actions to reduce the number of avoidable pressure ulcers. Feedback from the workshop is being used to refresh the pressure ulcer improvement plan for 2018/19.

An evaluation of both the falls and pressure ulcer review process took place in 2017 resulting in a streamlined approach for both, with a 72 hour review period to determine if the injury was 'avoidable', and if this was considered the case then the incident was moved to a full Serious Incident (SI) investigation, if not further investigation would not be required. This has resulted in clinical time being saved so that only cases deemed avoidable are investigated to ensure that there is learning from these incidents.

We are working with our partners across the city to re-establish the city wide pressure ulcer prevention group to ensure we are as proactive as possible in the area of prevention. We will also be looking to hold further events around falls and pressure ulcer prevention throughout the year and these will be factored into the actions plans for both falls and pressure ulcer prevention.

Our aims remain to continue to reduce harm from falls and pressure ulcers and to ensure that staff provide care that is both of a high quality and effective at all times.

Incident Management

Incident management was a quality account priority for 2017/18 with a particular focus on reducing the incidence of pressure ulcers and strengthening the incident management process to ensure investigations were completed in a timely manner and incidents closed within required timescales.

LCH has a policy which sets out the timeframes for investigating and closing incidents, according to the category of harm caused. Progress with these targets is outlined in Table 1.

This year modifications to the Datix incidents module have been made to enhance the monitoring of incident management and highlight overdue incidents. Since this information is on the 'home page' for most users, it is very clear how many overdue incidents users have within their caseloads acting as a visual prompt to ensure timely investigation and closure of incidents.

The Clinical Governance Team (CGT) also initiates a weekly email from Datix to all incident handlers and investigator who have an overdue incident, to allow these to be quickly updated. All overdue incidents not responded to are escalated within the Business Unit and monitored via Quality Committee reporting.

Incident Partnership Working

LCH has engaged with other providers across the city and the Clinical Commissioning Groups (CCGs) to look at how Serious Incidents (SI's) are managed. This has improved the links for undertaking joint investigations ensuring close working where more than one organisation is involved.

The Trust has amended its process for recording SI's relating to pressure ulcer damage following this partnership working and now only records 'avoidable harm' from Category 3, 4 or unstageable pressure ulcers as SI's. This enables investigations to focus on areas where the opportunity for learning is the greatest and also brings the Trust in alignment with other providers to ensure consistency of reporting.

Incident Investigator Training

Datix®
Software for patient safety

All incidents are logged onto our electronic Risk Management System (Datix) and this information is used to analyse where incidents occur and also patient outcomes. When a patient sustains moderate or severe harm as a result of an incident an in-depth, detailed investigation process is undertaken called a Root Cause Analysis (RCA). This is a nationally-recognised method of investigation to identify how and why incidents happen and findings from these investigations are used to identify areas where we can make changes, develop recommendations and share learning to prevent a recurrence of the incident and improve the care delivered to our patients.

A training programme for SI Lead Investigators has been developed and the training programme for all incidents revised to ensure that reporters/investigators at all levels have the right skills and knowledge.

New user and incident reporter training has also been developed and at the time this report was produced had been delivered to approximately 50 staff across the Organisation. Discussions have also taken place to provide focused training to specific staff groups and the CGT is working with services to facilitate this.

Effective

Table 2 shows the priorities relating to **effectiveness** set for 2017/18, the progress against each priority and further action required in 2018/19:

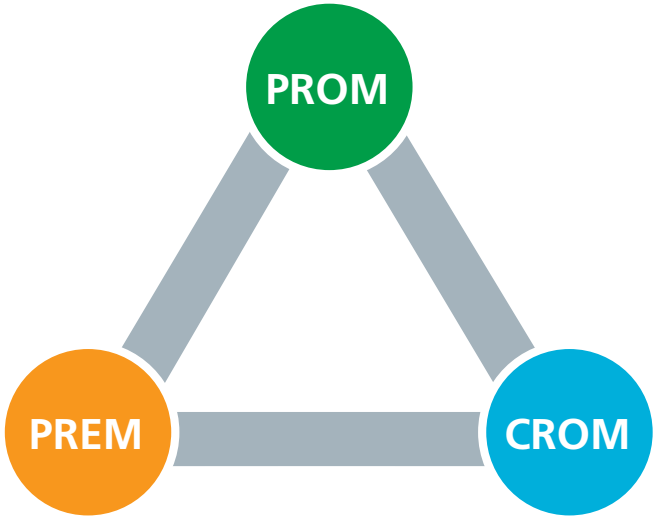
Quality area for action	Achievements to date	Comments
Outcome Measures	**Build on the progress made in 2016/17 and increase the number of services centrally reporting clinical outcome measures in 2017/18.** Significant progress has been made with this priority and a part time project manager recruited. An action plan has been developed and will continue to be implemented during 2018/19. **Partially achieved**	Further information on outcome measures is included within this report and work on this will continue throughout 2018/19.
Continue to progress the roll out of the e-rostering system	**Have clear rotas in place in a range of services including Neighbourhood Teams.** A new project plan has been developed and a new supplier identified following the termination of the contract with the initial supplier. Work will continue during 2018/19 to implement this. Not **Achieved due to the issues highlighted with the initial supplier**	The Trust is committed to this priority however the timescales for the project have been amended to reflect the project changes.

Outcome Measures

LCH is committed to the development and implementation of a clinical outcomes programme that takes account of and aligns itself to national, regional and local priorities. Services across the Trust have been collecting clinical outcome data on a regular basis; however LCH has identified the need for this data to be collected via a method more compatible with our electronic systems to enable more efficient analysis and reporting and for the clinical outcomes used in the Trust to be better directed by service and patient need.

There is currently no baseline data for the Trust as clinical outcome data previously collected has been done so via a method incompatible with the systems for extracting and analysing data. This is currently being addressed and baseline data collection will begin as part of a phased roll out in Q1 of 2018/19. Once the baseline is identified, a work plan will be created to address inequalities or areas where performance could be improved.

LCH has agreed upon a model for clinical outcome measurements in some of its services that takes a holistic approach to the measurement of clinical outcomes. This includes a Patient Reported Outcome Measure (PROM), a Patient Reported Experience Measure (PREM) and a Clinician Reported Outcome Measure (CROM).



The agreed PREM for use across the Trust is the Friends and Family test (FFT) which is currently used routinely in all services. There is, within some services, an opportunity to increase response rates although the Organisation does benchmark well against other community Trusts and is exploring ways to increase participation of service users in this measure.

PROMs and CROMs will vary depending on the service and patient specific needs, some of the measures will be validated measures and others will be developed in service, especially where provisions are highly specialised. The most widely used validated tools within the Trust currently are the EQ5D-5L and Therapy Outcome Measure (TOMS); these have been procured and are used in the EPR (Electonic Patient Record) System on first and last patient contact.

Neighbourhood Teams, MSK (musco-skeletal) and ICAN (Integrated Children with Additional Needs) Services have been identified as priority areas for clinical outcomes measurements and work will be planned following an assessment of the feasibility of a stepped roll out. A project Manager has been employed on a part time basis and is working with clinical and support services to facilitate and manage the planning and implementation of a feasible and meaningful clinical outcome measures project.

Measures of success for the clinical outcomes programme for 2018/19 will be:

1. **Enabling the use of outcome measures in System One via templates which allow data to be extracted easily**
2. **Increasing the use of PROMS and CROMS collected across the identified priority areas**
3. **Increasing participation of patients in the FFT (Trust preferred PREM)**

Work is continuing to identify a baseline which will enable the Trust to provide metrics towards the end of 2018/19.

E-Rostering System

An initial project plan was agreed with a supplier who had been contracted to provide the Trust with an e-rostering system. This contract was however terminated by mutual agreement in December 2017. The project followed the project closure process, including a full lessons learnt review to identify key aspects of the project that went well and also areas for improvement. The review also highlighted that there was still a requirement for an e-rostering system although the aims and focus of the project needed to be revised.

The e-rostering project business analyst has spent a considerable amount of time gathering intelligence about e-rostering suppliers and speaking with other NHS Trusts that have implemented such a system about their perspectives on e-rostering and the systems they are using. A desired new supplier has been identified, based on the available suppliers.

The Project Board met in February and agreed more detailed time lines for delivery of the project, the project structure and resources required for the different phases of work envisaged and work is progressing to implement the new project during 2018/19.

Caring

Table 3 shows the priorities relating to **caring** and **patient experience** agreed for 2017/18 and progress as well as further actions required during 2018/19:

Quality area for action	Achievements to date	Comments
Friends and Family Test (FFT)	**Continue to increase survey response rates to bring about an improved level of understanding of patient experience and satisfaction. The baseline target was set at 6.8%.** The overall response rate for 2017/18 was 5.4% which is below the baseline target. (Following a mid-year review however it had been identified that the target was ambitious and individual targets were agreed within each of the Business Units, and some services were successful in achieving these). **Not achieved**	Further information on the work around FFT is included within the report.
	Ensure FFT equality data is reflective of the patient population through promotion, in order to identify and better understand health inequalities; and bring about improvements in patient care. At the end of Q4 this indicator was rated 'Amber'. Currently there are a number of surveys in use within the Trust that do not ask for equality data which impacts on reported figures and further work is being undertaken regarding this. **Partially achieved**	The Equality and Diversity Manager is undertaking further work to explore this issue and identify actions to address this issue.
Duty of Candour	**100% of relevant persons should be notified of a safety incident (as per the definition) in person, given reasonable support in relation to the incident; and a written notification (unless declined).** During 2017/18 an apology was provided as appropriate in 100% of applicable cases and the Trust is therefore fully compliant with duty of candour requirements. **Achieved**	Further information on duty of candour is included within the report.

Friends and Family Test (FFT)

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses.

FFT has proved to be a powerful tool for service improvement by promoting a culture of increased responsiveness to patient feedback in the NHS. Through FFT, NHS staff receive regular, near real time feedback about the job they are doing. Often this feedback confirms what a great job they are doing, but where it is less positive it encourages staff to make changes in order to improve the quality of care experience." (NHS England, 2014)

The collection of FFT data has been compulsory for all NHS Community service providers since January 2015. LCH is compliant with the requirement to collect data and reports results regularly both internally and externally to NHS England via NHS Digital.

The Quality Account priorities set an overall Trust target of 6.8% for 2017/18 with a stretch target of 8%. The overall baseline was not achieved. However, recognising that this target was ambitious, services and business units set individual targets and many services were successful in achieving these and demonstrated improvement from the 2016/17 baseline.

More people are telling us what they think through FFT. During 2017/18 15,270 responses were received (5.35% response rate); with 96.7% of respondents saying they would recommend LCH services. This represents an increase in both figures compared to last year. People responding to FFT also provided 13,915 comments (positive and negative) about their experiences.

The Trust is currently reviewing its processes and exploring new ways of working to increase FFT response rates.

Duty of Candour

There is a statutory duty of candour for staff and organisations to be open, honest and truthful with patients when something has gone wrong with their care leading to moderate harm or above.

If a member of staff becomes aware of a patient safety incident that has resulted in moderate harm or above they need to:

- Speak with the patient as soon as possible after they realise that something has gone wrong
- Offer an appropriate remedy and support to put matters right
- Discuss with their line manager
- Record on Datix (an electronic risk management system)
- Record in the patient record that a suspected patient safety incident has occurred and also record if a verbal apology has been given.

Work has continued throughout 2017/18 to embed the duty of candour process and to raise staff awareness and incident handler responsibilities for accurately recording this process.

The Trust has provided an apology in **100%** of appropriate cases and is fully compliant with duty of candour requirements.

Being Open

Responsive

Table 4 shows progress with the 2017/18 quality priorities that fit within the **responsiveness** domain and actions that will continue during 2018/19:

Quality area for action	Achievements to date	Comments
Access to Services - Increase timely access to Child and Adolescent Mental Health Service (CAMHS)	**a) CAMHS: access to clinical intervention (i.e. following assessment) to be no longer than 12 weeks. Target to be measured from the date of being placed on the waiting list for intervention.** As of 9 April 2018 there were 29 children waiting over 12 weeks for a Complex Communications Assessment. **CAMHS Eating disorders** • 89.9% of routine referrals were seen within the 4 week target • 100% of urgent referrals were seen within the 1 week target **Consultation clinic** • There were 348 waiters on the waiting list at the end of March 2018. • 133 waiters are at 12+ weeks. Patient Choice applies to 2 of them • 16 of the 12+ week waiters either cancelled or failed to attend recent booked appointments • 86 of the133 current 12+ week waiters are due to be seen by the end of April • There are 20 High Priority waiters, all have appointments booked in except 2, both of these patients failed to attend recent appointments **Autism assessment** • The overall size of the waiting list is 72 waiters as of 31 March 2018 • Of these, 22 (31%) have been waiting 12+ weeks - Nine 4 week waiters are still to be booked in for a first appointment - One 7 week waiter yet to be booked in for a first appointment **Not achieved - although significant progress has been made.**	Further information is included within the report.

Quality area for action	Achievements to date	Comments
Access to Services - Increase timely access to Child and Adolescent Mental Health Service (CAMHS)	**b) ICAN: parent group intervention for Children with ASD diagnosis within 12 weeks of diagnosis - follow up medical appointments within 4 weeks of planned date** 100% of pre-school children given ASD diagnosis in Q4 were offered Stay and Play intervention within 12 weeks of diagnosis. **Achieved**	
	c) ICAN follow up appointments within 4 weeks of planned date Overall Community Paediatric clinic (CPC) - 52% Overall Paediatric Neurodisability Clinic (PND) - 53%	Further information is included within the report.
	d) See 80% of initial appointments for Occupational Therapy (OT) and Physiotherapy (PT) within 12 weeks As of 31 March 2018 91.2% of appointments for PT were within 12 weeks. 76.4% of OT appointments were within 12 weeks. 80% of patient were seen within 12.6 weeks. **Achieved**	Although this fell slightly short of the 12 weeks target 80% were seen within 12.6 weeks so this was close to achieving the stretch target.
	e) CUCS (Colorectal and Urinary Continence Service) Associate Practitioner initial assess 18 weeks and Specialist Nursing Review to reduce over the year to18 weeks **As of 31 March 18 the position is as follows:** Waiting times: Community Nurse Specialist (CNS) Urology – 17 weeks Colorectal – 23 weeks Assistant Practitioner – 16 weeks Waiting times have increased due to short/long term sickness and induction periods for new staff. **Not achieved**	In a small team such as CUCS one or two members of staff off sick has a significant impact on service delivery. Measures including overtime for weekend clinics have had to be cancelled due to sickness. Home visits remain in place to ensure progress is maintained. Additional AP hours have been agreed to extend the secondment to continue this progress. There is an ongoing focus to reduce waiting times.
Learning from Patient Experience	**a) 100% of partially and fully upheld complaints will have SMART action plans.** There was a demonstrable improvement over the year in the percentage of partially and fully upheld complaints that had SMART action plans and by the end of the year this target has been met. **Achieved**	Further information on this is included within the report.
	b) The Patient Experience Policy will be revised as part of wider service changes. The Policy is currently going through the Trust's approval process and it is anticipated that this will be completed by May 2018. **Achieved**	Further information on this is included within the report.

Access to Services

LCH continues to work to ensure that patients are able to access services in a timely manner. Co-working continues across services to look at what can be done to manage wait times given the staff challenges and increasing demand.

Within CAMHS new ways of working have been put in place to address capacity and demand and internal systems and processes are being reviewed with the aim of streamlining the service and being more effective. We continue to look at joint pathways with other LCH colleagues and external partners as well as looking at skill mix and succession planning, budgetary management and exploring the use of technology.
A recent audit was carried out to review capacity and demand and there are plans to re-audit this.

Learning from Patient Experience

Every time someone chooses to tell us about their experience at LCH it is a unique opportunity for learning and improvement.

As an organisation the Trust seeks to share and celebrate good practice while appreciating the courage of those who speak up when the expected levels of service are not met.

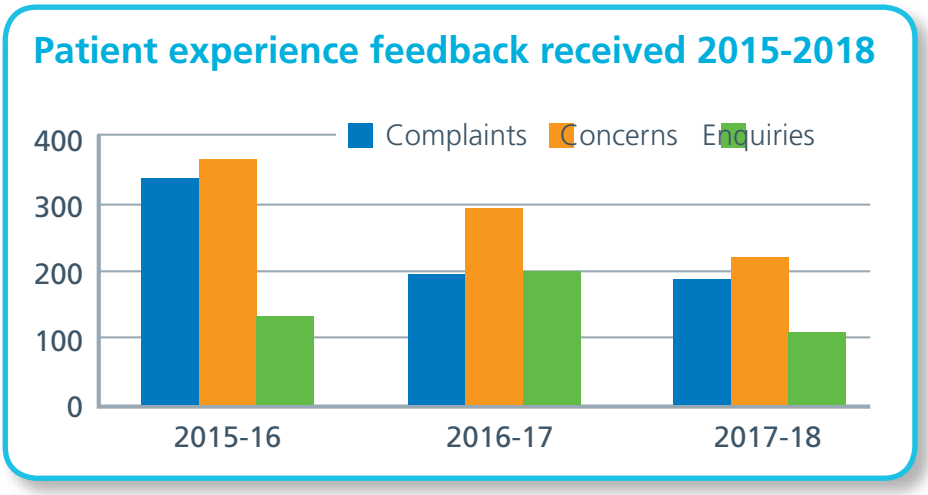
To help us to achieve this:

- The Service Lead reviews all completed investigations, draft responses and recommended learning and action plans prior to the response being sent for Executive review and CEO (Chief Executive Officer) review/sign off.
- Actions and learning and identified themes are reviewed and discussed at the Patient Safety, Experience and Governance Group (PSEGG).
- Compliments and outcomes of concern and complaint investigations are discussed with named practitioners as part of individual appraisal or supervision and with service teams.
- Patient Experience and Feedback is a standing item on team meeting agendas.
- The Patient Experience Team reviews all identified actions and progress of implementation of any changes and disseminates learning throughout the Trust through:
  - Regular reporting
  - Analysis of compliments, concerns and complaints through PSEGG and the Involvement Champions network
  - Updates in Community Talk
- Lessons learnt from complaints and also themes and trends are reported via Quality Committee to provide assurance to the Board that the Trust is fulfilling its statutory obligations.

In the last year the Trust has seen the amount of patient feedback received by traditional channels continue to reduce. During 2017/18 we received **188** complaints relating to services LCH provides. Eleven complainants asked the Trust to re-open their complaints to look at issues again. Three referrals were made to the Parliamentary and Health Services Ombudsman; (two of the referrals were about the same complaint) and none of these were upheld by the Ombudsman. There were also 221 concerns and a total of 107 enquiries recorded. We also received 2196 compliments.

Of the complaints we received, the Trust upheld either part or all of 51% of them and answered more than half of the complaints received within our target response time of 40 working days or less.

The table below shows the number of complaints, concerns and enquires received by the Patient Experience Team over the past three years.



The top themes for complaints in 2017/18 were:

1. Appointments
2. Clinical judgement / treatment
3. Attitude, conduct, cultural and dignity issues
4. Communication issues with the patient
5. Access and availability

In 2017-18, LCH set two Quality Account priorities for complaints:

a) All partially and fully upheld complaints should have a SMART action plan as part of the complaint response

b) The Patient Experience Policy will be reviewed and revised

The Patient Experience Team has worked with services involved in complaints to embed the practice of providing an action plan at the same time as a response is drafted to the complainant. This means action plans receive the same level of executive scrutiny as the responses we provide. During the year the percentage of complaints with an action plan has risen steadily from 55% at the start of the year to 100% by the end of the year, therefore the Trust was successful in meeting this target.

Patient Experience Policy

The 'Patient Experience: Dealing with Compliments, Concerns, and Complaints' Policy ensures that there is a consistent approach across the whole organisation in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. The Policy has been updated to reflect changes in the process regarding the required submission of action plans.

The adoption and implementation of this policy affirms the Trust's commitment to improving the quality and experience of care by:

- Encouraging and welcoming all patient feedback
- Making it easier for patients to tell us about their experiences
- Communicating clearly and regularly when concerns or complaints are made
- Being honest when mistakes are made or identified
- Using feedback to learn and take action to improve services

The Patient Experience Policy has been reviewed, revised and has completed the consultation process and it is anticipated the Policy will be ratified in May 2018. This priority has therefore been achieved.

Cast of Zoetrope

Patient Experience of Community Mental Health Services

The table below summarises patient experience of LCH **Specialist Child and Adolescent Mental Health Service** (CAMHS) interventions during this year and previous years:

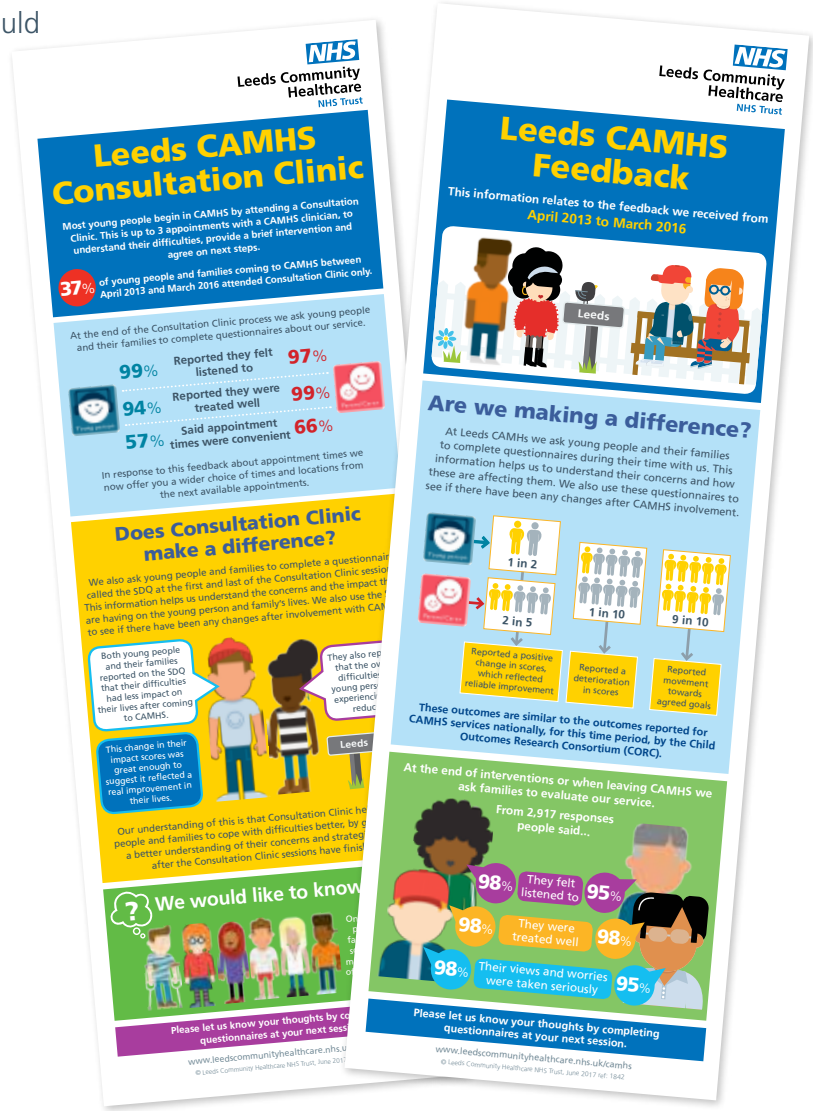
Reporting year	Community CAMHS		Inpatient CAMHS	
	Young persons' satisfaction	Parents and carers' satisfaction	Young persons' satisfaction	Parents and carers' satisfaction
2015/16	78.26%	88.15%	71.43%	86.46%
2016/17	82.18%	88.16%	79.17%	88.89%
2017/18	78.81%	88.29%	*	*

Source: CHI-ESQ, a CAMHS-specific satisfaction questionnaire used nationwide

*The completion rate for inpatients CAMHS satisfaction in 2017/18 was only 5 respondents, this was therefore not considered to be representative and the inpatient CAMHS figures for 2017/18 have thus been excluded. The Service is looking at ways to increase the response rate during 2018/2019.

LCH considers that these indicator scores are as described for the following reasons:

- **Recruitment** – Young people, parents and carers have participated in a number of recruitment events this year. Training has been provided around recruitment and the process and a scoring sheet that included a colour coded traffic light system and facial expressions has been developed which should be more suitable for the young people attending CAMHS.
- **Little Woodhouse Hall Guide** – A guide to the Unit has been developed and written by young people following feedback where it was considered that this would be useful for young people and their families prior to admission.
- **Participation meetings** – these have been established and take place regularly. A participation newsletter has also been introduced.
- **West Yorkshire Playhouse** – Our community and inpatient participation groups met the cast of Zoetrope following an invitation from the youth theatre director. Staff from CAMHS also had a stall in the foyer of the Playhouse displaying useful information.
- **Young people's stories** – We received feedback that young people and their families would like to see posters in waiting rooms with a positive theme. They also suggested that patient and families stories would give hope and as a result a new project is being developed to address this.
- **Patient Experience** – 'You said we did' posters have been introduced and parents have been invited to provide feedback and also to discuss feedback themes.
- **Eating Disorder Service** – Young people have been invited to a number of events this year and taken an active part in consultation regarding service development.



Leeds Children and Young People's Eating Disorders Service

Well-led

Table 5 below describes the priorities relating to **well led** for 2017/18 and progress with these priorities:

Quality area for action	Achievements to date	Comments
Leadership	**Develop leadership and management throughout the organisation through implementation of the leader development LEAD programme and Manager as Coach Programme.** The Trust continues to develop its leadership capability through its Coaching Strategy which supports the development of staff via four areas, 1-1 coaching, team coaching, health coaching and Manager as Coach (MAC). **Achieved**	Further details on the work around leadership is included within this report.
Staff Engagement	**Increase year on year the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey.** The overall engagement score has improved since 2016 and has been steadily increasing since 2013. **Achieved**	Further information on staff engagement and the findings from the Staff Survey are included within this report.

Leadership

The Trust continues to develop its leadership capability through its Coaching Strategy which supports the development of staff via four areas, 1-1 coaching, team coaching, health coaching and Manager as Coach (MAC).

Health Coaching

Building on last year's momentum and the fantastic work that was achieved in training staff in health coaching, this year has seen another 80 staff access the 2 day training from the children's ICAN service, adult neighbourhood teams and the long term conditions teams. In addition, the organisation has committed to another six, 2 day programmes with the potential to train another 120 staff from across the 3 business units up to July 2018. The health coaching approach has seen significant spread across the Leeds health and care system and has been a key piece of work aligning LCH with other key health and care organisations across the city to reach the ambition of a 'working with' approach with citizens. The future looks even more exciting having secured funding from the Better Care Fund to enable health coaching and the Trust to become part of a citywide framework offering skills training and embedding support for the 'working with' approach.

health coaching
better conversations
better health

LEAD Programme and Manager as Coach (MAC) Programme

Our leadership development is an integrated and sustained process, not a one off event, or series of disconnected events. The leadership concepts and understandings embedded in the LEAD programme are designed to be relevant, connected, and applicable to real world and work environment.

The programme offers a variety of experiential courses. An essential element of the programme is Manager as Coach (MAC) consisting of five modules. There are opportunities to attend the relevant sessions on the development programme that have been designed to equip new leaders with skills in the fundamental areas of management essentials. Small groups of about 6 LEAD participants will come together through a Peer Coaching Group. These sessions are facilitated in the early stages of group formation to help consolidate learning and encourage collective support, before becoming self-facilitated. As part of the programme, participants undertake a 360 Degree Feedback and personality assessment that is used to coach participants in their work performance and career. In addition participants have the option to attend a Mindfulness programme, as well as One-to-One Coaching.

Sixty eight managers have undergone Manager as Coach training over the past 12 months. At the 6 month evaluation managers reported that they have increased confidence, more time and ability to have challenging conversations. Frequently, participants have recommended the course to peers and direct reports working in the same service. This is helping to build and strengthen a coaching culture where a belief in the resource and potential of individual staff leads to their growth and development.

Our register of 13 accredited coaches and 3 coaches in training have sustained their commitment to coach despite the competing demands on their time. We have delivered six group-coaching supervision sessions and several 1:1 supervision sessions to maintain coaching standards, the development of coaches and motivation to continue practice.

All coaches have now been registered on mye-coach (the regional electronic data base supported and maintained by the Leadership Academy). Recording of activity has remained a challenge for the coaches as they are still not familiar enough with the system for this to be an automatic process. We will continue to encourage coaches to engage with this since this would help us to exploit the full potential of this system to provide useful intelligence about coaching activity.

In terms of health and wellbeing coaches continue to say that coaching offers them a chance to stop, think and challenge themselves enabling them to remain at work.

Staff Engagement

LCH values the views of staff and has several initiatives to engage with staff within the organisation.

Engagement events have taken place with three groups of staff – place-based frontline multidisciplinary staff in Chapeltown, Armley and Beeston; senior and middle managers across Leeds City Council; the NHS and the Leeds Universities and one session focused on University staff engaged in pre-registration training. These 'working with' and health coaching engagement sessions took place between November 2016 and June 2017 with the aim of the sessions being to work with health and care staff to generate discussions around the 'working with' principle and the associated approaches that includes health coaching, collaborative care and support planning, strength based social care and making every contact count (MECC).

The events were attended by 300 staff working in health and care organisations across the city alongside NHS England who attended one of the sessions. Feedback from all events was captured and will form part of the health coaching evaluation.

To date we have trained 240 staff in health coaching and we are currently bidding for additional funds to take the Leeds "working with" approach forward in a more integrated and coordinated way across the city.

LCH staff reported that having greater staff satisfaction, building up relationships with patients and promoting self-management has been core for them. Being able to have adult to adult conversations with each other has featured strongly as part of one to ones, clinical supervision, appraisals, team meetings and staff really value being listened to.

Key themes emerging from the events included:

- The real support for a push forward with the 'working with' principle.
- The need for skills development at scale for health and care staff.
- The need to introduce 'working with' / health coaching into academia.
- The great opportunity to unite the health and care system in Leeds through a unified conversation with those accessing health and care in Leeds.
- The need for real organisational sign up to this approach.
- The requirement for significant resource to change the culture of conversations.

Staff Survey

The results of the 2017 NHS National Staff Survey were formally released by NHS England on the 6 March 2018. The outcome of the staff survey for LCH is based on the results from over half of our workforce which is very encouraging.

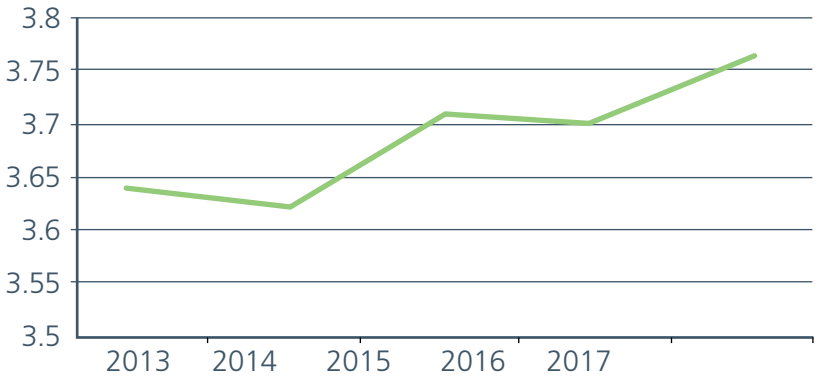
The purpose of the survey is to enable NHS organisations to use their results to review and improve staff experience.

The purpose of the survey is to enable NHS organisations to use their results to review and improve staff experience, which can directly contribute to staff providing better care. Regulatory bodies such as the CQC and NHS Improvement (NHSi) use the results from the survey to monitor on-going compliance with the essential standards of quality and safety.

The overall engagement score has improved since 2016 and has been steadily increasing since 2013 (see table below). LCH performs at average (-0.01%) versus the benchmark group. The engagement measurement comprises of three key areas:

- **Recommendation of the Trust as a place to work and receive treatment**
  (LCH scores above average)
  (Key Finding 1)
- **Staff motivation**
  (LCH scores average)
  (Key Finding 4)
- **Staff ability to contribute to improvements**
  (LCH scores below average)
  (Key Finding 7)

LCH Engagement Score 2013 – 2017



50 Voices

LCH has established a '50 Voices' Group that meets with the Chief Executive and other senior colleagues three or four times over a six month period to help the Trust think through difficult issues facing the organisation, and to help come up with the best solutions we can to create the working lives we want. Of course, this is not the only way staff can get involved with commenting on and shaping the way we work in the organisation and it is not a formal consultative body.

It is however a place for people from all parts of the organisation to come together and work with the Chief Executive on issues that they are unsure about how to solve - from dress code, to staff sickness, to lone working and estate strategy.

The Group is open to everyone within LCH regardless of their position. All staff need is an interest in being part of creating the best working lives we can – for all staff. Group members are invited to four meetings in total and also receive a few emails from the Chief Executive during their time in the Group however how much staff get involved is up to them. Feedback from participants is always good and staff are frequently surprised at how much they are involved.

Section 2

Additional Quality Improvement Initiatives during 2017/18

As well as the Quality Account priorities highlighted within the report, there has been a considerable amount of additional work undertaken within the Organisation to further improve the quality of care, using both new and innovative ways of working.

This section provides an opportunity to highlight some of this work using the CQC domains of Safe, Effective, Caring, Responsive and Well-led.

Safe

Infection Prevention and Control
Raising the profile of Infection Prevention through innovation and engagement 2017-18

Throughout the year the Infection Prevention Team has continued to address the challenges faced through increasing antibiotic resistance and the enhanced vulnerabilities of some of the patients we care for.

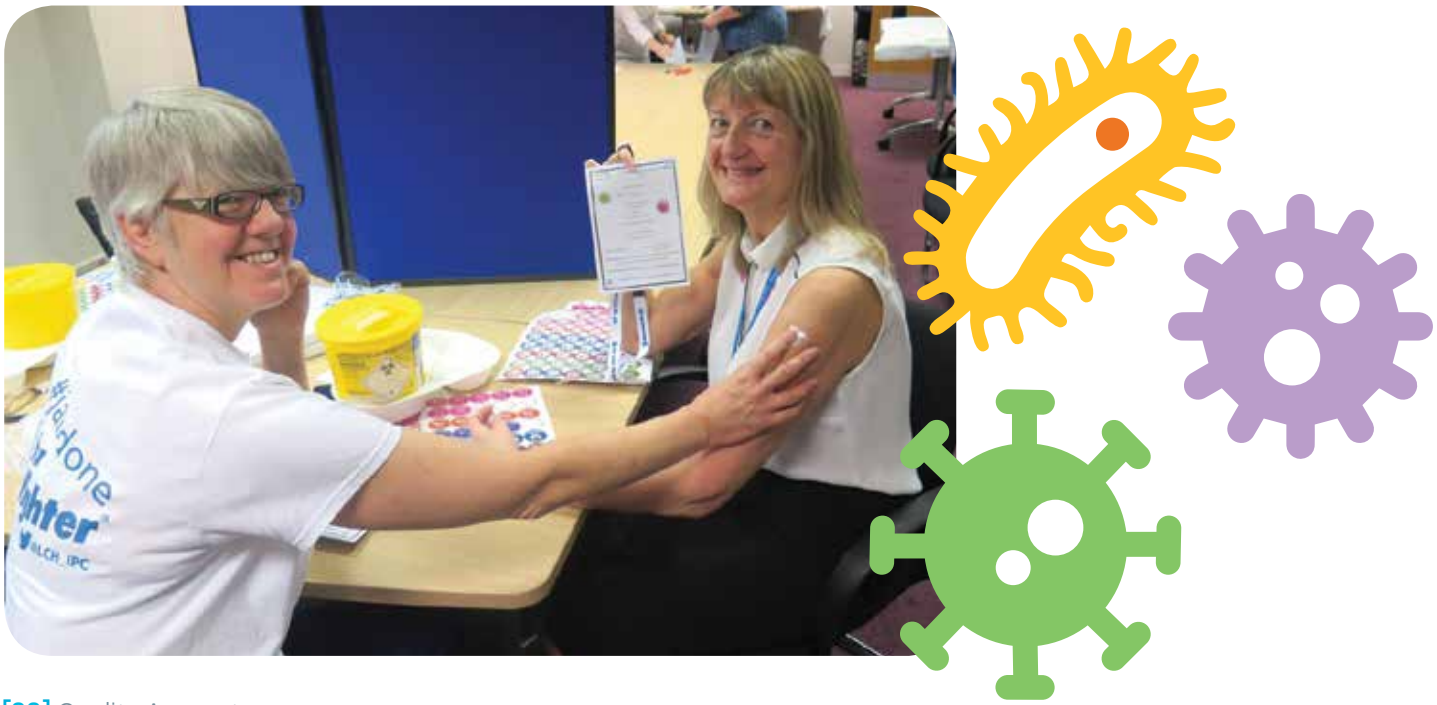
LCH continues to place infection prevention and basic hygiene at the heart of safe care and clinical practice, and we are committed to a "zero tolerance" approach to preventable healthcare associated infection.

Over the past year the Infection Prevention team has worked closely with care delivery staff both working within LCH and the wider health economy to promote a clear message emphasising the importance of safe infection prevention practice. Central to this has been a process of changing "hearts and minds" of staff by promoting the ethos that infection prevention is everyone's responsibility and should be an integral part of a patient's care. To date LCH has achieved the local and national targets for reportable infections: Clostridium difficile (CDI) and MRSA bacteraemia.

- No cases of MRSA bacteraemia have been assigned to LCH within 2017-18
- One case of CDI was reported on our Community Intermediate Care Unit at St James's Hospital during June 2017. A full Post Infection Review (PIR) was completed and this concluded that there were no lapses in care or evidence of transmission within the unit

Throughout this we have worked towards the following objectives:

- Raising the profile of Infection Prevention Control
- Addressing seasonally important issues such as influenza, Norovirus, hand hygiene
- Enhancing engagement with our Neighbourhood Teams and specialist departments
- Highlighting sharps safety compliance, both organisationally and with the general public
- Reinforcing that Infection Prevention and Control is everyone's responsibility



Safeguarding

LCH ensures there are systems and processes in place to promote the safeguarding and wellbeing of the people of Leeds.

The Trust monitors and develops practice in light of both local and national guidelines and works in partnership with patients, their families, carers and other agencies to ensure that it provides a safe environment for all patients.

Safeguarding is about engaging with people ensuring they have choice and control in safeguarding situations (Making Safeguarding personal: Guide 2014). 'Using a personalised approach that enables safeguarding to be done with, not to, people. An approach that enables practitioners, families, teams and Safeguarding Adult Boards to know what difference has been made'. (Local Government Association: Making safeguarding personal 2018).

Safeguarding is about engaging with people ensuring they have choice and control in safeguarding situations.
(Making Safeguarding personal: Guide 2014)

During 2017/18 we have supported staff across the Trust to work with our service users; encouraging everyone we come into contact with to trust that we will support them to live free from abuse, neglect or emotional harm.

We have demonstrated our commitment to this through:

- Revision of our Children Looked After Health Needs Assessment tool to bring this in line with the Education Health and Care Plan assessment tool so that these assessments can support each other, reducing duplication for us and more importantly for the children and families we deliver care to
- Participation in a Challenge Event facilitated by the Student Local Safeguarding Children Board, sharing all the ways in which we engage with children and families to help us shape our services to meet the needs of the people of Leeds.

Other developments have included clear and strong commitment to:

- The relaunched 'Neglect Strategy'
- Adopting the NHSE sponsored "Was Not Brought" approach; refocusing away from the expense and inconvenience missed appointment cause the NHS to giving consideration to why a child was unable to get to an appointment and addressing barriers to accessing services

Partnership working is crucial to safeguarding and Ofsted recognised the strength of this between LCH and colleagues in Social Care.

Legislative guidance impacts on our day to day practice e.g. the Reference Guide to Consent for Examination and Treatment, Department of Health (2009) and the Mental Capacity Act (2005). A template has been developed for use within our Electronic Patient Records (EPR) system to support staff in obtaining valid consent when providing care and treatment to patients. This ensures the recording of valid consent is lawful and supports clinical practice.

The new template has improved the documentation of consent and capacity assessments which enables the Trust to evidence how we are implementing the above legislation. Feedback from clinicians is that this not only streamlines the process for recording consent and capacity assessments, but also encourages more person-centred care, placing our patients at the heart of decisions about their care and treatment.

One final success has been achievement of the NHSE target of a minimum of 85% of our key frontline staff trained in recognising and responding to the needs of service users who may be at risk of radicalisation.

We envisage that 2018-19 will continue to be an equally challenging year as we continuously review, revise and improve on safeguarding practice with our colleagues in the Leeds Safeguarding Adults Board, Safer Leeds and the Leeds Safeguarding Children Partnership (formerly LSCB).

Guardian for Safe Working Hours
Doctors and Dentists in training

The role of the 'Guardian for Safe Working Hours' is designed to reassure junior doctors and employers that rotas and working conditions are safe for doctors and patients.

They are responsible for overseeing the work schedule review process and will seek to address concerns relating to hours worked and access to training opportunities. They support safe care for patients through protection and prevention measures to stop doctors working excessive hours and will have the power to levy financial penalties where safe working hours are breached.

Dr Turlough Mills was appointed as Guardian for Safe Working Hours (GfSWH) in October 2017.

During the period from July 2017 to April 2018 there has been one exception report during this time, submitted by a paediatric trainee. Actions taken to resolve these issues are detailed in this report.

There are gaps on the CAMHS specialty trainee rota from April 2018.

High level data

Number of doctors / dentists in training (total): 23
Number of doctors / dentists in training employed by LCH: 12

Annual data summary

Trainees within the Trust (February 2018)

Department	No.	Grade	Status
Adults	2	GP Trainees	Employed
CAMHS	5	STs (Specialist Trainees)	Employed (full time)
	4	CTs (Core Medical Trainees)	Honorary
	4	FYs (Foundation Year Trainees)	Honorary
Community Paediatrics	4	STs (Specialist Trainees)	Employed
	6	STs (Specialist Trainees)	Honorary
Sexual Health	1	ST (Specialist Trainee)	Honorary

Exception reporting

One report raised.

Working hours

No exception reports raised relating to working hours in this period.

Educational opportunities

One exception report raised by a paediatric trainee relating to using annual leave to complete administrative tasks, including attending supervision.

Rota Gaps

Out of Hours on call rota gaps in CAMHS

From April 2018, there are regular rota gaps in the CAMHS 2nd on call rota. The Trust is attempting to cover these gaps as locum shifts, using both existing and external workforce.

Fines

No fines have been levied by the GfSWH.

A full report will be tabled at the Trust Board later in the year, as required by the Junior Doctor's contract, to provide the Board with an evidenced based report on the working hours and practices of Junior Doctors within the Trust, confirming safe working practices and illustrating any areas of concern.

Effective

LCH conference 2018 – Professional Conference

On the 27 March 2018 LCH welcomed more than 50 staff and partners to our second annual clinical conference. The theme of the day was the 'Culture of Capturing Excellence'.

Through the course of the day we heard from external speakers and also some of our own staff. It was a really useful opportunity to pause and reflect on clinical excellence and the quality of care we provide in our services.

Core strands for the day focused on:

- Our quality journey and progress through the last two years
- The importance of research (we heard from two of our LCH researchers' in different clinical fields)
- How to establish, and the importance of, safety huddles and how we are piloting this in the Pudsey Neighbourhood team
- Using Quality Boards and the electronic Quality Board in Children's Speech and Language Therapy Team
- Raising awareness of the signs and symptoms of Sepsis
- How 'Better Conversations' can improve the quality of care we deliver
- Looking after ourselves and the importance of physical activity

The golden thread though all of this is our approach and drive towards continuous quality improvement. It's the approach we will be taking forward over the next year.

Reflection on the Non-Registered Staff Conference

On 2 November 2017 the Trust hosted a conference dedicated to the non-registered workforce. This was an opportunity for staff from a variety of backgrounds, both clinical and non-clinical to come together to share their work, learn from others who have developed in similar roles and to think about the contribution they make to the organisation, as well as exploring where and how their futures could develop.

Staff heard from a number of different speakers. We heard from three staff members about their career journeys and also their experience of being a user of LCH services whilst an employee.

Staff also participated in a number of different activities to get them thinking about coaching conversations and making the most of every interaction.

The day was well received and evaluations were overwhelmingly positive. Sixty one people attended and the main themes that arose were that of feeling valued, inspired and of self-development.

A number of participants stated that they enjoyed being part of events like this. They also fed back that they particularly liked the stories from the speakers and found them inspirational and asked if the event could be repeated.

Medicines Management: ePrescribing

Medicines are at the very heart of modern medicine however the systems for prescribing and administering them have remained largely unchanged for the last forty or fifty years. Meanwhile the medications used have increased in number and complexity, resulting in potentially greater risks for the patient of medication error.

In early 2017, LCH commissioned a piece of work to explore the opportunity for the Trust to introduce electronic prescribing. The project scoped out how the Community Paediatrics Service could move from the current hand written prescribing process to using the functionality within SystmOne to issue electronic prescriptions.

Electronic prescribing (ePrescribing) is the utilisation of electronic systems to facilitate and enhance the communication of a prescription, aiding the choice through knowledge and decision support and providing a robust audit trail. ePrescribing can deliver benefits for those who prescribe, administer and dispense medication including:

- More legible, complete medicines orders;
- Decision-making backed up by suitable information resources; and
- Richer and timelier interactions among the care team due to improved communication.

Running concurrently to the scoping project, the Service were implementing the roll out of Electronic Patient Record (EPR) as part of the organisational move to use electronic systems. EPR is now complete within the Service and new ways of working are being embedded.

The ePrescribing project recommended a way forward for the Community Paediatrics Service that would significantly improve both the patient pathway and communications with primary care in relation to all prescribed medication; both in clinic-based and remote (school) settings. In considering how to implement ePrescribing, during 2017/18 the Service has also explored whether they could incorporate the Electronic Prescription Service (EPS) into their pathway. EPS sends electronic prescriptions from where they are prescribed directly to a community pharmacy. Eventually, EPS will remove the need for most paper prescriptions.

NHS Electronic Prescription Service

The Community Paediatrics Service were planning to pilot the use of ePrescribing and EPS from their hub in East Leeds from Spring 2018 however we have been informed that EPS isn't currently possible within the Community SystmOne module. Nationally, NHS Digital is working on this, but work on this is not due to start until the summer of 2018.

Medicines Management Quality Improvement Work

Following the Care Quality Commission (CQC) inspection in January 2017 a number of concerns were raised regarding some areas of medicines management.

The Medicines Management team has proactively supported services in areas such as the development of action plans to improve systems and processes relating to medication. This has included providing focused support to a number of services including Hannah House.

A Multidisciplinary Approach to Managing Heart Failure

The Community Cardiac Service has been managing patients with a diagnosis of heart failure for over 10 years.

Any medical support had largely been ad hoc, trying to get a quick phone call with a Cardiologist for advice. In recent years this patient population has becoming increasingly complex due to people living longer but with more unstable symptoms and multiple comorbidities. There are now also many more treatment options available to them which can be difficult to coordinate.

In order to increase the quality of care these patients receive and to support the nurses in making very complex decisions, it was agreed that more medical input was needed. Through improving links with the Heart Failure team within Leeds Teaching Hospital NHS Trust (LTHT) we set up monthly MDT (Multidisciplinary Team) meetings where a Consultant Cardiologist, a Consultant in Palliative Medicine, a Cardiology Pharmacist, and a number of Community Cardiac Nurse Specialists come together to discuss complex (often palliative) patient cases and agree a management plan. As well as improving the quality of care for these patients, the MDT meetings have helped to improve the knowledge and skills of the Cardiac Nurses in making treatment decisions.

They have also developed a weekly Cardiology 'Virtual Clinic' on SystmOne, where the Cardiac Nurse books patients into a Cardiologist's rota with a specific issue or question. The Cardiologist then reviews the patient's records virtually (from the acute trust) and writes a management plan in the patient notes for the Nurse to carry out.

To date 127 patients have been reviewed in the virtual clinic and 77 patients discussed at the MDT meetings. Both these initiatives avoid the need for these, often frail patients, to travel to hospital for appointments with the Cardiologist, and have undoubtedly saved admissions to hospital. This has been of huge benefit in developing a great working relationship between the Community Service and the Acute Trust.

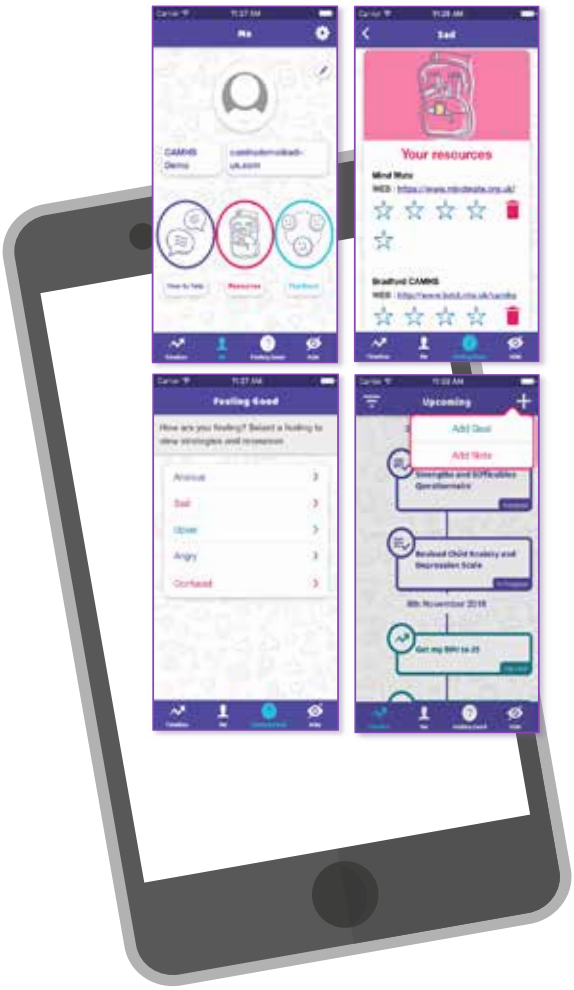
In light of the success of this initiative, a business case has been developed for consideration with a view to mainstreaming the pilot and improvements made during the pilot.

"Let Me Show U" App

An app has been developed by ICAN (Integrated Children with Additional Needs) Services to:

- Empower young people, putting them more in control of their health, care team and daily lives
- Support the transition of young people with Cerebral Palsy and complex needs from children's to adult services. The app uses video, text, photos, links to aid sharing, communication and training

e.g. video demonstrating communication, video demonstrating safely loading a wheelchair into vehicle, education health and care plan outcomes and how to support young people achieve these and emergency information on their condition. This is done via a secure platform integrated with NHS systems allowing feedback and updates.



StepUp! Community Children's and Adolescents Mental Health Service (CAMHS) App

Leeds CAMHS has started to use a StepUp! App as part of their work with young people. StepUp! is an app developed by Lydia Burfield and Dr Julie Franklin designed for young people aged 14 and above, to help them get the most out of their face to face CAMHS appointments. It is not intended to replace seeing a CAMHS worker and young people don't have to use it if they don't want to.

The rationale behind the development of StepUp! was to offer more effective and efficient care to the young people and families that we see in CAMHS in a young person-friendly way. Young people and their families wanted to be "in control" of this information and feel empowered to share this with other individuals or agencies/services if and when required.

The app has been co-designed in partnership with service users (young people and their parents), as well as clinicians and administrators within LCH. It maps well against the direction of travel nationally and fits with the pathways currently being developed. CAMHS are in the process of rolling this out to trial and evaluate with 50-100 young people.

The Performance Information Portal

In early 2017 the Business Intelligence Team (BIT) developed an online information system that was deployed across the organisation meaning that for the first time the Organisation had the ability to view service level performance on a range of digital devices.

PIP is available to all staff allowing easy access totimely data which enables more effective and evidence based improvement decisions to be made. Staff can view their own data, effectively taking ownership of it and improving data quality, as they challenge the data to ensure it is representative of their service.

PIP uses data from clinical and patient administrations systems and visualises a range of measures across services and is interactive, dynamic and simple to use. A number of awareness raising sessions were delivered but the spread in the use of PIP has also been quite organic. In a very short space of time the Organisation has gone from reactive reporting to proactive reporting and intelligence.

Performance Information Portal

A real benefit of PIP has been the ability to triangulate measures to monitor performance, highlight early warnings and signpost areas for further investigation. As PIP has developed and teams have seen how it can facilitate decision making, further reports have been developed to reduce regular tasks and creating extra capacity.

Caring

The Patient Experience Pledge

The Patient Experience Team is here to help if you have a question or want to tell us something about our services. We are also here as an alternative to approaching the services directly.

In 2017 we began a programme of updating Patient Experience at the Trust. We started by making the name of the team that deals with your feedback the focus of our e-mail address and leaflets. We moved away from using the description of Patient Advice and Liaison Service (PALS) in order to more accurately reflect the scope of services the Patient Experience Team can offer.

During 2018 we want to embed key messages about our caring and compassionate approach to Patient Experience feedback based upon mutual respect and working together. This will be our Patient Experience Pledge. Work on this project has already begun including attendance at a public engagement event hosted by Healthwatch where service users, stakeholders and members of the public reacted positively to the Pledge.

LCH and our staff welcome all of your feedback about the services we provide; whichever way you want to tell us. You can contact us by phone, e-mail, via the Friends and Family Test, social media, our website or even…face to face!

Even though fewer people are raising complaints and concerns, more people are telling us what they think through the Friends and Family Test.15,270 responses to the FFT were received (5.35% response rate); with 96.7% of respondents saying they would recommend LCH services. This represents an increase in both figures compared to last year. People responding to the FFT also provided 13,915 comments (positive and negative) about their experiences.

The Patient Experience Team can be reached at **lch.pet@nhs.net** or on **0113 220 8585.**

‘Freedom to Speak Up’ Guardian Role

The ‘Freedom to Speak Up’ Guardian role is a statutory requirement following national reports including the report by Sir Robert Francis into the Mid Staffordshire NHS Foundation Trust which exposed unacceptable patient care and a culture which meant staff did not raise concerns. This report ‘Freedom to Speak Up’ focused on creating a more open and honest culture in the NHS where staff could raise concerns.

The ‘Freedom to Speak Up’ Guardian role is independent reporting directly to the Chief Executive and the Trust Board with the aim of ensuring that staff concerns can be heard within a supported environment that encourages people to speak up.

The ‘Freedom to Speak Up’ Guardian role is one year old and during that time the Guardian has met with Trust staff and sought to ensure their voices are heard in the organisation. The Guardian has raised concerns from staff about behaviours, culture and leadership. The work of our Trust has recently received national recognition at the National ‘Freedom to Speak up’ Guardian Conference.

> “It is an honour to hear the voice of our staff and reflect their stories, struggles and hopes back into our organisation.”

This work has linked with the national work of NHS Improvement on whistleblowing. It has also shared lessons and learning with external agencies such as Yorkshire Royal College of GPs.

The ‘Freedom to Speak Up’ Guardian offers a safe space for staff to be listened to and supported. A questionnaire for staff that have spoken with the Guardian has been made available to further develop the work. Feedback from the questionnaires will be reviewed to inform future developments of the Service.

This role links to many areas such as patient care, retention, organisational development (OD), service improvement, culture change and leadership.

Responsive

Equality and Diversity

If we are to realise the vision of delivering the best possible care to all communities, it is essential that our workforce is as diverse as the community we provide services to. To this end, during the last year we have continued work to build knowledge, skills and behaviours within the healthcare community.

In common with other public service organisations we have policies to guide us in achieving this aim; however, it is the way we implement our policies that makes a difference.

At LCH we continue to raise awareness of equality issues, in particular we have established and resourced the LCH Black, Asian Minority Ethnic (BAME) staff network creating an inclusive environment for patients and staff.

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 with the aim of ensuring that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

LCH has been named in the 2017 WRES data analysis for Trusts report as performing better than other NHS Trusts in two of the nine indicators; percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months and numbers of staff personally experiencing discrimination at work from manager/team leader or other colleagues.

To work towards reducing the numbers of staff experiencing inequality of opportunity or treatment, we continue to provide opportunities for all staff to access face to face 'Unconscious Bias' awareness sessions. In the past year 180 staff have undertaken this development opportunity. 'Unconscious bias' can be defined as our implicit people preferences, formed by our socialisation, our experiences and our exposure to other's views about other groups of people.

This year resources were put into the Stonewall Workplace Equality Index and LCH was ranked 318th which is an improvement from 360th last year.

In 2018 LCH is taking part in the Inclusive Top 50 UK Employers, which is a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within their organisation.

In 2014 LCH received the 'Disability Confident' - employer accreditation, in 2018 we will begin work to achieve a 'Disability Confident' – leader accreditation in 2020.

Well-led

Mentorship and Coaching

During the past year 68 managers have undergone Manager as Coach training and at the six-month evaluation reported they have increased confidence and more time and ability to have challenging conversations. Participants have frequently recommended the course to peers and direct reports working in the same service. This is helping to build and strengthen a coaching culture where a belief in the resource and potential of individual staff leads to their growth and development.

Our register of 13 accredited coaches and 3 coaches in training have sustained their commitment to coach despite the competing demands they experience on their time. We have delivered 6 group-coaching supervision sessions and several 1:1 supervision sessions to maintain coaching standards, the development of coaches and motivation to continue practice.

All coaches have now been registered on mye-coach (the regional electronic data base supported and maintained by the Leadership Academy). Recording of activity has remained a challenge for the coaches since they are still not familiar enough with the system for this to be an automatic process. We will continue to encourage coaches to engage with it and this would help us to exploit the full potential of this system to provide useful intelligence regarding coaching activity.

In terms of health and wellbeing coaches continue to say that coaching offers them a chance to stop, think and challenge themselves enabling them to remain at work.

There are 3 LCH staff registered as a mentor on mye-coach who have experience in this role. Although it was planned to roll out training to those interested in mentorship this has not been taken forward in the past year due to lack of resources.

Section 3

Statements on Quality as Mandated in the Regulations

This section of the Quality Account contains all the statements that we are required to make. These statements enable our services to be compared directly with other organisations and services submitting a quality account.

Review of Services

During 2017/18 LCH provided and/or sub-contracted 61 NHS services with £109.3m funding. LCH has reviewed all the data available to it on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by the LCH for 2017/18.

Transformation

The significant transformation of our clinical and corporate services continues as we look for further opportunities to make quality, outcome and efficiency improvements.

The roll out of the Electronic Patient Record (EPR) and mobile working for all 13 Neighbourhood Teams was completed in the autumn of 2017. The transformation of the Neighbourhood Teams has now moved into its final phase as they complete Holistic EPR Assessments for their full patient caseload and transition to New Ways of Working (NWoW). At the time of writing, NWoW has now been rolled out to 6 of the 13 Neighbourhood Teams with implementation plans currently in place within three further teams. The remaining Neighbourhood Teams are all scheduled for completion by the autumn of 2018. The Neighbourhood Nights service has also been reviewed to fully align them with NWoW by the summer of 2018.

The Electronic Patient Record (EPR) has also been rolled out to the specialist services, CIVAS (Community Intravenous Antibiotic Service) and Neurology with the latter going live with their EPR in April. Adult Speech and Swallowing are also in the early planning stage of their EPR Project with a planned go-live in the summer of 2018.

In the meantime the highly ambitious Children's Services Transformation Project centred around four pathways:

1. A re-design of the Clinical System Architecture supporting the EPR
2. Practice and Pathways
3. Coding and Outcomes
4. Standardisation of EPR with architecture, practice, pathways and outcomes is in the early stages of design, with a planned completion in 2019

The following are examples of how we have improved quality within the Business Units during the last year.

epr electronic patient records

Adult Business Unit (ABU)

Steps being made to standardise and improve quality of care

The Adult Business Unit (ABU) includes, following the repatriation of several city-wide services in November 2017, the following services:

- 13 Neighbourhood Teams (NT's)
- Neighbourhood Nights
- Community Care Beds
- Bed Bureau
- End of Life Care
- Health Case Management
- Leeds Integrated Discharge Service
- Community Geriatricians
- Continence, Urology and Colorectal Service
- Wound Prevention and Management Service
- Falls
- Pharmacy Technicians
- SPUR (Single Point for Urgent Referrals)

Ongoing work to develop a more consistent locality-based approach across all ABU Services has built on the learning from the Palliative Care Lead model, which was shortlisted for a Health Service Journal award. This will enable all services to work more closely with Primary Care and other city-wide partners, building on the collaborative work already underway with NTs.

To continue to develop the NT model over the past year, we have focussed on and made progress in being able to understand the staffing in place, the clinical skills they have and how they deliver quality care. This was acknowledged by the CQC who awarded adult services an overall 'good' rating with 'outstanding' for caring.

Electronic Patient Record (EPR), as key enabler for improvement and standardisation, has been rolled out across all NTs with work ongoing to review and migrate all existing pre-EPR care records into the electronic format. This offers an opportunity to review caseloads in depth and establish 'New Ways of Working' within the NTs.

Several measures have been developed further to standardise the quality of care and reduce variation:

Safe

- Continuous Quality Improvement is being embedded across the ABU, including the pilot of the accredited daily approach to Safety huddles in Pudsey, focused on reducing falls building on the existing model of safety briefings within all Neighbourhood Teams (NT's).
- The use of Quality boards has been established and following feedback from the recent internal audit, key actions have been identified to improve awareness and ownership across the full NT.
- We continue to develop our work on understanding and learning when incidents have occurred. This year a 72-hour review of any no/minimal/moderate harm was introduced to determine whether a formal RCA incident review was required. This supports more timely management of incidents, understanding and sharing of contributory factors.
- Skills and competency levels in clinical staff are monitored quarterly within the NT. Quality meeting, resulting in the temporary recruitment of a clinical skills trainer working directly with NTs to support competency sign-off. The recently established Clinical Education Team provides clinical training support across key skills areas.

Effective

- Clinical care frameworks – completed in 2017/8 the wound care framework that applies to 25% NT activity and the holistic assessment framework that applies to every patient on the caseload.
- Increased clinical supervision rates provide both support to staff and assurance of good clinical practice.

Responsive

- Case management and caseload reviews continue to be established across all caseloads as a key enabler in monitoring quality and efficiency of care delivery.
- Since establishing the NT Capacity and Demand tool in the last year, we have continued to refine and develop the functionality to support service delivery in the NTs. The recent internal audit identified key areas for further development. Part of this work has been to develop the NT essential visit criteria, which ensures that care required on a given day is delivered, regardless of service pressures at the time.
- The recent introduction of Occupational and Physiotherapy lead roles within the NTs is leading to a reduction in waiting times and a greater focus on rehabilitation and clinical skill mix in the registered and non-registered therapy workforce.
- All clinical referrals to NTs are now triaged by an experienced NT clinician which supports a consistent and efficient deployment of NT resources and ensures patients are assessed according to their needs.

Caring

- The CQC published the final reports on LCH in August and we are delighted that Adult services were rated overall 'Outstanding' for caring.

Well led

- Daily handover process is now fully established and allows daily check-in and support from a senior clinician to all members of the caseload cluster team, contributing to both management and quality of care. Important messages, including those from the Director of Nursing and Clinical Lead for ABU, are now raised at these daily meetings.

Children's Business Unit

The Children's Business Unit (CBU) is part of, and promotes, a Working Together culture with Leeds City Council, schools, local agencies and services in aspiring to the Leeds ambition of being the best city in the UK for children and young people to grow up in.

The Children's Business Unit has written a new strategy for Children's services within LCH and how it works with wider partners. This will be officially launched in May 2018 and will be the main focus of work for the coming months and year. The strategy is based on seven key objectives for children's services which are:

- Agree and develop fully integrated pathways for children and young people in Leeds
- Demonstrate the effectiveness of services through outcomes and best practice
- Children and young people will have a positive experience of our services
- Services will be delivered within budget, be cost effective, productive and value for money
- Retain and expand services (where appropriate) by being tender-ready and open to business development opportunities
- Services will have a workforce that is skilled and competent to meet the changing health and wellbeing needs of children and young people
- Maximise the potential of technology

To make this possible Children's services actively seek to enable children and young people to meet their potential and live healthy lives by keeping them safe, helping them to achieve their goals, listening and responding to their needs, promoting empowerment, and encouraging young people and their families to actively participate in their own care. This is being achieved by services developing pathways that are evidence based, promote best practice and span across services to enable seamless delivery.

The CBU adopts an outcome focused approach, encouraging children, young people and their families to identify their own outcomes and aspirations, with services supporting and facilitating the achievement of outcomes. Services actively encourage children, young people and families to be involved in service strategy, delivery and development to ensure they receive a positive experience of Children's Services and the CBU embraces and acts on learning and feedback. The CBU has appointed a participation lead and a dedicated participation worker who facilitate young people's consultation groups, involving young people in website design, App development and multi-channel approaches including YouTube and podcasts.

Evidence indicates that the earlier children, young people and families can obtain information, support and guidance, the more positive the outcome for the young person. Access to best practice advice, early intervention and self-care is being offered; coupled with the single front door, single point of access, ensuring that families access the right service at the right time.

Children's services are attuned to the critical importance, throughout a child's life, of effective, seamless transitions and have been developing stronger links with the local authority, schools and adult services to ensure that children and young people are adequately prepared for transitions. In addition to ensure that their goals and aspirations are upheld and heard within their journey through services and education.

The CBU has a strong, dedicated workforce who cares passionately about the offer and experience of children and young people who access services and is supported by an organisational commitment to continuous quality improvement. A critical component of achieving this is to maintain a skilled workforce that is competent, supported and valued. Supporting staff is a key objective and has enabled the philosophy of how we work to be revised. By adopting a health coaching / restorative model, staff are moving away from the role of "expert" to one of facilitator and supporting children and families to aspire and meet goals and outcomes. This initiative has been coupled by reviewing team skill mix and offering increased training for staff to feel confident in their role and have the ability to work positively with families to find their own solutions.

Specific examples of achievements within the CBU include:

- Shortlisted for the Health Service Journal awards (2017) for:
  - Improved Partnership between Health and Local Government – Health Coaching and "Better Conversations" ,
  - Clinical Leader of the Year - Infant Mental Health,
  - Compassionate Patient Care – Outstanding Breast feeding Standards
- Infant Mental Health Team developed 'Understanding Your Baby' films for inclusion in a Baby Buddy app from Best beginnings. The app features 12 'Understanding your Baby Films'. The official launch of the films was held alongside the launch of the Best Beginnings 'Out of the Blue' initiative at the Royal College of Obstetricians and Gynaecologists in the presence of Prince William and Prince Harry.
- Health Visiting received 'Gold Standard' for Involvement within Health Visiting services
- CAMHS clinicians and young people were involved and consulted in the development of the West Yorkshire Playhouse production of "Zoetrope" – a groundbreaking play about young people and mental health by the Leeds Youth Theatre and First Floor.
- Young people in the CAMHS inpatient unit at Little Woodhouse Hall created an information guide for young people, parents, carers and professionals to support a smooth transition to the inpatient unit. The guide offers directions, what to expect on admission, experiences of previous young people, and the types of help available with a FAQ section.
- Presentation within the LCH AGM showcased a range of digital developments for use by children, young people and families
- The weight management service, Watch IT, worked with Dance Action Zone Leeds (DAZL) enabling the service to provide dance activity and opportunities for children seen within the Watch It service.
- Celebratory Event which offered a range of children's services an opportunity to showcase and present aspects of service delivery, an event that was very positively received by a wide audience.

watch it

Specialist Business Unit

The following are examples of achievements made by the Specialist Business Unit (SBU) to improve the quality of its services during 2017/18:

Improving Access to Psychological Services (IAPT)

All IAPT services have a target which states that 50% of people who complete treatment should achieve recovery. This target has been a considerable challenge for most IAPT Services as it only counts the number of people that were above the clinical cut-off before treatment but below following treatment. It does not account for those people that have shwn any degree of real improvement (i.e. improving by a set number of points on the IAPT assessment scales but who have not moved to recovery).

Although the citywide recovery rate in Leeds has increased each year since 2014, it has remained below the 50% target and in 2016/17 we achieved 45%.

A range of successful initiatives have been put in place across the service over the past 18 months with a view to achieving (and exceeding) the target. A 'Recovery Working Group' was established in April 2017 to pull together the various recovery focused work that was being carried out. Specific aims were as follows:

- To provide clear and consistent support and guidance to clinicians in order to increase recovery rates across all clinical elements of the service
- To support clinicians to achieve a 50% recovery rate
- To oversee new innovations aimed at increasing recovery rates, using a 'Plan, Do, Study, Act' cycle

Initiatives have included the development of a 'One Minute Guide' which is a good practice guide for clinicians. We have also developed an Outcome Feedback Tool which helps to identify patients not progressing as expected and who may be at risk of poor outcomes. It indicates if a patient is or isn't 'on track' to achieve recovery. This information is then used together with the patient to agree an appropriate plan.

The result has been that currently we are on track to exceed the national target of 50% – we are 52.3% year to date. If we maintain this during January, February and March we will have achieved our highest annual recovery rate since the service began and demonstrates the quality of support offered to our service users.

Pan Leeds Occupational Therapy Project

This is a group of leaders who have come together to look at how the Occupational Therapy (OT) workforce across Leeds, from different organisations, can be supported to work together to provide better services to patients and service users.

Over the last 12– 18 months the group has collected a lot of information by talking to Occupational Therapist's through a series of engagement events with staff from across the city including the three Health Trusts, Leeds City Council and third sector organisations. People that use the services have also been invited to share their thoughts and views so they can be understood and considered during this project. Following this feedback some key pieces of work have been agreed to help improve the OT facility in Leeds.

Successes to date include two joint events to celebrate OT Week 2017; demonstrating partnership working at its best, as well as creating much valued networking opportunities for the workforce. Future plans include the development of an OT graduate rotation programme across the three health trusts and Leeds City Council, providing invaluable development opportunities for new graduates.

Oral Nutrition Support (ONS) Passport

The Oral Nutrition Support (ONS) passport has been in effect in the dietetics service for over two years now. Around 150 people self-manage their nutritional care using this tool (22% of patients requiring ONS), with 24 patients contacting the department for rapid access support when needed.

It is estimated that this model has saved 79% of clinical time that would have otherwise been required for this patient cohort using the previous model, whilst allowing patients who go through a period of requiring active care to receive it more responsively than previously.

This cohort has been a strong focus for patient involvement this year, and feedback is being collated in order to understand patient experience more fully. This ties in with a quantitative review of the impact that passport has had.

From a safety perspective, each new member of staff is given a session at induction to explain the role of the passport. There are criteria for who is eligible to be considered and when someone is transferred to passport there is a checklist to ensure that all aspects of care have been addressed and documented. To ensure these are being met a clinician has undertaken the role of auditing the documentation against the checklist, on an ongoing basis and another clinician has taken on a similar role with the focus on prescribing recommendations.

The Quality Impact of Evaluating the ONS Passport

Although the passport has been an embedded part of practice for over two years the evaluation work enables us to understand the impact of the project. The project has looked at the demography of the patients who are using the passport, to understand which groups of people tend to be suitable. We have analysed the activity attached to these patients before and after the passport, which has helped to appreciate the amount of capacity which has been created through self-management. We have briefly examined the nutritional supplements prescribed, to help us learn more about the prescribing effectiveness of the project.

This work has aligned with the team's focus on involvement of our passport patients (and their carers) in helping us understand the lived experience of the passport and have actively sought feedback, which has been highly insightful. The current evaluation phase is tying together our learning to identify any further changes to practice.

Diabetes Transformation Funding

We have been fortunate to receive time limited investment from the Diabetes Transformation Fund which has resulted in investment in Foot Protection in the Podiatry service and Structured Education in the Diabetes service.

The Structured Education programme aims to provide accessible, appropriate structured diabetes education for adults diagnosed with Type 2 Diabetes to support them in the effective management of their condition. Likewise, the investment in Foot Protection has allowed us to work with our partners in Leeds to develop a Multidisciplinary Foot Care Team (MDFT) to prevent and manage diabetic foot problems across the city more effectively. Both services will help patients with diabetes reduce the risk of developing associated complications, thereby improving their quality of life.

The funding was received in April 2017 and teams have worked tirelessly to develop models that are appropriate for Leeds, recruit to required staffing positions, engage with key stakeholders and implement the new models. The first cohorts of patients began using the services in Quarter 3 and we eagerly await the outcomes as we monitor the impact the new services have for patients.

Trial of Locality Based Models for delivering MSK Services

Providers and commissioners have been working jointly to develop and test new ways of managing patients with musculoskeletal (MSK) conditions.

Aims of the service model

- Deliver genuine population-based healthcare, based on meeting the musculoskeletal needs of the combined practice populations of all the general practices based within the locality
- Design services that focus on self-management and proactive care
- Improve patient experience of care
- Demonstrate positive clinical outcomes in a robust and routine manner
- Achieve a high degree of system integration that will tackle systemic inefficiencies and lengthy waits
- Be capable of being delivered on a citywide footprint in a manner that is equitable, aims to reduce health inequalities and is financially sustainable

Implementation

- Development of a draft service model by clinicians from general practice, physiotherapy, orthopaedics, rheumatology and pain services endorsed by LCH and Leeds Teaching Hospitals Trust (LTHT) and the Senior Management Team of the Leeds Clinical Commissioning Groups Partnership
- Approved proposal introduced to test service models in a number of localities across Leeds
- Currently recruiting localities of GPs to implement and test new models.

Key features of the model

- Development and introduction of alternative referral, including self-referral
- Development and introduction of a Locality Based Multidisciplinary Team (MDT)
- Expansion of interventions to improve lifestyle
- Expectation that service providers, primarily LCH and LTHT will change the way that they deliver services in order to better reflect the service model being trialled. Both these providers have committed to realigning services as required

Expected benefits for the patient

- Early assessment and diagnosis of their musculoskeletal condition
- Early agreement on appropriate treatment pathway/treatment plan
- Timely intervention where required
- Support in making lifestyle changes and in engaging in long term supported self-management

For the practices

- An alternative resource to manage the way in which musculoskeletal patients have their needs met, swiftly and in line with best practice and evidence
- Reduce the load on individual GPs, and extend access to primary care
- The opportunity to shape, influence and improve citywide musculoskeletal services

Patient Involvement work at the Wetherby Young Offenders Institute (WYOI)

The team has developed a new induction process which is delivered to Young People within the first two weeks of their sentence, when prison regime allows. The induction is a 30 minute interactive talk which covers key health issues for young people.

Following feedback from a previous prison inspection and from comments on FFT (Friends and Family Test) the waiting room has undergone some small improvements including the provision of information boards on relevant health topics, a selection of books and activities for boys to look at whilst they wait, paper copies of healthcare information and a quarterly in-house newsletter.

We have worked in partnership with WYOI kitchen staff, who agreed to support our Healthy Eating message by donating fresh fruit daily and a selection of fruit is now available in the waiting room for all patients attending clinics. As well as promoting healthy eating, this also provides Young People with some distraction whilst they wait to be seen and has received a positive reaction from the boys.

We are currently trialling a new approach to encourage attendance to healthcare. To mirror some community practices, we are going to be offering incentives for every appointment attended for the Dentist, Optician, Physiotherapist, Psychiatrist, Long Term Conditions clinic and for Sexual Health testing. The prison has agreed that we can issue one Merit each time, which is worth 25 pence in the tuck shop and it is planned to review this regularly to see how it is working. This scheme also responds to the recommendation from the last HMIP report (5.19) that 'Merits should be awarded by staff from all areas'.

Wetherby Young Offenders Institute (YOI) and Adel Beck Secure Children's Home won a Nursing Times Award in November 2017.

A CQC inspection of Wetherby YOI has taken place and early indications are that the visit went well although the report will not be published until later in 2018.

Clinical Audit

All clinical audits that are planned to be undertaken within LCH **must** be registered on the clinical audit and effectiveness registration database. The monitoring of each audit includes results, summary report and improvement/ action plans.

National Clinical Audits

During 2017/18 five national clinical audits and three national confidential inquiries covered the NHS services that LCH provides.

During that period LCH participated in 100% of national clinical audits and 100% of national confidential enquiries, of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that LCH was eligible to participate in during 2017/18 are as follows:

Eligible National Clinical Audits
Chronic Obstructive Pulmonary Disease
Sentinel Stroke National Audit Programme
National Audit of Intermediate Care
Parkinson's Audit
Falls and Fragility Fractures Audit programme (FFFAP)

Eligible National Confidential Enquiries
Mental Health Clinical Outcome Review programme - National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
Young People's Mental Health
Chronic Neurodisability focusing on cerebral palsy study

The national clinical audits and national confidential enquiries that LCH participated in during 2017/18 are as follows:

National Clinical Audits participated in
Chronic Obstructive Pulmonary Disease
Sentinel Stroke National Audit Programme
National Audit of Intermediate Care
Parkinson's Audit
Falls and Fragility Fractures Audit programme (FFFAP)

National Confidential Enquiries participated in
Mental Health Clinical Outcome Review programme - National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
Chronic Neurodisability focusing on cerebral palsy study

There were no national audits applicable to our organisation that we did not participate in.

The national clinical audits and national confidential enquiries that LCH participated in, and for which data collection was completed during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Number of cases submitted	Percentage
National Chronic Obstructive Pulmonary Disease (Clinical Audit of Pulmonary Rehabilitation services)	Organisational audit submitted - 28 April 2017 Clinical Audit: data collection completed – figure not available presently	100% of all cases identified
Sentinel Stroke National Audit programme	April 2018 - Data has been submitted monthly into the National database. This is analysed nationally	100% of all cases identified
UK Parkinson's Audit	Service users clinical data submitted Organisational Audit datasubmitted	100% of all cases identified
Falls and Fragility Fractures Audit programme (FFFAP) – Hip Sprint Audit	Organisational questionnaire submitted Clinical Audit data submitted	100% of all cases identified
National Audit of Intermediate Care	Organisational Audit submitted 43 service users questionnaires submitted 14 PREM questionnaires (this is returned directly by the service user)	100% of all cases identified

National Confidential Enquiries	Number of cases submitted	Percentage
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	National Report will be published which confirms LCH participation. No individual report available at this time.	100% of eligible cases
Chronic Neurodisability Study – cerebral palsy	Organisational questionnaires completed. 1 case identified.	100%

The reports of 7 national clinical audit(s) were reviewed by the provider in 2017/18 and LCH intends to take the following actions to improve the quality of healthcare provided:

National Audit	LCH action 2015/16
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	The report recommendations do not identify individual Trusts. Any action plans and learning will be based on the overall submissions nationally.
Sentinel Stroke National Audit programme	This audit requires information to be inputted into a national database. The results are published online and currently unavailable for review.
Chronic Obstructive Pulmonary Disease (clinical audit of pulmonary rehabilitation services)	National report published which identifies recommendations to improve the care for patients undergoing pulmonary rehabilitation due to chronic obstructive disease (lung disease). Individual local report has been published and recommendations currently being reviewed.
Chronic Neurodisability Study – cerebral palsy	National report published which identifies recommendations to improve the care provided to patients aged 0-25 years with Chronic Neurodisability condition with cerebral palsies.
Parkinson's Audit	Individual Service Level report published April 2018. Recommendations currently being reviewed prior to Improvement plan being developed.
National Audit of Intermediate Care	National report and Organisation level Report published which is currently under review.
Falls and Fragility Fractures Audit programme (FFFAP)	National report published which identifies recommendations. Local Results and recommendations identified within the report are currently being reviewed.

Local Clinical Audit

The reports of **84** local clinical audits were reviewed by the provider in 2017/18 and LCH intends to take the following actions to improve the quality of healthcare provided:

- The Diabetes Service completed an audit which looked at the compliance for providing an insulin passport following commencement of insulin treatment. The findings from the audit have ensured further discussions with other services to monitor elements of the Insulin Passport Scheme within the electronic patient record system. This includes education of staff and implementation of the Standard Operating Procedure (SOP) for use of the passport.
- An audit by the South Leeds Independent Centre (SLIC) showed a considerable improvement in the number of falls reported during this period. This reduction is a great achievement, reflective of the changes staff have made to improve patient safety. This has been achieved through implementing the following interventions: through completion of the Tier 2 assessments and falls care plan within 24 hours of admission; implementation of a falls log; daily 'Focus 5 for falls/safety briefing'; use of the falling star symbol; hourly rounding; use of sensors on admission; and using extra low beds and fall mattresses.

During 2017/18 all services were required to participate in the annual documentation audit and produce an improvement plan to identify required improvements. Our Neighbourhood Teams within the Adult Business Unit included collection of data relating to end of life care, pressure ulcer management and falls in keeping with some of the priorities for improving patient care in the organisation.

Additionally, the Infection Prevention and Control Team undertake a range of local audits. These include; Environmental audits, PLACE audits and Essential Steps to Safe, Clean Care audits. These audits aim to reduce the risk of microbial contamination in everyday practice and to ensure our environment is managed in a way that minimises the risk of infections to patients, staff and visitors.

This table does not include audits that will be continued into 2018/19:

Local clinical audits completed during 2017/18 - by business unit

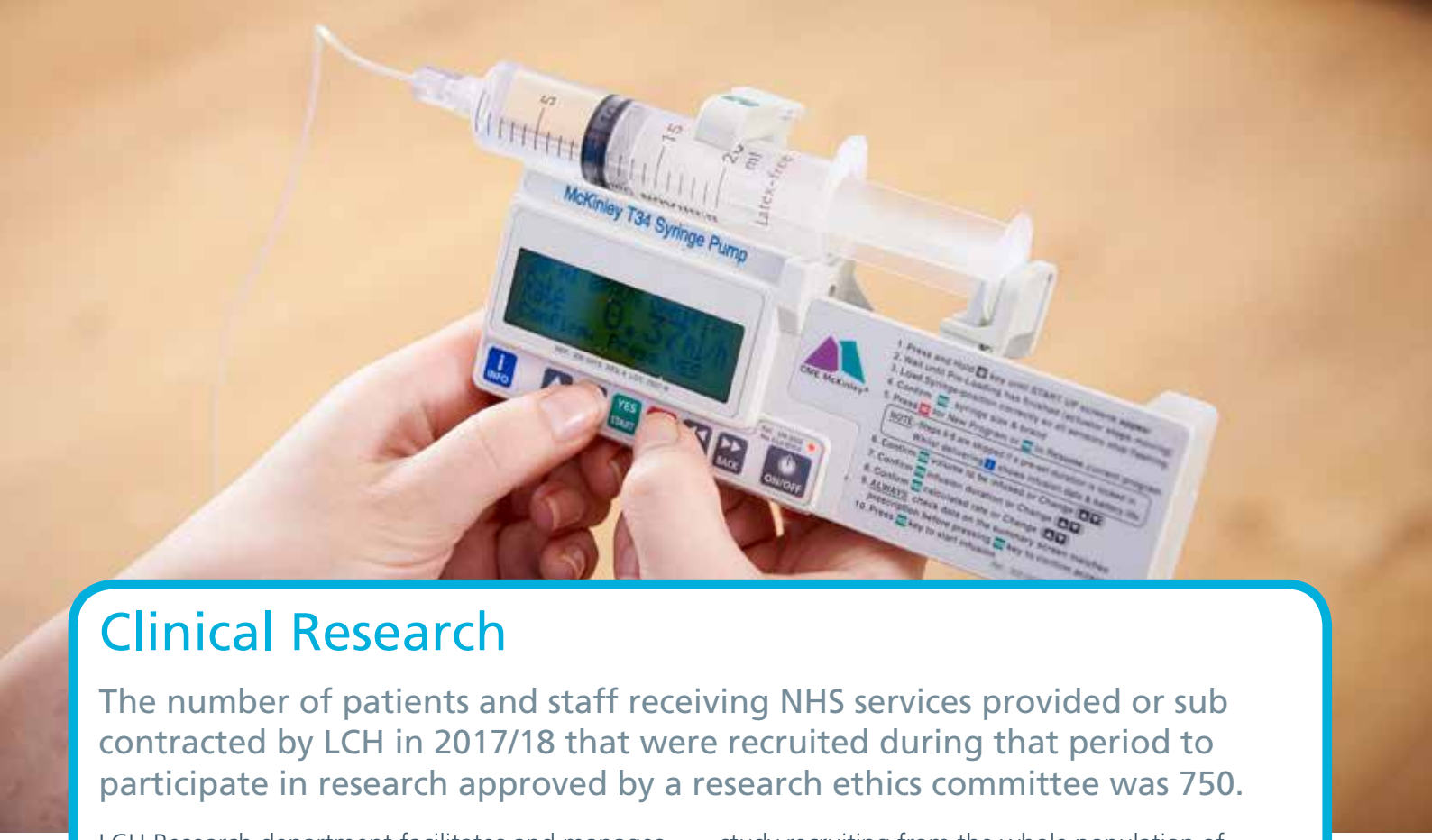
Adult Services		
• Documentation Audit	• Audit of Outcome measure	• Catheter Management Audits
• Skills Audit (all Neighbourhood Teams)	• Sling Audit	• Health and Safety Audit in CICU
• Environment Audit	• Themes and Trends from Datix Management System-Safeguarding	• Audit into the Use of Pads within Care Homes
• PLACE Audit	• Audit to Evaluate the Number of Falls	• Equipment Cleaning Audit
• Quality Tracker (all Neighbourhood Teams)	• Medicine Management Audit	• Hand Hygiene Audit
• Holistic Assessment (all Neighbourhood Teams)	• Controlled Drug Audit	• Quality of Care Neighbourhood Teams

Children's Services

- Clinical Supervision Audit
- Documentation Audit
- Environment Audit
- PLACE Audit
- Speech and Language Service Evaluation benchmarking
- Aetiological Investigations of Childhood Deafness
- Exploration of Service User Views on Convenience of Appointment Time
- SUDIC Process Audit
- Audit of Appointment Times
- Inpatient Controlled Drug Audit
- Hand Hygiene Audit
- Calibration Recording Audit
- Mattress Audit
- Audit of Reports by CAMHS and Socrates as part of ESREP
- Scanning of Audiology Results in Health Centres
- Audit of Access Assessment Form 1
- ADHD Medication Clinic Audit
- Re-audit with Child Development Team MPOC Audit
- Audit of Appropriateness of Investigations Performed

Specialist Services and Health and Justice Services

- Synergy / CSSD Clinic Protocol Dental Nurse Compliance
- Documentation Audit
- Environment Audit
- PLACE Audit
- Clinical Supervision Audit
- Audit of Compliance for Providing an Insulin Passport following Insulin Initiation
- Re-audit of CSSD Tick Sheet within Dental Services
- Re-audit of Therapist Time
- Re-audit of Radiography Audit
- Quality of Referral Forms
- Hand Hygiene Audits
- Appropriate use of referral pathways for patients at Rothwell Clinic
- Use of Transport for patients attending clinics
- Dietetic Pressure Ulcer Management Audit
- Placemat (clinical guidance) use in ASPIRE
- Audit on Completion of Generic Wound Assessment Template
- Re-Audit PGIC Compliance
- Controlled Drug Audit
- Antimicrobial Stewardship at Wetherby Young Offenders
- Best Interest Narrative on System 1
- Monthly Health and Safety audit tool for clinic rooms
- Process of blade removal audit
- Use of Purpose T risk screen on System 1



Clinical Research

The number of patients and staff receiving NHS services provided or sub contracted by LCH in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 750.

LCH Research department facilitates and manages LCH participation in projects that range from nationally funded multicentre research to student research and local service evaluations.

The Trust continues to host strong research collaborations in a number of services, in particular in musculoskeletal, wound care and palliative care through strong links to St Gemma's Hospice.

We have particularly increased participation in CAMHS studies over 2017/18 and worked in partnership with the neighbouring mental health Trusts on delivering and developing studies. "ASPECT "(a trial of one session treatment for phobias vs CBT with Leeds York Partnership Foundation Trust) is ongoing, whilst "Using QbTest to aid the identification of Attention Deficit Hyperactivity Disorder (ADHD) in young people in the criminal justice secure estate" (with South West Yorkshire Partnership Foundation NHS Trust) secured funding from the Research for Patient Benefit stream of the National Institute for Health Research (NIHR) and is due to start in 2018. Participation in a national study regarding identifying the costs of autism diagnosis, working with the Sussex Community Foundation NHS Trust was also delivered during the year.

LCH has continued to be very active in recruiting participants from across the Trust to the Yorkshire Health Study. This is a large questionnaire cohort study recruiting from the whole population of Yorkshire. Whereas last year our recruitment to the study focussed on staff groups, this year recruitment has been predominantly from patient groups.

One of our Trust's Specialist Physiotherapists (Dr Christine Comer) was successful in obtaining a prestigious Clinical Lectureship award from the NIHR. Her study is about developing a clinical pathway algorithm for lumbar spinal stenosis. This will build on work that she has been involved with as the LCH Principal Investigator for the multi-site clinical trial "BOOST "(Better outcomes for older people with spinal trouble) led by the Nuffield Department of Orthopaedics, Rheumatology and Musculoskeletal Sciences at the University of Oxford. This trial has been a significant piece of research within the Trust and as a site we have been a very successful recruiter.

An ongoing challenge for the Trust is that of releasing capacity within service teams to deliver research. One new approach to this deployed recently is the use of the LCH staff bank (CLASS) to specifically employ service staff to deliver trial activity. The OTIS study is a trial of a falls risk assessment tool with the research intervention delivered by two CLASS employed OTs. We hope that this more flexible approach to delivering a specific research intervention will be a model that can be utilised in future research participation for studies that are relatively "standalone".

Commissioning for Quality and Innovation (CQUIN)

A proportion of LCH income in 2017/18 in based on achieving quality improvement and innovation goals agreed between LCH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Commissioner	CQUIN goal	Reporting process/achievement	Actual (YTD)
LSE CCG	Improvement of staff health and wellbeing	This requires organisations to achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress.	Partially achieved 87.5%
LSE CCG	Improving the uptake of flu vaccinations for front line staff within Providers	This CQUIN sets a target for 17/18 of 70% of staff having received the flu vaccination.	Achieved
LSE CCG	Supporting Proactive and Safe Discharge – Community Providers	This is aimed at supporting proactive and safe discharge for those aged 65+ admitted via non elective routes. It will require joint working with the acute trust as they have a similar national CQUIN.	Achieved
LSE CCG	Tobacco screening, brief advice, referral and medication offer	These 3 CQUINs apply to adults (18 plus) admitted to inpatient units for longer than a day. It requires monthly data submission to confirm the number of patients: • Screened for smoking (a) • Given brief advice and (b) • Referred on (c)	Achieved
LSE CCG	Alcohol screening and brief advice or referral	These 2 CQUINs apply to adults (18 plus) admitted to inpatient units for longer than a day. It requires monthly data submission to confirm the number of patients: • Screened for drinking risk levels (d) • Given brief advice or referred (e)	Achieved
LSE CCG	Improving the Assessment of Wounds	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	Achieved
LSE CCG	Personalised Care and Support Planning	This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions.	Achieved
LSE CCG	Supporting Local Areas: Engagement with STP	During 2017/18 the provider is required to contribute to STP transformation initiatives and demonstrates to the STP governance arrangements how it is supporting and engaging in the local STP initiatives.	Achieved
LSE CCG	Supporting Local Areas: Control Total Risk Reserve	If a provider delivers its agreed organisational control total in 2016/17, the CQUIN will be paid at the beginning of 2017/18 to the provider, who will be required to hold it as a reserve until release for investment is authorised.	Achieved

Commissioner	CQUIN goal	Reporting process/achievement	Actual (YTD)
NHS E H&J	Staff Health and Wellbeing	This CQUIN requires an improvement in staff health and wellbeing across the service. 1a Improvement of health and wellbeing of NHS staff, 1c Improving the uptake of Flu Vaccinations for front line staff within providers.	Achieved
NHS E H&J	Continued development and evaluation of Comprehensive Health Assessment Tool (CHAT) health and wellbeing pathways for children and young people	This CQUIN will measure the effectiveness and outcomes of identified evidence based multi-disciplinary health and wellbeing pathways developed as part of the 2016/17 CHAT CQUIN. It will also give the opportunity to identify any further developments required in the pathways to optimise outcomes.	Achieved
NHS E H&J	Escort and Bed watch	The Escort and Bed watch CQUIN aims to look at alternative ways to manage healthcare within the Prison setting and in turn reduce the amount of hospital transfers and bed watches taking place.	Achieved
NHSE Public Health	Reduce Health inequalities by improving uptake Screening and Immunisation Programmes	The Provider should be able to demonstrate how they identify and address any health inequalities in the S7a Services they deliver; evidencing procedures they have in place to identify and support those persons who are not accessing the service (including those with protected characteristics, mental health conditions and learning disabilities), those considered vulnerable/find services hard to reach and take proportionate and appropriate actions.	Achieved
NHSE	CAMHS Transitions	This CQUIN will improve transition/transfer/discharge planning, improve patient and carer involvement, and improve experience and outcomes with regard to transition between services.	Achieved
LW CCG	AQP Spinefit	Conduct an audit into the nature and effectiveness of onward referrals to Tier 3 specialist pain services.	Achieved

Care Quality Committee (CQC) Registration, Ratings and Improvement Plans

LCH is required to register with the Care Quality Commission (CQC) and its current registration status is full registration without condition.

The CQC published the final reports on its announced inspection, 31 January – 2 February 2017, and unannounced inspections of Hannah House, Leeds Sexual Health and the Single Point of Urgent Referral on 29 August 2017. We were delighted that the CQC rated the Trust overall as **'Good'**, the CQC's previous rating being 'Requires Improvement'.

The CQC found that the Trust had successfully addressed most of the improvement requirements it had identified in its comprehensive review in November 2014. The CQC found several areas of outstanding practice, particularly within community health services for adults:, a project to improve patient flow, the development of pharmacy technicians which had supported staff and improved patient compliance, and also in the speech and language therapy and musculoskeletal services. Adult services were rated overall 'Outstanding' for caring.

The CQC found that:

- Our staff are passionate about providing good care and treat patients with dignity and compassion, involve our patients in their care, promote independence and self-care, meet the individual needs of patients including the needs of vulnerable people, and work well together for the benefit of our patients across all disciplines.
- We have a stable and cohesive leadership with accessible, visible leaders who work collectively.
- We have an open and transparent culture and our staff articulate the Trust values and strategy.
- We have good staff engagement and good patient feedback.
- We have a strong governance process and a 'maturing safety culture'.

The CQC identified further improvements needed in the safety of some services and rated Hannah House, Leeds Sexual Health Service and our CAMHS inpatient service, Little Woodhouse Hall as 'requires improvement'. All other services were rated 'Good'.

Key focuses for the Trust have been:

- Ensuring staff at Little Woodhouse Hall, Hannah House and Leeds Sexual Health service receive the necessary training and supervision, including safeguarding training and supervision, and have the necessary competencies.
- Hannah House: recruitment to ensure appropriate, safe and sustainable staffing levels and reducing the number of cancellations, strengthening management of medicines; strengthening identification and escalation of risks through introducing the use of quality boards, safety huddles and strengthening team meetings and improving our engagement with families and creating a more welcoming environment for children and their families.
- Little Woodhouse Hall: strengthening safeguarding notification processes, supporting staff with the roll-out of new restraint methodologies, ensuring actions plans are implemented in a timely manner and ensuring staff are aware of Duty of Candour requirements. The service has increased access to therapies and strengthened engagement with families.

The CQC identified a limited number of improvement requirements for our adult in-patient units: CICU (Community Intermediate Care Unit), SLIC (South Leeds Independence Centre) and the Community Neurology Rehabilitation Unit. The actions for CICU and SLIC were closed as a result of CICU being decommissioned and management responsibility for SLIC transferring to the Local Authority as a result of the service being re-procured on 31 October 2017. As a result of the CQC inspection the Trust has reviewed dementia training and introduced face to face training.

SMT and Quality Committee receive assurance through monthly reporting regarding progress with implementing and embedding our CQC action plan. The Director of Nursing has quarterly engagement meetings with the CQC to review progress in implementation of the action plan and wider quality performance and management. We are making good progress in addressing CQC's concerns and are working towards completing all actions by 31 May 2018.

We have consistently met our requirements for safer staffing in inpatient areas.

We have been compliant with our overall agency cap set by NHS Improvement.

LCH has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has not taken enforcement action against LCH during 2017/18.

Secondary Uses and Hospital Episode Data

LCH submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- that included the patients valid NHS Number was 100% for admitted care and was 99.98% for outpatient care
- that included the patient's valid General Medical Practice Code was 99.25% for admitted care and 99.99% for outpatient care

*The above confirms data available for 1 April 2017 to 28 February 2018; the submission timetable for data does not require data for 2017/18 (to 31 March2018) to be submitted until May 2018.

Information Governance

LCH is expected to achieve overall Level 2 compliance in 2017/18 and to be graded green (Satisfactory) as part of the Information Governance Toolkit assessment conducted annually. This ensures that LCH has the relevant policies, procedures and working practices in place to comply with the requirements of the Data Protection Act and mitigate risk across the organisation.

The Trust has also taken steps to become compliant with the new General Data Protection Regulation (GDPR) which is due to come into force in May 2018 through the appointment of a Data Protection Officer to support the implementation and maintenance of the GDPR and the development of an action plan to ensure the necessary actions are taken prior to the introduction of the new legislation.

LCH also deals with large volumes of requests for personal data and consistently meets statutory deadlines in compliance with the Data Protection Act 1998 and Access to Health Records Act 1990 legislation.

Deadlines are consistently met in line with the Freedom of Information Act 2000 requirements.

Some directed actions we have already taken or commenced to improve our compliance score are:

- Ensuring all staff complete the Information Governance Training on commencement of employment within LCH, whether this be on a temporary or permanent basis.
- Introduction of a more robust process to ensure our staff have access to Information Governance Training before being provided access to clinical information systems. This includes removing access to the systems should the validity of their training expire.
- Introduction of a mandatory annual cycle of refreshing Information Governance training, which is administered and monitored through our Electronic Staff Record System (ESR).
- Staff who support responses to Subject Access Requests have been provided with bespoke training, which will be refreshed on an annual basis.

Payment by Results

LCH was not subject to the Payments by Results clinical coding audit during 2017/18 by the audit commission.

Staff Satisfaction

The table on the next page shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends*, as reported on the NHS National Staff Survey**. This includes comparison with previous years.

*current definition: "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"

**definition has changed since Quality Account guidance was issued

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National average	Highest/ lowest
2013/14	2970	60%	67%	76%-60%
2014/15	2960	64%	70%	83%-62%
2015/16	2672	69%	73%	82%-67%
2016/17	2790	65%	73%	86%-65%
2017/18	2781	70%	73%	83%-65%

As with previous years, the Trust has seen a degree of change across all services that may have impacted on our percentage. We see 70% as a positive outcome given the ongoing challenges our staff face on a daily basis and this is a 5% increase from 2016/17. 89% of our staff feel that their role makes a difference to patients/service users.

For the last 3 years we have included the most recent LCH NHS Staff Survey results for indicators:

- 'KF19' reported in the LCH 2015 results as **KF26** *(Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months)*

In 2016/17 we achieved 16% for this indicator, which is a 7% decrease compared to 2015/16 and 4% lower than the national average for other community Trusts. In 2017/18 this indicator remained static but performing above average relative to other community trusts at 16%, with the national average being 19% and the best score for a community Trust being 15%

And:

- 'KF27' reported in the LCH 2015 results as **KF21** *(Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard*

In 2016/17 we achieved 92% for this indicator (an increase of 3% compared to 2015/16), showing us to be above the national average of 90%. In 2017/18 we achieved 90% (a decrease of 2% on 2016/17, but above the national average for 2017/18 of 88%, with the best score for a community Trust in 2017/18 being 92%.

What else are we doing?

Our focus this year continues to be on staff retention and also working with a more structured approach to improving quality across the Organisation which is a key part of building the working lives we want.

The features of this include:

- A clear and structured methodology for undertaking quality improvement that will become our way of doing things. This is based on the Model for Improvement (Institute for Health Improvement) and adapted from the approach successfully implemented in East London NHS Foundation Trust.
- A focus on engaging frontline staff in undertaking quality improvements both those that they wish to see at team or service level, as well as wider engagement in organisational improvement priorities.
- Patient perspectives forming a core part of our ongoing improvement work.
- Leadership development (LEAD) including Quality Improvement – and the role of leaders in creating the environment where improvement and engagement can flourish.
- Working with the Improvement Academy as our improvement partner to support the training of staff in improvement science, including data and measurement

There will also be additional focussed energy on building our senior leadership capability that will contribute to the improvements we can make to our patients' lives.

Improving Access to Psychological Services (IAPT)

Satisfaction within the Improving Access to Psychological Services (IAPT) is collected and recorded as part of a national data set.

The LCH patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period is given in the table below:

Reporting year	Percentage satisfaction all of the time
2013/14	77.0%
2014/15	83.5%
2015/16	84.2%
2016/17	83.5%
2017/18	83.4%

LCH considers that this data is as described for the following reasons:

- Patient Experience data collection is a national requirement of all IAPT Services, with satisfaction measured post screening and at the end of treatment.
- Audits are carried out quarterly by the service

The IAPT Partnership at LCH intends to take the following actions to improve this indicator score, and so the quality of its services by:

- Reviewing all patient feedback on a regular basis and sharing learning across the service.
- Continuing to work collaboratively with key partners in secondary care mental health to improve the mental health pathway and service user experience
- Seeking the views of service users regarding service improvement initiatives
- Continuing to improve access to the service by increasing direct access via workshops and groups designed for specific communities.
- Improving service information for service users by redesigning the website to include short videos about the therapies provided, as well as redeveloping service user information leaflets

leeds iapt
Improving Access to Psychological Therapies

Patient Safety Incidents

The table below shows the number and percentage of patient safety incidents (PSIs) reported within the LCH during the reporting period and previous years, and the number and percentage of such patient safety incidents that resulted in severe harm or death. This highlights a positive position with the number of PSI's being consistent with last year's figures.

The way these incidents are categorised and reported has changed through developments over time hence 2016/17 figures are comparable to 2015/16 figures only. LCH reports all incidents that affect our patients; however some occur in other organisations, for example care homes or other hospitals. The breakdown below of incidents occurring within our care at LCH and those occurring in other organisations is included to reflect the balance of incidents that are directly linked to our organisation. The greyed sections represent all PSI incidents for that year whereas the latter two years' compare LCH PSI's only.

Reporting year	Number of all patient safety incidents	Number (and %) of patient safety incidents that occurred within LCH care	Number of patient safety incidents that resulted in severe harm or death (caused directly by the PSI)	Number as a percentage of all patient safety incidents
2012/13	2371	Unavailable for these years	20	0.84%
2013/14	3199		35 (30 severe harm + 5 deaths)	1.09%
2014/15	3927		27 (25 severe harm + 2 deaths)	0.69%
2015/16	4207	3215 (76.4%)	49 (47 severe harm + 2 deaths)	1.2% (LCH PSI incidents)
2016/17	4189	3156 (75.3%)	61 (60 severe harm + 1 death)	1.93% (LCH PSI incidents)
2017/18	4759	3250 (68.3%)	63 severe harm (8 avoidable, 50 unavoidable, 5 ongoing). No avoidable deaths	1.9% (LCH PSI incidents)

LCH considers that this number and/or rate are as described for the following reasons:

- Staff are encouraged to be open when something untoward has occurred through the reporting of incidents and learning from these
- We are continually developing the incident reporting processes to improve the quality of the data we can produce

LCH has taken the following actions to improve the quality of its services, by:

- Continuing to promote the reporting of all incidents that occur within our services
- Providing training on incident reporting and investigation for all staff
- Providing training on investigating serious incidents for managers and holding a register of trained investigators
- Training programmes for Datix have been updated and are provided frequently, with bespoke sessions available for specific services/teams
- Continue to review and improve the systems in place for reporting incidents in order to ensure we are capturing all the important information that we can learn from, to prevent a recurrence of when things go wrong
- Increasing the involvement of all levels of staff and members of the public in discussions about how the organisation can improve learning from incidents and other sources of information
- Benchmarking our organisation against other community Trusts to assess our performance against other organisations that are performing well
- Assurance is given that within the NRLS (National Reporting and Learning System) dataset, LCH data remains aligned to other comparable organisations

Inquests

During 2017/18 we have registered by the Coroner to be involved in 21 inquests, 9 of which have been concluded. LCH has not received any Prevention of Future Death (PFD) reports served by the Coroner under the Coroner's (investigations) Regulation 28.

Mortality Surveillance

During 2017 the Trust's Learning from Deaths Policy has been written and is in the process of being implemented.

The Policy is in line with national requirement and builds on the work that was already underway in LCH. This ensures that all deaths in the organisation where our services were delivering direct care and case managing the patients care are investigated appropriately to determine if there is any learning.

There are two levels of investigation and all relevant cases as per the definitions in the policy will undergo as a minimum level 1 investigation.

The Organisation is also actively involved in LeDeR (Learning disabilities mortality review programme) and is currently undertaking four reviews in line with national guidance regarding this. This is producing significant learning in this area which will be invaluable in improving services for people with learning disabilities in the future.

The Mortality Surveillance Group continues to develop and is currently chaired by the Deputy Director of Nursing and has representation from all clinical services in the Trust. This Group will continue to meet bi-monthly and develop the mortality surveillance processes further in 2018.

Trusts are now being asked to report and update on the 'Learning from Deaths' process that was instigated across the NHS in 2017. The Trust developed and published a 'Learning from Deaths Policy' as requested by the date of 30th September 2017. This policy sets out the process to be followed in relation to learning from deaths.

The Trust already had a strategic Mortality Surveillance Group chaired by the Medical Director and sub-groups of this in each of the business units, the remit of these being to review deaths and in particular unexpected deaths and ensure a full and robust investigation is completed and the learning shared. To ensure this is a robust process every death of a patient within an LCH service is now subject to a level 1 investigation, which will establish if there is any reason to investigate the circumstances of the death any further. If at this stage that is the case, the death will be subject to a level 2 investigation. This will be undertaken by a senior clinician, either a medical practitioner or an advanced clinical practitioner. In addition any child death is subject to the sudden unexpected death in infants and children (SUDIC) process if unexpected and all child deaths, even if expected, are part of the child death overview panel (CDOP) process.

Some deaths within the Organisation are also subject to Serious Incident (SI) review as well and therefore subject to an in depth root cause analysis investigation, this includes any death in custody, a death as a result of sepsis or any death where there is significant concern about the circumstances.

As the organisation is a community Trust it has been a work in progress to ensure we can report on accurate numbers in terms of total deaths across the Organisation. This is partly because we have had to determine if a patient has died under our care, when that care might be very sporadic, for example, a 3 monthly podiatry appointment and also because quite a large number of our patients cut across several different services within the Organisation and therefore we have at times been recording duplicate deaths. The Organisation will be at the point where it can accurately record the total numbers of deaths and then break that down into expected and unexpected for 2018-19. For the purpose of this Quality Account we cannot accurately provide the figures but are confident that all deaths where there is a cause for concern are investigated appropriately. In future Quality Accounts the total number of deaths will be reported.

We are able to provide information for the period 1st January 2017 to 31st December 2017 of those deaths that were subject to an in depth review and these are as follows:

Adult Business Unit (ABU)

(predominantly Neighbourhood Teams)

Between January 2017 and December 2017 there were 30 cases presented at the ABU Mortality Review meeting and of those 2 were escalated to the strategic organisation wide Mortality Surveillance Group.

Specialist Business Unit (SBU)

(which covers a number of different services including podiatry, police custody and specialist nursing services)

In 2017 there were 17 deaths recorded. Of these 14 have had a level 1 review with 3 of these having a level 2 review. There were 2 deaths that followed the SI process and for 1 death the mortality review was undertaken by Leeds Teaching Hospital Trust (LTHT).

Children's Business Unit

All deaths have either gone through the SUDIC or CDOP process as described above. In addition 2 have been discussed at the business unit's mortality review group.

From all of the above reviews learning is shared at the organisation strategic mortality surveillance group and via several other means within the business units and wider across the whole organisation if required. Examples of learning include reminding staff in the Children's Business Unit about safe sleeping for infants and young children. In the Specialist Business Unit there was some learning about a reminder within the IAPT service about communication pathways. In the Adult Business Unit there was learning around the management of sepsis and several events have been held in the trust focusing on this and it is now part of infection, prevention and control training and resuscitation training to continue raising awareness.

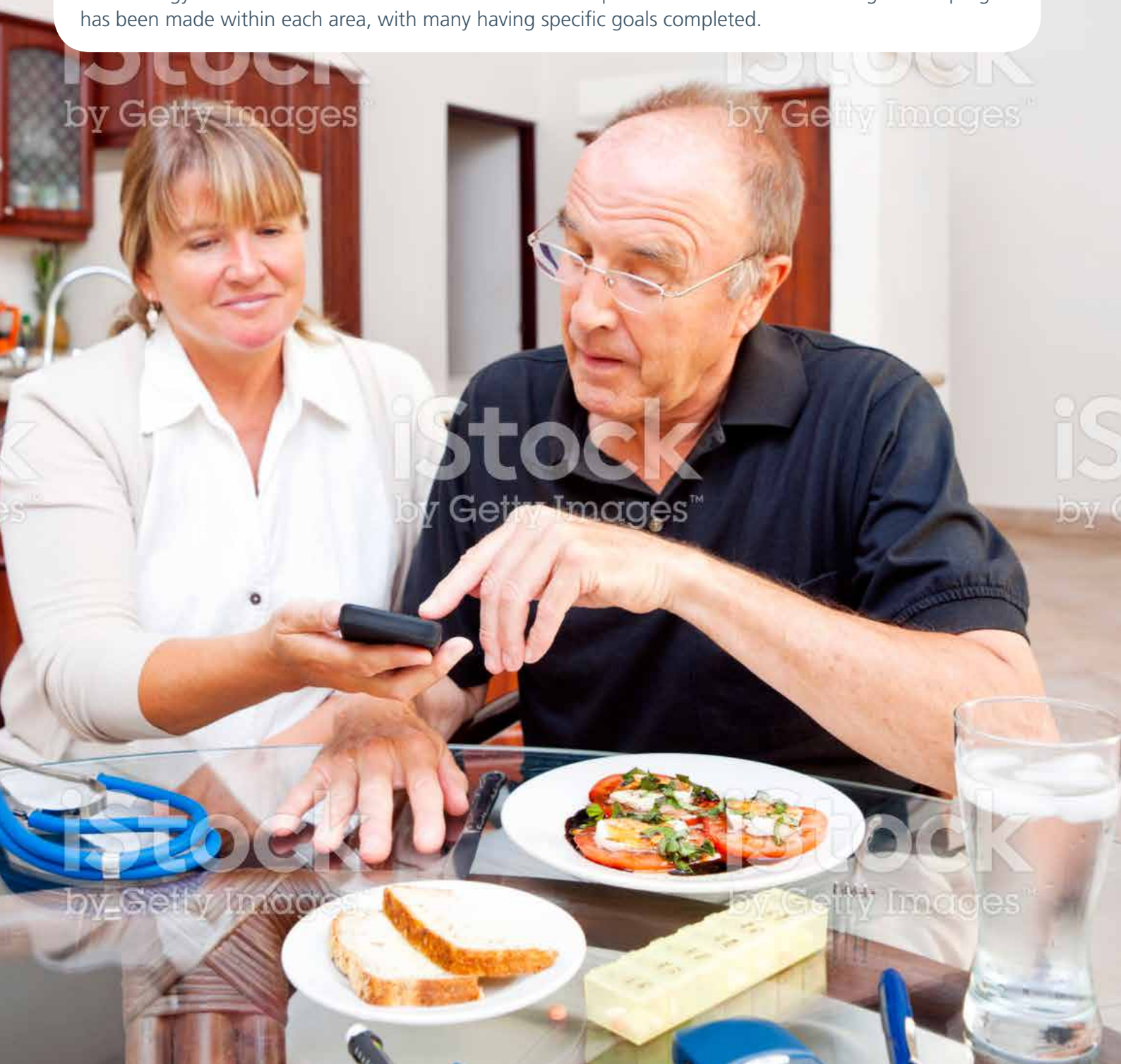
The Organisation is fully committed to learning from deaths and will continue to refine this process over the coming year to ensure that it is robust, open and transparent.

Section 4

Quality Improvements for the Coming Year

As reported in last year's Quality Account the Board approved the Quality Strategy for 2016-18 in February 2016. The Strategy described the quality improvement ambitions of the Trust aligned to the organisational strategic objectives.

The Strategy identified six action areas with a total of 21 separate actions within these. Significant progress has been made within each area, with many having specific goals completed.



Highlights of the achievements include:

Action Area 1
Continuous Quality Improvement

Several initiatives are now embedded to support services to continuously improve the quality of patient care. These include better use of data and information to support decision making through the introduction of quality boards, use of safety huddles where specific care needs are highlighted and better access to and use of performance information.

We will continue to work on improving our use of data and using outcome measures to show the quality of the services we provide. To support this we have made significant progress in rolling out the electronic patient record (EPR) to services so that information is more readily captured.

Action Area 2
Leadership and culture
Our 11: the working life you want

We are implementing our Professional Strategy for Clinical Staff and have refreshed our behaviour framework which sets out how we expect all our staff to behave and work together. We have developed a number of leadership development programmes to support staff in their roles.

Action Area 3
Our Community

We are better at saying sorry after an incident has occurred and we now have a well-established system in place to ensure this happens.

Recruitment remains challenging due to a national shortage of key staff groups, therefore recruitment and retention remains a priority for us. We have implemented several initiatives to support this including a revised preceptorship programme to support newly qualified staff; work with stakeholders to develop new roles; and improved staff engagement through establishing the 50 Voices Group.

Action Area 4
Empowering patients/patient centred care

We are rolling out a new approach for working with patients and service users called health coaching which has a focus on promoting self-care and on identifying what outcomes are important for the patient. We will continue to expand this to all services to ensure the approach is embedded.

Action Area 5
Learning systems

We have improved how we use information from other areas to identify how we are doing and to learn from each other. Our staff have also contributed to the development of national guidance relating to wound care assessment. We have developed a culture of learning from incidents and share learning through bulletins and through business unit forums

Action Area 6
Suite of projects

This action area outlined a number of key projects which would continue to be focused on through to business as usual. A number of these have been highlighted in the categories above (personalised care planning; patient voice at Board; Our 11; recruitment and retention). A number continue to be key areas of focus for the Trust:

- Pressure ulcers and falls – significant progress has been made over the past 18 months though the Trust recognises that more needs to be done. The work plan for falls reduction is on track. Both areas of avoidable harm retain a high level of focus and have dedicated work plans.
- Mobile working continues to be embedded
- There is continued work on developing outcome measures for each service

A new Quality Strategy for 2018-2021 has been developed and signed off. The Strategy describes an overarching quality objective to strengthen our approach to quality improvement with a focus on understanding data in order to give the necessary assurances on the quality of our services. Using this approach we will focus on four priority areas:

1. Prevention, proactive care and self-management
2. Patient experience and engagement
3. New models of care
4. Workforce

Professional Strategy for Clinical Staff
- developing and engaging staff

In October 2016, the Board approved the Professional Strategy for 2016-2020. The purpose of this Strategy is to set out our aspirations for our clinical workforce and how we can best work together with patients and partners to ensure the professional competency and skills of our clinical workforce.

The Strategy has four aspirations that will guide and support the development of the professions to deliver quality services within LCH. Underpinning each aspiration are objectives with measures of success. A number of the objectives are cross cutting and underpin more than one aspiration.

A Clinical Professional Council (CPC) has been set up to ensure a cohesive and coordinated approach to delivering the aspirations of the professional strategy. The CPC offers LCH an opportunity to foster a culture of professional and clinical leadership and influence the development of services by clinicians advising on quality standards. It provides an opportunity for health care professionals to come together from across the business units to share good practice, reduce variation and build professional relationships supporting LCH in the delivery of effective, high quality clinical services and care. It also provides the opportunity for ground level staff to have their professional voice heard and develop their leadership skills.

Safe

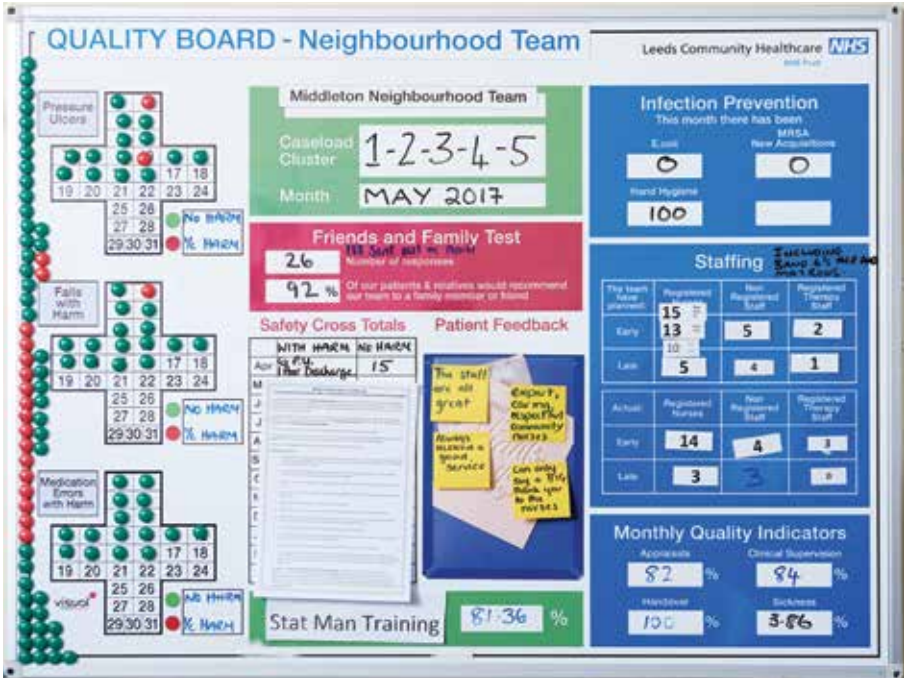
Introduction of Quality Boards
- supporting staff to understand how their team is doing

Quality Boards were introduced in the Adult Business Unit in June 2016 within the 13 Neighbourhood Teams and CIC Bed Bases, to promote safer care and improve clinical outcomes for patients.

The boards display information regarding patient feedback, incidents, clinical supervision and, staffing levels. They help staff to focus on successes, where improvements are required and provide an opportunity to reflect on the quality work being delivered in their team. Safety Huddles and Neighbourhood Team Safety Briefing meetings are held around the boards, where conversations include updates on patients and their condition, identification of any changes in care required and acting on any concerns.

The Quality Boards are utilised on a daily basis within all Neighbourhood teams and support the sharing and understanding of their quality information.

A recent Quality Board audit has identified areas to enhance the use, ownership and effectiveness of this quality tool. The audit recommended actions are all on track and the linked roll out of daily safety huddles at Caseload cluster level is underway. The aim is to have six teams active with daily safety huddles by the end of September 2018, supported by our safety huddle coach.



Quality Improvement Priorities 2018/19

The priorities identified in the Quality Account have clearly stated outcomes with SMART (Specific, Measurable, Achievable, Realistic and Timely) actions.

The 2018/19 priorities were approved at the Quality Committee on 19 February 2018 and revised at the subsequent Quality Committee in April 2018. These have been aligned to the revised Strategy and the Trust's business priorities.

There are some new priorities for 2018/19 as well as some priorities that have been carried forward from 2017/18 that have been refreshed.

A. Providing harm-free evidence based care

Quality area for action	Projected outcomes 2018/19	Indicators
To reduce avoidable harm	To reduce the number of avoidable pressure ulcers.	1. 50% reduction in avoidable Cat 4 pressure ulcers from the 17/18 figure with an overall aim of no Cat 4 pressure ulcers. 2. 20% reduction in category 3 avoidable pressure ulcers from 2017/18 baseline.
Achieve or maintain good or outstanding rating for all services (CQC and internal Quality challenge +)	To increase the number of services rating themselves as good or outstanding against the Quality Challenge+ Standards and to demonstrate improvement for services that have been rated as requiring improvement by the Care Quality Commission.	1. 70% of services rate themselves as good or outstanding through the Quality challenge+ self-assessment. 2. 80% of services rated as good or outstanding following a (Quality Challenge+) peer Quality visit. 3. Good and outstanding services will share learning and approaches to achieving the Quality Challenge+ standards with other services. (Quality Challenge +partners). 4. Services currently rated 'requires improvement' by CQC achieve a good or outstanding rating if re-inspected.
Always Events	Learning what quality care means to our patients, and working in partnership with our patients to improve their experience of LCH using the Always Events Toolkit.	1. 200 staff within LCH to attend always events awareness sessions. 2. At least two services from each of the Business Units will have identified an always event with their service users.

B. Engaging staff, service users and the public to improve the quality of care

Quality area for action	Projected outcomes 2018/19	Indicators
Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community	Evaluation of self-care service currently being trialled in Neighbourhood Teams and adoption of principles into business as usual.	1. Embed self-management approach in Neighbourhood Teams (informed by pilot evaluation). 2. NT staff trained to enable roll-out and embedding of LCH's NT self-management model in line with the agreed plan.
	To review patient's confidence in self-care within the new Foot Protection Service within the Specialist Business Unit.	1. Evaluate the confidence of patients in following self -management care plans within the new Foot Protection Service.
	Continue to roll out and embed health coaching/restorative approach as part of asset based approaches to support better conversations and patients to be empowered to self-manage.	1. Roll out and embedding of health coaching and restorative practice in services across the organisation in line with the agreed city-wide plan. (number to be determined for LCH). 2. Measures put in place to evaluate the impact of better conversations and 'working with' patients.
Quality Improvement	Develop a clear and appropriate QI model and improvement methodology for use across the organisation which is evidence-based.	1. Up to four learning QI projects to be undertaken during 2018/19 on key priority areas. In addition, up to 8 projects will be undertaken at team / service level using the agreed QI methodology.
Family and Friends Test (FFT)	A) Increase the response rates for FFT using baseline from the end of 2017/18	1. Increase the uptake of FFT across all Services to achieve a minimum 3% increase in response rates by the end of 2018/19. 2. Services to share learning and 3 changes made as a result of FFT feedback from service users.
	B) Ensure FFT equality data is reflective of the patient population through promotion, in order to identify and better understand health inequalities; and bring about improvements in patient care	1. Services to improve on the equality of FFT data from the baseline developed from the 2017/18 data.
Outcome Measures	Increase the number of services using outcome measures that are effective and meaningful and ensure that data from outcomes is extracted to ensure that outcome measures are meaningful (NB A baseline is currently being established)	1. Implement the roll out of an outcomes programme that is clinician agreed and patient determined and in line with the Business Committee agreed plan.

C. Access to services

Quality area for action	Projected outcomes 2018/19	Indicators
Access to services	Reduce internal waiting times, understand waits and agree further priority areas for intervention.	**CAMHS Service** All first appointments will be undertaken within 12 weeks.
		Access for Children with Additional Needs (ICAN) 1. Pre-school children will be seen for ASD assessment within 12 weeks. 2. All patients should have a follow up medical appointment within 4 weeks of planned review date. 3. 80% of initial appointments for OT and PT to be seen within 12 weeks.
	To develop a pilot in one service in relation to tracking follow-up appointments. The learning from this will be used to shape a plan to develop this across services.	1. Service identified. 2. Pilot plan and project established. 3. Learning will be identified. 4. Evaluation completed in relation to potential to roll out across services and business requirements to enable this.

D. Recruitment and retention of staff

Quality area for action	Projected outcomes 2018/19	Indicators
Leadership	Develop leadership and management throughout the Organisation through implementation of the leader development LEAD Programme and development of the senior leadership team.	Reporting will be timed with cohorts to the programme. We will measure the quality impact to through surveys which will assess: 1. Achievement of Personal learning objectives 2. Impact on the team 3. Feedback from line managers To be conducted 6 months following completion of the cohort to allow for change to take place.
Staff Engagement	'Creating the working life we want' by increasing year on year the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey.	Increase in the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey.
Staff Retention	To improve retention and reduce trust turnover.	1. Reduce staff turnover to 14.5% from 14.8% 2. Delivery against the NHS Improvement retention plan

Quality Challenge+

2017/18 has seen the Trust continuing asking practitioners, teams and services to review the care they provide against 10 Quality Standards; this is our Quality Challenge+ Framework.

The standards provide a mechanism for services to assess themselves against our policies, our behaviours, national indicators and guidance, alongside the Care Quality Commission's five domains of quality.

So what has happened? All services have completed a self-assessment and rated themselves as ***good, requires improvement or inadequate***. This year in line with our CQC inspection more services identified themselves as good, providing examples of innovative and caring practice. But the self-assessment is only part of the Framework. The Quality Challenge+ Framework also includes a **Quality Visit** to services, a means to both celebrate achievements and identify where improvements need to be made, as part of our commitment to continuous improvement.

Quality Visits are undertaken by colleagues and include involve talking to staff and patients about their experiences. Visitors also observe the day to day work of the service, which could be in the patient's home, a health clinic, an inpatient unit or other setting. At the time of writing there have been 38 visits with a further 7 panned prior to the end of March which will mean a total of 45 visits will have taken place. An outcome of the visit is both verbal and written feedback to the service and a plan to visit again to follow up issues and provide continuous assurance of the quality of our services.

So what have we learnt? There is some outstanding practice with staff showing compassionate care across our services with service users reporting they felt safe and listened to, but we have also leant we could do even better so in 2018/19 we plan to:

- Continue using the Quality Challenge+ Framework, following positive feedback from staff
- Challenging our services to describe how they provide quality care, with more emphasis on user and staff feedback and engagement
- Include service users as part of Quality Visit team
- Share more of the learning across services by organising "Conversations" between services

Quality challenge + Great care every day

Caring

Palliative and End of Life Care

Neighbourhood Teams (NTs) and our neighbourhood night service support patients with palliative care needs to be cared for in their home or care home without nursing, with the aim of preventing unnecessary hospital admission at the end of life. Last year's Quality Account included reference to a new Neighbourhood Palliative Care Lead role developed to support staff within NT's to deliver high quality palliative and end of life care. Over the last year this role has become fully embedded and improvements have continued to be realised across NTs.

- 85% of patients with palliative care needs died in their preferred place of death
- Additional information about patients preferred place of death has given further assurance as 89% of patients died in either their first or second preferred place of death
- 87% of patients died out of hospital

- More patient deaths have been verified by NT staff, reducing the pressure on GP services and the time waiting for a GP to attend, particularly out of hours: 72% of patients who died at home had their deaths verified by LCH nurses
- New practice and guidelines to support effective symptom management for patients have been introduced
- A new approach to assessing, reviewing and sharing information about patients palliative care needs has been implemented to further support a personalised approach to care
- More staff have attended training and been supported in practice. Staff report this has developed their skills and increased their confidence in meeting the psychological, physical and emotional care needs of patients
- The number of patients with identified palliative care needs known to NTs has increased by 16% this year compared to last year and the number of visits by NT staff have increased by 22%

The improvements made by NTs and our neighbourhood night service in delivering this care have been recognised by the CQC and nationally, with an entry **An Integrated Neighbourhood Team Approach to Improving Palliative Care for Patients and Carers** shortlisted for the Health Service Journal Compassionate Patient Care award.

What the CQC said:

Patients …were consulted in their future care plans, involved in their care assessments, and planning. We observed this happened with patients who were at the end of life…

Thank you so much for your kindness and support during six difficult weeks

We saw emotional support being offered to an end of life patient and their relative. Staff took time to listen to relatives anxieties and understood the need to discuss their emotions

The love and respect you gave her is something I have never witnessed before

Responsive

Specialist Community CAMHS: Improving Access to the Service

During 2017/18 the service has been addressing the waiting times for an autism assessment for school aged children and young people. This was achieved through a number of initiatives:

- Saturday assessment clinics
- Twilight/evening assessment clinics
- Standardising how we do things across the service to improve outcome and efficiency
- Offering specialist training and resources to staff to ensure a high level skill in the assessment service
- Bidding for and being successful in gaining some monies from NHS England to implement and run a waiting initiative including all of the above as working a partner agency to provide assessments.
- Referral rates have remained fairly static throughout 2017-18 to date, averaging out at 17.5 per month
- At the start of April 2017 there were 183 ASC waiters, 136 of these (74%) had been waiting more than 12 weeks, with the longest wait times for first appointments being over 52 weeks.
- The ASC waiting list position as at the end of Feb-18 is 68 waiters, 25 (37%) of which have been waiting 12+ weeks with most of these children being expected to be seen in March/April 18.
- We are aware that this waiting time is well below both local and national trends and initiatives continue to ensure a maintenance of a low waiting list

Well-led

Across the Trust we have so many examples of great service provision, leadership and a culture of compassionate care. This year, 15 services submitted an HSJ (Health Service Journal) award entry and we got shortlisted for five.

Workforce Work Stream

Leeds Plan Principle

We are team Leeds

Working as if we are one organisation, taking collective responsibility for and never undermining what is agreed. Difficult issues are put on the table, with a high support, high challenge attitude to personal and organisational relationships

Workforce Strategic Aims	To develop an appropriate and agile workforce for Leeds - a workforce that works flexibly across organisational boundaries ensuring we have the right skills, in the right place at the right time	The Leeds health and care workforce is valued, well trained and supported – a workforce that feels motivated with access to continued professional development	To develop a system leadership approach across the health and care workforce in Leeds - supporting the workforce to work together as one team, providing the best care and support in the right place at the right time
Activity to support the delivery of the strategic aims	Including: • Develop a shared understanding of the future design and make-up of the Leeds health and care workforce • Harmonising HR practices and processes • Growing the local Leeds workforce • Facilitating mobility/ ability of the workforce to "Hot desk" across partners	Including: • Support the development of skills to enable better conversations • Creating a digitally fluent workforce • Develop a system wide health and wellbeing offer • Develop pathways and opportunities with higher education providers • Inform the work programme of the Leeds Health and Care Academy	Including: • Developing system leaders and a system approach • Developing cross system relationships and accountability • Supporting the development of locality teams • Embedding "Working With"/"Better Conversations" approach • Workforce engagement to embed new approaches

Achievements

- 'We are team Leeds' workshop in May with the Partnership Executive Group (PEG) and Leeds Plan Delivery Group (LPDG) helped set the key organisational development priorities to support partnership working and the concept of one health and care workforce for the city
- The OD Hub was established early August and has facilitated people working across the systems to come together. The aim of the OD Hub is to facilitate and role model system leadership to enable people across the health and social care system to co-create work with an emphasis on the relationship aspects of the work to enable culture change. This will be achieved through facilitating partners to come together and work together to tackle system change.
- It is through this innovative approach and development of good relationships that the OD Hub has secured agreement with the National NHS Leadership Academy to co-produce a system leadership approach for the city. The resource consists of an organisational psychologist and others who will work with the city for 6 months to provide a fresh approach to systems leadership, to create the conversations, convergence and systems approach to flow into key work streams.
- The work with the National Leadership Academy will act as a catalyst to drive a system approach with leaders. It is likely that this work will also achieve national recognition as the National Leadership Academy are keen to use this work as an exemplar in terms of the approach to support system level working.

Mentorship

There are 3 LCH staff registered as a mentor on mye-coach who have experience in this role. Although it was planned to roll out training to those interested in mentorship this has not been taken forward due to lack of resources this past year.

Improving Recruitment and Retention

Recruitment and retention remains a key priority in 2017/18 and we have an established Recruitment and Retention Steering Group which meets monthly to prioritise and co-ordinate the issues and challenges relating to recruitment.

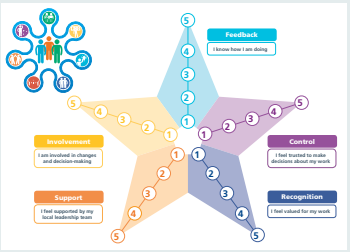
A Recruitment team has been established and it is important that we recruit staff with the right values and the right skills and experience to ensure high quality, safe and effective patient care. We have focused on areas requiring high volume recruitment by designing, facilitating and administering standing interview panels and assessment centres. This approach supports the Trust in securing a consistent workforce supply in areas/professions which are hard to fill due to national shortages. We are also developing our future attraction strategy which focuses on the development of the Trusts website to promote the full range of benefits on offer to candidates and the use of social and digital media.

To ensure that we continue to develop and retain our existing workforce, we are also updating the Trust's intranet site, to make it easier for staff to find and access the information they need, such as development opportunities and the benefits available. Work continues on leadership development, staff engagement and 'Creating the Working Life we want' and 'Building the Workplace we want' and remains the focus of our retention effort. This will support us in retaining staff and supporting them to develop the working life they want.

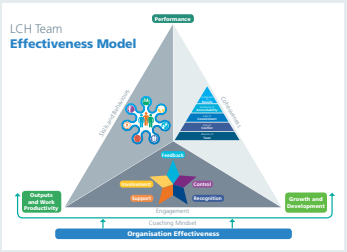
How we build the **working lives we want**

Our Eleven: Shared Vision, Values and Behaviours

Individuals



Teams



Leaders

Building leadership skills

L Leadership
E Exploration
A Ability
D Development

Resilience

Wellbeing

Improved wellbeing for self and others

Quality Improvement Approach

QI skills and training | QI projects | Leadership for improvement | Staff engagement

Individual | Team | **Coaching mindset** | Managers as Coach | Health

How do we build who we are?

Priorities → Recruitment → Potential + performance → Talent + careers

Organisational structure / infrastructure

Who is in charge, what are my responsibilities, what am I accountable for?

Where do I sit? | What is my kit? | Where do I talk to people?

How our quality and Quality Account quality improvement priorities will be monitored throughout the year

The indicators from the quality account priorities are monitored on a quarterly basis through the Senior Management Team. These indicators also feature within our monthly reports, which are reviewed by Business Committee and Quality Committee before being presented to our Trust Board.

Reporting and monitoring in this way ensures that senior managers and the Trust Board are aware of how we are performing against our quality improvement priorities. It is also an opportunity for them to scrutinise and seek further assurance on any actions underway to make those improvements, in order to ensure they are achieved.

At Business Unit level a detailed review of the indicators is included in the information shared with services, as part of their regular performance reviews and on quality impact assessment dashboards made available to them. This enables services to know how they are doing in relation to quality improvement. Work is ongoing to ensure that following an incident, learning from it is consistent, effective and shared.

The Trust has revised its governance structure and a sub-committee called the Patient Safety, Experience and Governance Group (PSEGG) established. During 2017/18 a number of workshops have been held, chaired by the Executive Director of Nursing. These bring together staff, managers and the public to look at themes and learning from incidents and experience. From those workshops actions are identified with a view to progress against these and the impact of them being monitored by the Group. We recognise that there is still work to do to embed and develop this function in order to ensure it fulfils its purpose to improve the quality of care through learning from experience; and assure the Quality Committee on the safety and quality of our services. This will be continue to be a focus of our work throughout 2018/19.

Section 5

Statements from Others on the Quality of LCH Services

Healthwatch Leeds, Overview and Scrutiny Committee for Health and Public Health and Social Care for Leeds

We feel that the Quality Accounts reads well and is comprehensive. However, we have found it a bit of a challenge to find supporting evidence of where LCH has engaged with service users/public to influence their activities, the focus of the report comes across as more in relation to staff based quality improvement and integration activities.

It's good to see the case studies being included (p10-11) however it's unclear what level of patient involvement/feedback/engagement there has been in the pressure ulcer prevention work for example (p14).

The learning from experience section (p21-23) also raises questions, although they have achieved their goal of having the SMART action plans it doesn't really give a flavour of what has actually changed as a result, it still seems more focussed on the process rather than the experience or learning outcomes.

There is a good example of responding to patient feedback with the StepUp app (p33) and we are pleased to see their commitment to expanding the Patient Experience Pledge for 2018/19 (p35.)

There are some good examples of the impact of feedback leading to changes at Wetherby YOI but there was also an almost throw away comment about Nursing Times awards (p43) – it would be useful a couple of lines were added to state what these were for as it's a positive accolade getting a national nomination let alone winning one!

Overall we feel that LCH has continued to build some good foundations and we would want them to be able to narrate a stronger story next year as to how the local user voices have been engaged with and influenced change and development of services.

Some points:

1. There is a concern nationally about CAMHs services. In this Quality Account LCH state that 20% of patients wait more than 3 months to be seen. This appears to be a very high proportion of patients (1 in 5 waiting 3 months or more, and they are a very vulnerable group). We think it would be beneficial for the Trust to highlight why they think this has occurred and how they are addressing this (through 'co-working', presumably with LYPFT?).
2. It is gratifying to read the section on the 13 Neighbourhood teams and that they continue to incorporate Consultant Geriatricians. There is a need to improve the care of older people and avoid unnecessary admission to hospital, prevent readmission and potentially expedite discharge. It would be useful to know if there are plans to expand the engagement of geriatricians working in the community eg. Less people providing more time thus relating to primary care and neighbourhood teams much better.

Healthwatch Leeds comments on Quality Improvement Priorities

Given the increasing number of older people in society and the consequent pressure on hospital and social care it is a little surprising that none of LCH's Quality Improvement Priorities relate directly to older people. Does LCH have any plans for improving its services and care of this important client group?

NHS Leeds Clinical Commissioning Groups

Thank you for providing the opportunity to feedback on the Quality Account for Leeds Community Healthcare NHS Trust for 2017-18.

This report has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided for review and comment is in draft form and additional information will be added and amendments made before final publication. The lack of data in places makes it difficult to offer a fully informed view of some areas, so please accept our observations on that basis.

We would like to congratulate the Trust for the 2017 CQC overall rating of 'Good' demonstrating progress from the previous rating of 'Requires Improvement' in 2014. We will continue to work with the Trust to ensure the action plans for services rated as 'requires improvement' are addressed and we look forward to seeing similar progress at Hannah House, Leeds Sexual Health Service and Little Woodhouse Hall during 2018/19.

It is encouraging to see that staff engagement is improving and we look forward to seeing this trend continue to rise during 2018/19. A clear approach is being taken with conferences held for registered and non-registered staff, and the '50 voices' initiative is a good vehicle for engaging staff at all levels in a meaningful way. We are pleased to note the national recognition gained for the work of the Freedom To Speak Up Guardian, however we would have liked to see some examples of actions the Trust has taken in response to the concerns raised around culture, leadership and behaviours.

We recognise the investment made in staff coaching and hope that the challenges the programme has faced with resources and competing demands can be overcome to support this initiative in 2018/19. There is evidence throughout the report of a commitment

to staff training and particular recognition is given to the Trust's attainment the 85% compliance target set by NHS England for WRAP Level 3 training.

We acknowledge the progress made in the NHS Workforce Race Equality Standard, with regards to staff experiencing harassment, bullying or abuse and discrimination at work. It is good to see where external validation is taking place, in particular the commitment to diversity and equality, and where information is coming from.

The Trust should be commended for the number of compliments received, a positive comparison to the number of complaints and concerns received in 2017/18. We also note the progress made regarding the number of action plans for upheld or partially upheld complaints and recognise the effort this will have involved. It would have been helpful if the report had provided some examples of changes made as a result of patient feedback to indicate further the embedding of learning from complaints.

Work to engage patients is demonstrated through the use of patient stories at Board level. This is a powerful mechanism to ensure a proactive approach to engaging with, and listening to, patients and the public. We would expect the Trust to utilise this approach to encompass stories about care or services that did not go well, alongside the success stories, to ensure a balanced view is represented and to help with identifying opportunity for learning and improvement.

Safety appears prominently in the report with evidence of work to improve the timeliness of incident management. We welcome the commitment to involve patients and carers in the work around learning from incidents to ensure the best possible outcomes and to improve care. We look forward to receiving updates from the Patient Safety, Experience and Governance Group in 2018/19.

The Trust has achieved an exceptional compliance rate of 100% with the implementation of Duty of Candour, and we anticipate this commitment to openness and honesty can be sustained and advanced into the next year.

We are pleased to note the continued work to reduce the number of avoidable category 3 pressure ulcers and reducing the numbers of harmful falls. It is disappointing that there was a rise in avoidable grade 4 pressure ulcers during 2017/2018, however we recognise that a fresh approach has been adopted and we look forward to seeing the refreshed plan for 2018/19. We are in support of the re-commencement of the pressure ulcer prevention group to support joint working across the system.

It is disheartening to see that the CAMHS waiting

times continue to be a challenge for the Trust, however we recognise the good progress shown in the ICAN services.

The Trust has been successful in achieving the RCN awards for the integrated healthcare to children service and young people in custody. The work to improve the attendance at healthcare sessions for young offenders is impressive and this demonstrates a commitment to health services for this vulnerable group.

We also are pleased to see new approaches via the use of technology and digital apps to engage people, specifically with younger patients. The Step Up app and the Let Me Show U App are excellent examples of how digital approaches can improve patient care. Using a co-production methodology to establish these is a positive step and we look forward to seeing the evaluations and impact over time of these tools.

The Trust should be praised for the targeted improvements made within infection control, particularly in having no MRSA cases during 2017/18. We look forward to seeing these accomplishments continued into 2018/19.

The detail about what new ways of working for the neighbourhood teams entails is not clear in the report, although the EPR and mobile working initiatives are encouraging. We look forward to seeing the completion of the e-rostering roll out plan in 2018/19.

The breakdown of measures, developed to standardise the quality of care within adult services, into the quality domains is a really effective way of capturing the detail of these initiatives. We would like to see a consistent approach across the other business units.

The work to improve the outcome for service users of IAPT is excellent and working with those who are not on track to achieve their outcome indicates a caring and supportive approach.

We are encouraged to see examples of collaborative working within the report. In particular the joint working with LTHT to improve and realign MSK services to better meet patient need, and we look forward to hearing further developments on this. The involvement with the multi-disciplinary foot care team in the diabetes service also further exhibits strong collective ambitions and the strengthening of partnership working with Primary Care is welcomed.

It is difficult to assess the full range of improvements made as a result of local audit due to the limited information currently available, however we are appreciate the inclusion of some of the changes made as this is important to show how the organisation learns and we look forward to seeing further progress from the audit programme.

The Quality Challenge+ framework continues to be a productive way of engaging staff in the business of quality improvement and is to be applauded. There appear to be a plethora of projects ongoing with the aim of quality and service improvement and it would be good to see how these feed into each other and how learning from them is shared.

We commend the Trust on exploring new ways of promoting self-management through the development of online resources and applications for staff. The Performance Information Portal is an excellent initiative in helping staff understand the performance of their teams, services and the organisation.

We are eager to see the further development of outcome measures as this has been a priority for some time. There were some priorities from 2017/18 that still require some work and it would be useful to have some clear indication relating to how this will continue, if it isn't a specific priority for 2018/19.

We are supportive of the 2018/19 quality priorities which are strong and strategic and in line with the Trust's key priorities for improvement. We are keen to see the momentum grow and the improvements made within these areas during the next 12 months. We are delighted to see the inclusion of the Always Events Framework and are keen that this will be developed to ensure care is delivered in partnership with patients and service users. We would like to see this initiative identify and sustain reliability in person/ family centred care delivery processes, and not just be a means to achieving the expected standard of safety.

We hope that this approach and the other priorities identified will bring a successful year ahead of quality improvement for LCH.

We appreciate the opportunity to review the report and hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Leeds Community Healthcare NHS Trust's Response to Comments Received

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Acknowledgements

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2017/18 Quality Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, the Senior Management Team and the Board of Directors.

This Quality Account provides an insight into how we are working to realise our vision, values and strategic objectives, and our Quality Strategy. Quality is at the heart of everything we do; we hope we have demonstrated within this document how quality is created, embedded, developed and improved within LCH through sharing examples of initiatives underway to help us achieve these aims.

In line with other NHS organisations, we produce an Annual Reports and Accounts to outline our financial and other key performance measures. These can be found on our website at **www.leedscommunityhealthcare.nhs.uk**

How to Comment on the Quality Account

If you would like to comment on this document you may do so:

- By email to **lch.pet@nhs.net**

  Please ensure you include **'Quality Account 2017/18 feedback'** as the subject of your email.

- In writing to:

  The Clinical Governance Manager
  Quality Account 2017/18 Feedback
  Clinical Governance Team
  Leeds Community Healthcare NHS Trust
  1st Floor, Stockdale House
  Headingley Office Park
  Victoria Road
  Headingley
  Leeds LS6 1PF

Services provided by Leeds Community Healthcare NHS Trust

For a full list of our services, please visit our website:
www.leedscommunityhealthcare.nhs.uk/our_services_az/

Glossary

Appraisal – a method of reviewing the performance of an employee against nationally agreed standards within the NHS.

Antibiotic – A drug used to treat bacterial infections.

Antimicrobial resistance – The ability of bacteria and other microorganisms to resist the effects of an antibiotic to which they were once sensitive. Antibiotic resistance is a major concern of overuse of antibiotics. Also known as drug resistance.

Audit – a review or examination and verification of accounts and records (including clinical records).

BME/BAME groups – Black and Minority Ethnic or Black, Asian and Minority Ethnic is the terminology normally used in the UK to describe people of non-white descent.

Care Quality Commission (CQC) – Health and Social Care regulator for England.

Clinical supervision – a reflection process that allows clinical staff to develop their skills and solve problems or professional issues. This can take place on an individual basis or in a group.

Clinical coding – an electronic coded format that describes the condition and treatment given to a patient.

Clostridium difficile (Cdiff) – an infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics.

Commissioners – organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).

Continuous Quality Improvement (CQI) – a management approach that organisations use to reduce waste, increase efficiency, and increase internal (employee) and external (customer/patient) satisfaction. It is an ongoing process that evaluates how an organisation works and ways to improve its processes.

CQUIN (Commissioning for Quality and Innovation) – a financial incentive encouraging Trusts to improve the quality of care provided.

Datix – an electronic risk management system (database) used to record incidents, complaints and risks for example.

DOLS (Deprivation of Liberty) – DoLS protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.

Duty of Candour (DoC) – a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

E-Rostering – an electronic staff management tool used to plan staff requirements and reported on staff hours worked, annual leave, sickness etc.

Equality Delivery System (EDS2) – part of the NHS Equality and Diversity Council's pledge to commit to implement two measures to improve equality across the NHS. This system helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination.

Friends and Family Test (FFT) – a measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family.

HbA1c – refers to glycated haemoglobin (A1c), which identifies average plasma glucose concentration which is an important measure for patients with diabetes.

Health Service Journal (HSJ) – a former weekly news print magazine, now a website, covering British National Health Service, healthcare management and health policy.

Information governance – the rules and guidance that organisations follow to ensure accurate record keeping and secure information storage.

Innovation and Research Council – this is an independent body which brings together the seven Research Councils, Innovate UK and Research England.

Inquest – a judicial inquiry to ascertain the facts relating to an incident.

Leeds Institute for Quality (LIQH) – an organisation that enables clinicians to develop shared expertise in innovation and improvement.

Leeds Plan (Leeds Health and Care Plan) – a strategic plan that aims to achieve a whole city approach to healthcare in Leeds and make Leeds the best city for health and wellbeing.

Leeds Safeguarding Children's Board (LSCB) – a statutory body which is independently chaired and consists of senior representatives of all the principal agencies and organisations working together to safeguard and promote the welfare of children and young people in the City.

Medicines management – processes and guidelines which ensure that medicines are managed and used appropriately and safely.

Meticillin resistant Staphylococcus aureus (MRSA) – blood stream infection caused by bacteria that is resistant to some treatments.

Methodology – a system of methods used in a particular area of study or activity.

Multi-Agency Looked After Partnership (MALAP) – a network that brings together partners from across services and sectors with a shared aim of improving outcomes for looked after children and young people in Leeds.

NHS England (NHSE) – the central organisation that leads the NHS in England and sets the priorities and direction of the NHS.

NHS Improvement (NHSI) – an NHS organisation that supports us to provide consistently safe, high quality, compassionate care.

National Institute for Health and Care Excellence (NICE) – an organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services.

National NHS staff survey – a survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS.

National Reporting and Learning System (NRLS) – a central database of patient safety incident reports.

Neighbourhood Multi-disciplinary Teams (MDTs) – integrated teams of health and therapy staff working as a team within a location (neighbourhood) in the community.

Norovirus – a group of viruses that are a common cause of food poisoning and acute gastroenteritis ("stomach flu") that can strike quickly and make a person feel very sick but which typically resolves within 2-3 days. The characteristic symptoms are nausea, vomiting, diarrhoea, and abdominal cramping.

Outcome Measures – a measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue.

Patient Advice and Liaison Service (PALS) – a service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible.

Patient experience – feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment.

Patient satisfaction – a measurement of how satisfied a person felt about their care or treatment.

Payment by results – the system applied to some services whereby NHS providers are paid in accordance with the work they complete.

Preceptee – a person undergoing preceptorship (see below).

Preceptor – an experienced member of staff who provides role support and learning experiences to the preceptee to assist them acquire new competencies.

Preceptorship – a structured period of transition for a newly qualified member of clinical or therapy staff when then begin their employment in the NHS.

Pressure ulcer – damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing.

Public Health England – an organisation that works to protect and improve national health and wellbeing, and reduce health inequalities.

Risk Assessment – a process to identify risks and analyse what could happen as a result of them.

Root cause analysis (RCA) – a method of investigating and analysing a problem that has occurred to establish the root cause.

Scrutiny Board (Health and Well-being and Adult Social Care) – a function of the local authority with responsibility to hold decision makers to account for the services they provide.

Serious Incident (SI) – these are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Sign up to Safety Pledge – a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

Strategy – the overall plan an organisation has to achieve its goals over a period of time.

Stonewall – a lesbian, gay, bisexual and transgender (LGBT) rights charity in the United Kingdom.

Subject Access Requests (SAR) – requests made for personal information under the Data Protection Act 1998.

Standard Operating Procedure (SOP) – a set of step-by-step instructions compiled by an organisation to help workers carry out routine task.

Sustainability and Transformation Plans (STPs) – the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Systm One – a clinical record keeping system that the Trust uses to record clinical information and clinical discussions.

Trust Board – the team of executives and non-executives that are responsible for the day to day running of an organisation.

Unconscious bias – unconscious bias happens by our brains making incredibly quick judgments and assessments of people and situations without us realising.

Quality account

2017 : 2018

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NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19
9 (i)

Meeting Trust Board 25 May 2018	**Category of paper** *(please tick)*	
Report title Year-end Report on Delivery of 2017/18 Operational Plan Priorities	**For approval**	
Responsible director Executive Director of Finance & Resources **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by Business Committee 25 April 2018, SMT 18 April 2018	**For information**	

Purpose of the report

This report provides an overview of delivery at the year-end of the 4 corporate objectives and associated priorities and success measures. Business Committee receives quarterly reporting on progress and forecast delivery at year-end, Board receives a mid-year and year-end report.

Main issues for consideration

The Board and its sub committees, through the many reports received, Board workshops and service visits, have been well sighted on plans and progress towards achieving the corporate objectives and priorities.

Year-end performance

Each priority is RAG rated. The RAG rating reflects an overall assessment of progress and performance in relation to the priority, not solely the component success measure RAG ratings.

At year-end:

- 12 (57%) of the 21 priorities are on track (green)
- 9 (43%) were narrowly missed – timeframe, delivery requirements (amber)

Assessment of reasons for not achieving targets

Business Committee and SMT considered the reasons for priorities not being achieved:

Internal factors

- **Corporate objective 1: Ensure consistent delivery of high quality care**
  Priority 1.1: Act on agreed recommendations from external reviews: AMBER
  CQC inspection: Good engagement by services however pace of progress for Hannah House was impacted by operational pressures on the service manager due to staffing levels, wider workforce issues and temporary management arrangements

until October 2017. Leeds Sexual Health service also impacted by operational pressures on the service manager due to staffing levels and issues with ESR and LTHT's e-learning system. This has been recognised and Operational and Clinical Lead roles separated which will increase capacity.

- **Corporate objective 3.2 Continue to improve staff engagement and morale**
  Priority 3.2: Reduce sickness. AMBER
  It remains unclear why LCH's sickness rate remains higher than peer organisations. It will remain a priority in 2018/19.

Composite of internal and external factors

- **Corporate objective 1: Ensure consistent delivery of high quality care**
  Priority 1.2: Deliver Quality Account priorities: AMBER
  Different factors impacted on the various Quality Account priorities not achieved e.g.
  - Protect patients from harm: zero Cat 4 avoidable pressures. SMT and Quality Committee were aware when setting this target that this would be a challenging target to achieve and is confident that the systems and processes are in place to enable continuing year on year improvement.
  - Establish electronic rotas in a range of services including NTs. Target not met because the approach taken, to work with a supplier to develop a bespoke community solution, did not meet the Trust's requirements.
  - FFT response rate (also priority 1.8). Requirement to review FFT targets and approach to ensure services are enabled to adopt best practice and targets are appropriate. SMT progressing.
  - Improve access (also priority 1.5): AMBER. CAMHS Autism Spectrum Disorder Assessment and Consultation Clinic; ICAN Complex Communication Assessment and follow up medical appointments: AMBER. CAMHS reflects a delay in fully implementing new ways of working within the service which will balance capacity with demand. ICAN reflects the impact of Specialist Health Visitor and medical staffing challenges and increasing demand.

- **Corporate objective 2: Create sustainable services**
  Priority 2.1: Consolidate and develop sustainable integrated NTs: AMBER
  Reflects continued capacity and demand pressures due to sickness, turnover and difficulty recruiting to vacancies whilst continuing to provide responsive service to maintain flow during winter period.

- **Corporate objective 3. Continue to improve staff engagement and morale**
  Priority 3.3. Fill substantive posts required for effective delivery: AMBER
  Reflects local and national shortages in workforce supply for key roles including Band 5 and 6 nurses and scope to further improve the efficiency and effectiveness of recruitment systems and processes. This remains a priority for 2018/19.

Factors outside the Trust's control

- **Corporate objective 4: Take a lead role in delivering new models of care in the city**
  Priority 4.2 Develop New Models of Care: AMBER**.**
  Reflects the pace of development of New Models of Care by commissioners and partners city-wide and commissioners having taken back control of developing an integrated adult Mental Health pathway but not currently progressing it.

Recommendations
The Board is recommended to:

- Note progress at year-end in delivering the 2017/18 priorities
- Consider the assessment of the reasons for not achieving the priorities

Key	Priority/success measure achieved	Slight under performance &/or slippage vs original time-scale	Priority/success measure not achieved

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Year-end status
1.1 Act on agreed recommend-ations from external reviews: CQC, Ofsted, HMIP	Implement agreed recommend-ations within timescales agreed by Board / sub committees	Overall: AMBER: reflecting slippage on the high priority CQC QIP ❑ CQC Inspection: AMBER reflecting slippage in time-scales for completing the QIP. At year-end, 5 of the 8 'must-do' actions and 26 of the 36 'should do' actions are complete. Original time-frame for completing 'must-do actions' was 30 March 2018: revised to 15 June 2018. Original time-frame for completing the 36 should-do actions was 30 April 2018: 2 actions to complete by 30 May and 2 by 30 October. Good engagement by services. Pace of progress at Hannah House and Leeds Sexual Health service impacted by operational pressures on service managers due to staffing levels, and additionally at Hannah House, wider workforce issues and temporary management arrangements till October 2017. ESR issues being progressed as part of a wider review of ESR. ■ CQC Ofsted joint SEND inspection: GREEN. There were 2 key focuses: • strengthening quality of information in the Education Health and Care Plans: a quarterly moderation panel has been introduced, satisfactory progress being made • SLT waiting times have reduced from 102 children waiting > 12 weeks for assessment or follow up prior to the summer waiting time initiative, to 17 at year-end. All 17 children have an appointment booked. The average wait is 9-12 weeks ■ Her Majesty's Inspector of Prisons (HMIP) inspections: GREEN. HMIP undertook a review of HM Young Offenders Institute Wetherby over the two weeks commencing 5 March 2018. In the second week, they were joined by a CQC Inspection Team, which inspected the healthcare element of the service under the Respect domain of the prison inspection regime. Early informal feedback has been very positive.

Key	Priority/success measure achieved	Slight under performance &/or slippage vs original time-scale	Priority /success measure not achieved

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Year-end status
1.2 Deliver Quality Account priorities and remedial action plans in place where any deviation	Delivery against Quality Account SMART indicators	Overall: AMBER – reflecting balance of performance against 17 priorities Of the 17 Quality Account priority outcomes, 3 are rated red, 4 amber, 10 green ■ Protect patients from harm: target to reduce Cat 3 avoidable pressure ulcers by 10% exceeded (35% reduction). Zero target for Cat 4 avoidable pressure ulcers not achieved: 3. Pressure ulcer workshop concluded systems and processes are effective but need to be continuously reinforced ■ Establish clear rotas in a range of services including NTs: not achieved. A new e-rostering supplier has been identified : business case to be considered by April 2018 Business Committee. ■ FFT response rate organisational target: 6.8%, Quality Account stretch target: 8% not achieved: 5.4%. See slide 5 ❑ Recording of FFT Equality data: recording of equality data increased against the 2016/17 baseline for 4 of the 6 population characteristics. See slide 5 ❑ Improve access to ICAN: 2 of the 3 access targets not achieved. See slide 4 ❑ Incident management – SI policy standards for closing incidents in 30 day and low / no harm incidents in 15 days not met although significant improvement against 16/17 baseline ❑ Outcomes: Cardiac and Diabetes services are now reporting outcomes. See slide 3
1.3 Develop leadership throughout the organisation (QA priority)	• Evaluate Lead programme • Deliver further LEAD programme and 4 Manager as Coach (MAC) programmes	Overall: GREEN reflecting success measures delivered ❑ 2nd LEAD programme completed March 18, immediate impact evaluation was very positive. 6 month evaluation of 1st LEAD programme was very positive ❑ 7 MAC programmes were delivered over 18/19

Key	Priority/success measure achieved	Slight under performance &/or slippage vs original time-scale	Priority /success measure not achieved

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Year-end status
1.4 Develop use of tools & provision of information supporting quality improvement: • Outcome reporting (QA priority) • Use of Quality Boards • Roll out safety huddles	• Increase in teams reporting outcomes • Sexual Health & agreed Childrens services using Quality Boards • Monthly safety huddles	Overall: GREEN – reflecting balance of delivery ■ Outcomes: AMBER. Cardiac and Diabetes services are now reporting outcomes (PAMS) for specific patient cohorts. Respiratory service to start reporting in quarter 1. If successful it will be extended to other patient cohorts. The Project Manager in post since January '18. The initial phase of work is to assess current reporting and produce a plan for developing increased reporting ❑ Quality Boards: GREEN Children's Bus Unit: Quality Boards routinely updated at Hannah House, Little Woodhouse Hall and SLT, continuing to embed use of them within the services and link to handovers and safety huddles. Specialist Business Unit: 9 services have received their Quality Boards. The Community Neuro Rehab Centre will finalise Quality Board design in Q1 18/19. All services have agreed the process for embedding use within teams; to be implemented in Q1 18/19. ❑ Safety huddles: GREEN Children's Bus Unit on track: continuing to develop use of Safety Huddles at Hannah House and Little Woodhouse Hall. Specialist Business Unit: Sexual Health service to consider introducing Safety Huddles, all other services in Specialist Business Unit have decided not to introduce Safety Huddles principally due to the spread of staff across the city. The Community Neuro Rehab Centre has nursing handover 3 times a day and a weekly MDT meeting which provides effective focus on safety.

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Year-end status
1.5 Improve access (QA priority)	• CAMHS Autism Spectrum Disorder (ASD) • ICAN • CUCS initial assessment, Specialist Nursing Review • Understand waits and agree priority interventions	Overall: AMBER – reflecting balance of progress ■ CAMHS: Zero ASD waiters >12 weeks - not achieved: Q4 22, down from 134 at Q2. Continue to run additional core and temporary clinics, funding of outsourced assessments extended . Neuro pathway redesign continues which will release capacity once fully implemented. Focussing resource on ASD assessments caused significant increase in waiting times for consultation clinics. Although a recovery plan was implemented, at end of Q4 133 patients waiting 12+ weeks. Of these, 86 due to be seen by the end of April '18. 2 ❑ ICAN: • Complex communication assessment: not achieved, 29 children waiting over 12 weeks due to significant reduction in Specialist Health Visitor capacity and continued increasing demand creating significant challenges in managing both assessment and intervention wait times. • follow up medical appointments within 4 weeks of planned date: not achieved – Community Paediatric Clinics: 52%, Paediatric Neuro Disability Clinics 53%. This reflects ongoing medical staffing challenges resulting in requirement to focus on meeting the 18 week target for new patients. Expect performance to improve over the next two months as a result of recruitment. • 100% of parent group intervention for Children with ASD diagnosis within 12 weeks of diagnosis and 80% of initial OT and PT appointments within 12 weeks: targets achieved ■ CUCs: 100% of Associate Practitioner initial assessments within 18 weeks: target achieved
1.6 Improve workforce continuous improve-ment capability	• Review leadership development programme content • Participation in QI training: Improvement Academy, LIQH, Core Improvement Concepts training	Overall: GREEN – reflecting delivery of success measures ❑ QI leadership session developed and offered as part of LEAD programme. All participants now directed to Improvement Academy Silver level training. ❑ QI training accessed by 87+ LCH staff: LIQH 3; Improvement Academy 40+; LCH internal training (LEAD & Preceptees): 44 ❑ Significant progress achieved in development of QI Approach as a 2018/19 corporate priority :

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Year-end status
1.7 Maintain safe staffing in in-patients and develop safe staffing in community teams in line with national guidance	• Inpatients safe staffing target 97% • Achieve national agency cap • National guidelines compliance	Overall: GREEN – reflecting full achievement ❑ Inpatients safe staffing target (97% or above): GREEN. Target exceeded every month except October: 94.2% ❑ National agency cap: achieved ❑ National guidelines compliance: GREEN. As reported at Q1, SMT reviewed National Quality Board guidance about District Nursing safe caseloads and staffing levels and determined that there is no additional work arising
1.8 Improve patient feedback information (QA priority)	Quarterly increase in FFT response rates and equality data from 16/17 baseline: 6.8% to 8%	Overall: AMBER – reflecting partial achievement of equality data recording ■ FFT response rate: RED Target not achieved: 5.4% for Q4 down from 7.4% for Q3. In year additional action taken to agree improvement targets for each Business Unit ❑ Increase in recording of equality data: AMBER recording of equality data increased against the 2016/17 baseline for 4 of the 6 population characteristics. Having identified that there are a number of surveys in use that do not ask for equality data, will audit all surveys currently used by services.
1.9 Compliance with Duty of Candour requirements (QA priority)	Q1: target 90%, Q2 onwards: 100% compliance	GREEN: 100% compliance target achieved. Duty of Candour applied to 13 incidents.

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 2: Create sustainable services

Priority	Success Measure	Year-end status
2.1 Consolidate and develop sustainable integrated NTs: • Fully implement EPR & new ways of working • Roll out e-rostering	• Improvements in NT staff FFT vs Q1 baseline • By year-end 80% of workforce in each NT competent in key clinical skills including EPR / mobile working • EPR and new ways of working rolled out to all NTs • Clear rotas in place	Overall: AMBER reflects continued capacity and demand pressures due to sickness, turnover and difficulty recruiting to vacancies, and continuing to provide responsive service to maintain flow during winter period. The success measures reflect key developments, not current service sustainability. ▪ Staff FFT – await Q4 results. Staff survey feedback for NTs mixed; teams currently reviewing and developing local action plans ■ Skills competency GREEN. On track. Clinical skills trainer post extended to Sept 2018 to support maintenance of skills. Work will be ongoing in 2018/19. ❑ EPR / NWOW – AMBER. EPR commenced in all teams. NTs all went live with EPR mobile working in October and continue to migrate existing patients to electronic patient records. Amber reflects slippage in time-frame for completing NWoW. Revised timescale agreed with EPR Project Board: commenced November 2017, all teams scheduled to complete by August 2018. ■ E-rostering – RED. Timescales and approach revised during 2017/18 as a result of the contract for developing and implementing an e-rostering system being ended by mutual agreement. Anticipate rollout in 2018/19 subject to Business Committee approval. Interim electronic rotas established in all NTs. Other significant actions to maintain NT delivery and support NT development completed / ongoing include daily citywide capacity and demand tool completion and review, system wide escalation management and mutual aid, caseload review training and support, LCH Winter Planning group chaired by Director of Operations to develop Team LCH, delivery of winter support initiatives using short term funding (some continuing into 2018/19), development with partners and implementation of new referral template for NTs to improve quality of referral information and staff support measures (e.g. lunches and massages).

Key	Priority/success measure achieved	Slight under performance &/or slippage vs original time-scale	Priority /success measure not achieved

Corporate objective 2: Create sustainable services

Priority	Success Measure	Year-end status
2.2 Develop organisational approach to assessing and driving service sustainability • Expand services where we excel and are the provider of choice • Support services to be ready to respond to tenders	• Complete service self-assessments for services being tendered in 17/18 six months ahead of expected tender date • Confirm services we want to expand by end of June '17 • Expansion strategy in place by end of September '17	Overall: AMBER – reflecting slippage in delivery but good progress ❑ Complete service self-assessments for services being tendered 6 months ahead of expected tender date: self-assessments now completed systematically as part of tender-ready activities. Looking at scope to reduce duplication with the Quality Challenge . ❑ Confirm the expansion strategy : Business Development strategy which includes the expansion strategy was approved by Business Committee October '17 and Board November '17. Actively scanning and progressing expansion opportunities in line with the strategy. Additional resource has been brought in to the Business Development team with a remit to identify and develop income generation opportunities. The traded services project is now being implemented.
2.3 Commence estates rationalisation	Delivery of key milestones monitored by Business Committee	Overall: GREEN reflecting 17/18 targets achieved: financial savings, reduction in estate (square metres) and space utilisation • Vacated James Reid House and Shaftesbury House in October '17 – leased space. Significant progress towards vacating St Marys' hospital site. • Stockdale House 3rd floor leased for relocated Health Visiting, School Nursing and SLT Admin staff and Senior Ops leadership. A major focus in quarter 4 has been understanding requirements to enable development of future office models and identification of further estates rationalisation projects

Key	Priority/success measure achieved	Slight under performance &/or slippage vs original time-scale	Priority /success measure not achieved

Corporate objective 2: Create sustainable services

Priority	Success Measure	Year-end status
2.4 Develop a clear Children's services offer	Clear strategy by end of June 2017	GREEN: Children Strategy approved by Board in February 2018. Business Committee agreed a revised time-frame to reflect the impact of changes and gaps in the Childrens Business Unit senior leadership team and Board sub committees requesting revisions. Draft Childrens Strategy submitted initially to Business Committee September 2017.
2.5 Meet financial targets	Achieve the Control Total and Capital Resource Limit	GREEN: The Trust achieved the control total and did not exceed the capital resource limit

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 3: Continue to improve staff engagement and morale

Priority	Success Measure	Year-end status
3.1 Further embed Our Working Lives Star and team effectiveness model • targeted team coaching • continue using coaching strategy to support Better Conversations	Improvements in 2017 national staff survey results • Ability to contribute to improvements at work • Staff motivation at work • Recommend LCH as a place to work: >52% Achieve turnover target: 15% - revised to 14.5% Feb 18	Overall: GREEN reflecting achievement of success measures ❑ Staff survey results • Ability to contribute to improvements at work: 2017: 68%, 2016: 66% • Staff motivation at work: 2017: 3.89, 2016: 3.83 • Recommend LCH as a place to work: 2017: 55%, 2016: 48% Continued to develop a coaching culture: team coaching support to NTs maintained, identified and provided support to Children's and Specialist Business Units, 1:1 coaching provided , delivery of LEAD and MAC programmes (see 1.4) and rolling out health coaching (see 4.1) ❑ Turnover target: GREEN. YTD Trust target achieved: 13.9% at year-end, continued downward trend from 15.6% at the end of month 1. Significantly below the Community provider average: 17.2%.
3.2 Refine the managing attendance policy • Strengthen management of regular short-term sickness absence when no underlying health condition • Provide earlier supported intervention for long term absences	Achieve 17/18 sickness target: 5.2% and CQINs: • 5% improvement over 2 years on staff survey questions on health and well-being, stress, MSK • staff flu immunisation target: 70%	Overall: AMBER reflecting balance of achievement ■ Sickness absence: RED: 5.6%, target not achieved although improvement on Q3 (6.5%) which reflected a spike in sickness in Adult BU. Undertaking in-depth analysis of sickness absence to identify hot spots, trends and patterns which will inform redesign and development of more tailored approaches and practice. To agree lead for sickness, project focus and develop a project plan. CQINs: ❑ Health and Well-Being: AMBER. 5% improvement for MSK CQIN, 4% for health and well-being CQIN. Action to support this included re-introducing health checks in January 2017 and continued focus on our Feel Good Pledge supported by information on Elsie ■ Staff flu immunisation: GREEN. Immunisation target achieved

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 3: Continue to improve staff engagement and morale

Priority	Success Measure	Year-end status
3.3 Fill substantive posts required for effective delivery	• Sustain time from placing advert to filling vacancies by role / service • Recruit in line with Adult Workforce Plan	Overall: AMBER status reflects difficulty in recruiting to all vacancies due to national shortages causing insufficient supply of key roles. ❑ Time taken to fill vacancies: not reported in quarters 3 – 4 as new metrics being developed to provide better insight about efficiency of the recruitment process. Feedback from candidates being requested to support development of resourcing in relation to recruitment, on-boarding and induction. Developed use of social media to support attraction campaigns, literature and website refreshed. ❑ Recruit in line with Adult Workforce Plan: AMBER. Not able to fully recruit to vacancies: key focuses continue to be recruitment of newly qualified Band 5 community nurses and Band 6 healthcare professionals. Recruitment Oct 17 – March 18: Band 3: 3 (plus 3 for night service) Band 5 nurses: 30 recruited including 21 newly qualified nurses who qualify in Summer 2018 (plus 1 for night service) Band 6 nurses: 8 (plus 4 for night service) Continue to work with local universities to prepare new qualified nurses graduating September 2018 and focus on attraction - external website refreshed, 1st Adult BU Open Day held in March aimed at 3rd year nurse students Focus of ABU Workforce Plan is establishing and maintaining the workforce required through strengthening recruitment and retention, skill-mixing and staff development. Prison Custody new service model requires recruitment of 30 HCPs: 19 recruited to date + 2 to LCH's Bank.
3.4 Reduce the number of staff leaving within 12 months of start date	• Use stability index metric to measure retention of staff: 85% • Leavers in first 12 months: target 19-22%	Overall: GREEN reflects achievement ❑ Stability index : GREEN. Target (85%) achieved : 85.8% ❑ Leavers within 12 months: GREEN. Target achieved: 12%. Progressive reduction since April '17. All 3 Business Units below target: Adults BU reduced from 21% at April 17 to 10%, Childrens BU from 13% to 6% and Specialist from 19% to 13%. 12-point Retention plan agreed in quarter 3 for delivery in 2018/19.

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 4: Take a lead role in delivering new models of care in the city through system integration

Priority	Success Measure	Year-end status

4.1 Shift the way we work with patients and carers to a strengths and asset based approach aligned with social care model and health	• Secure commitment from partners city-wide to a plan that will drive a shift in the way we work to a strengths based approach at the pace required to deliver the Leeds Plan
	• Deliver health coaching training
	  • NTs: 10 x 2 hour introductory sessions - approx 30 per session
	  • 5x2-day: max 20 staff per session
	• Positive evaluation of 2-day training
		Overall: GREEN reflects balance of delivery
		❑ City-wide commitment: GREEN. January PEG agreed to fund the £600k shortfall for the 2 year 'Better Conversations' project to support a consistent city-wide strengths based approach across health and social care. September '17 Health and Wellbeing Board had approved £300k funding. Recruited to the team in Q4. To agree deployment in Q1.
		■ Deliver health coaching training: AMBER
		• NT's unable to release staff for introductory sessions due to capacity pressures. However, a strengths and asset based approach underpins the Armley and Chapeltown self management pilot. All therapists and Community Matrons already trained in health coaching (key skill), 120 staff have attended motivational interviewing or health coaching taster sessions
		• 2-day sessions: target exceeded - 7 session delivered.
		❑ 2-day training provided across health and care partners evaluated positively for all variables

4.2 Develop new models of care Work with primary care and LYPFT to redesign and implement the community based mental health offer • Contribute to develop't of LTC pathways and models for the city	• Integrated mental health pathway designed and implemented • Participate in developing and implementing new models for Diabetes, MSK, Respiratory, Cellulitis	Overall: AMBER reflects good progress but some areas outside LCH control ❑ MH pathway: AMBER. No change since Q2: commissioners are not progressing pathway redesign. Work continues at service level to implement PBR. The service is working with commissioners to develop/influence transition requirements. ❑ NMoC: AMBER. Developments include: • Diabetes NMoC: Participating in engagement work and citywide workshops due to be held in June and September regarding future NMoC based on the Super 6 model. • MSK: continuing delivery of 3 MSK pilots (alternative models) whilst working with commissioners to develop the NMoC. • Virtual Respiratory Ward: recruitment is well underway; staff coming into post and being inducted. The medical model is being finalised. Service to go live by July '18 • CIVAS: Community Hub model is being piloted in Armley and a second community hub at St James will start imminently . This will create the necessary capacity for pathways direct from primary care.

Key | Priority/success measure achieved | Slight under performance &/or slippage vs original time-scale | Priority /success measure not achieved

Corporate objective 4: Take a lead role in delivering new models of care in the city through system integration

Priority	Success Measure	Year-end status
4.3 Engage pro-actively in STP and Leeds Plan development and implementation including: • multispecialty community provider hubs building on NT NMoC pilots • Develop LCH as the under-arching structure and ready for '18/19 alliance commissioning	• All NTs working with clusters of GPs in the developing locality models • Clarity about alliance model / ACO governance • Roll out leadership work around neighbourhoods • Virtual budgets starting to be held and understood at cluster/cohort level	Overall: GREEN reflecting good progress LCH continues to be at the heart of developing changes and taking this work forward. This is a multi-agency programme, and success is not simply down to LCH alone. There has been good progress; plans are in place and being developed during quarter four which will ensure progress continues next year at pace. ❑ All NTs are working with clusters of GPs in the developing locality models ❑ The Alliance continues to work together and is developing its relationship working through a new model of urgent care and developing its thinking on frailty. There have been three workshops developing the model of governance and framework for ways of working. 18/19 will be the start of a year where we will be testing different models of frailty with our alliance partners and other partners in the city. Conversations continue about LCH and the Confederations working together to create an underpinning structure. ❑ The LCPs work is led by Chris Mills supported by Steve Keyes. We play a key part in the steering group and a work programme is now developed. All NTs are mapped against GP clusters and work is developing. ■ Initial discussions have taken place with a GP practice within 1 LCP about developing holding of virtual budgets.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM
2017-18
(10ai)

Meeting: Trust Board, 25 May 2018	**Category of paper** *(please tick)*	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 16 May 2018 Quality Committee, 21 May 2018 Business Committee, 23 May 2018	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during April 2018.

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.
It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

More detailed narrative on each of the individual indicators will be available in the domain reports.

Main issues for consideration

Caring Domain
LCH has inpatient beds in both Specialist and Children's Business Units. The percentage of Inpatient respondents recommending care in has remained at 100% for 3 months and is rated green. 95.6% of respondents would recommend care in the community. The Adult Business Unit (90.1%) is rated red against a target of 95.0% Both Children's and Specialist Business Units are rated green.

E**ffective Domain**
The measures in this domain are reported quarterly so will first appear in the Performance Brief for June 2018.

Responsive Domain
The Trust has performed well in its indicators relating to waiting lists with all rated as green for April.

Patient Contacts are reported as -11.6% below profile in April and -1.4% below the April 2017 level.

Well Led Domain
Staff turnover is rated green for April (13.9%) against a target of 14.5%
Staff leaving the organisation within 12 months (13.0%) is rated as green.
Total sickness absence is below the target of 5.8% at 5.4%
Short term sickness (1.9%) and Long term sickness (3.5%) are both rated green for April.
April has seen a small improvement to 81.9% of staff having an appraisal but remains below the target of 95.0%
The percentage of staff reported as being compliant with the 6 statutory and mandatory training

requirements is reported as 91.4% but remains below the target of 95.0%

Finance Domain
At this early point in the year the Trust is overall in line with the planned financial performance. CIP delivery has been good for April and pay is in line with expectations. Staffing levels are 130 wte below funded; temporary staffing is in place to mitigate service risks.

The forecast outturn demonstrates there are some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the proposed pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will be monitored closely as the year progresses.

Recommendations
The Committee is recommended to:

- Note present levels of performance
- Determine levels of assurance on any specific points

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, April 2018

Senior Management Team – 16th May 2018
Quality Committee – 21st May 2018
Business Committee – 23rd May 2018
Trust Board – 25th May 2018

Executive Summary

This report provides a high level summary of performance within Leeds Community Healthcare (LCH).

It highlights any current concerns relating to contracts that LCH holds with its commissioners.

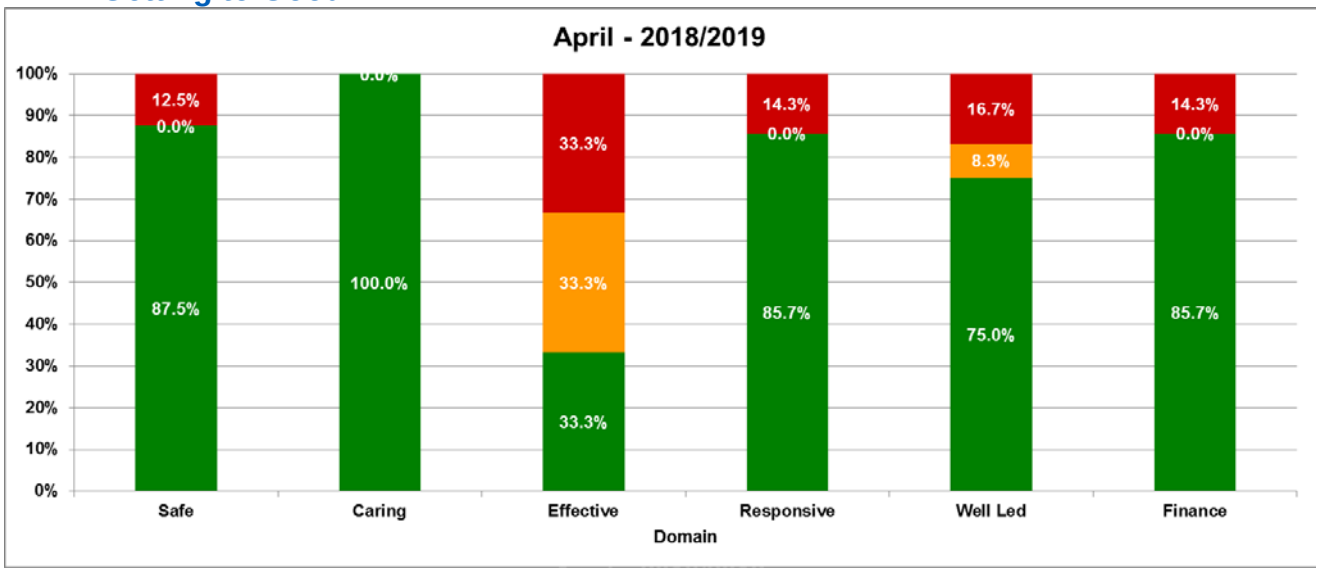
It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

1. High Level Performance Summary

1.1 Summary of Performance Against High Level Indicators

Please note that the charts included below do not represent the CQC key lines of enquiry. They do reflect the Trust's high level indicators which are aligned to the CQC domains.

1.1.1 Getting to Good



A visualisation of each domain measures to show progress to "Good", where Good is green and achievement of trust approved targets. Based upon monthly reporting.
This replaces the donut visualisation.

1.1.2 Safe Domain

The annual target for avoidable category 3 pressure ulcers is 10 and 3 have been reported in April. There was zero category 4 pressure ulcers reported in April.

1.1.3 Caring Domain

LCH has inpatient beds in both Specialist and Children's Business Units. The percentage of Inpatient respondents recommending care in has remained at 100% for 3 months and is rated green. 95.6% of respondents would recommend care in the community. The Adult Business Unit (90.1%) is rated red against a target of 95.0% Both Children's and Specialist Business Units are rated green.

1.1.4 Effective Domain

The measures in this domain are reported quarterly so will first appear in the Performance Brief for June 2018.

1.1.5 Responsive Domain

The Trust has performed well in its indicators relating to waiting lists with all rated as green for April.

Patient Contacts are reported as -11.6% below profile in April and -1.4% below the April 2017 level.

1.1.6 Well Led Domain

Staff turnover is rated green for April (13.9%) against a target of 14.5%
Staff leaving the organisation within 12 months (13.0%) is rated as green.
Total sickness absence is below the target of 5.8% at 5.4%
Short term sickness (1.9%) and Long term sickness (3.5%) are both rated green for April.
April has seen a small improvement to 81.9% of staff having an appraisal but remains below the target of 95.0%

The percentage of staff reported as being compliant with the 6 statutory and mandatory training requirements is reported as 91.4% but remains below the target of 95.0%

1.1.7 Finance Domain

At this early point in the year the Trust is overall in line with the planned financial performance. CIP delivery has been good for April and pay is in line with expectations. Staffing levels are 130 wte below funded; temporary staffing is in place to mitigate service risks.

The forecast outturn demonstrates there are some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the proposed pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will be monitored closely as the year progresses.

1.2 Statutory Breaches

Leeds Community Healthcare NHS Trust is currently performing within all nationally set targets.

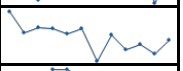
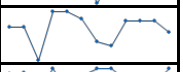
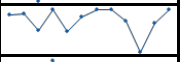
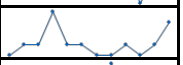
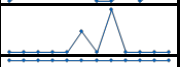
2. Contract Related Performance Highlights

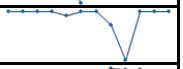
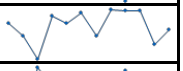
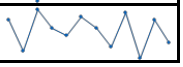
No contract related performance issues this month

Leeds Community Healthcare NHS Trust

Director of Nursing Report

Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		Target	Apr	May	Jun	Q1	Forecast	Rolling 12 Month Trend
Overall Safe Staffing Fill Rate - Inpatients	2018/19	>=97%	99.7%				●	
	2017/18		97.0%	100.5%	95.9%	97.7%		
Patient Safety Incidents Reported in Month Reported as Harmful	2018/19	0.55 to 1.1	0.94				●	
	2017/18		0.79	1.03	0.92	0.92		
Potential Under Reporting of Patient Safety Incidents	2018/19	1.17 to 2.79	2.04				●	
	2017/18		2.01	2.48	2.15	2.22		
Serious Incident Rate	2018/19	0 to 0.23	0.05				●	
	2017/18		0.05	0.06	0.06	0.05		
Percentage VTE Risk Assessment Completed*	2018/19	>=95%	100.0%				●	
	2017/18		-	-	-	-		
20% Reduction in Avoidable Category 3 Pressure Ulcers	2018/19	10	3				●	
	2017/18		1	0	1	2		
0 Avoidable Category 4 Pressure Ulcers	2018/19	0	0				●	
	2017/18		0	0	0	0		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2018/19	100%	100.0%				●	
	2017/18		100%	100%	100%	100%		

Caring - staff involve and treat people with compassion, kindness, dignity and respect		Target	April	May	June	Q1	Forecast	Rolling 12 Month Trend
Percentage of Staff Recommending Care (Staff FFT)	2018/19	>=73%					●	
	2017/18		81.0%			81.0%		
Percentage of Inpatients Recommending Care (FFT)	2018/19	>=95%	100.0%				●	
	2017/18		100.0%	100.0%	100.0%	100.0%		
Percentage of Community Patients Recommending Care (FFT)	2018/19	>=95%	95.6%				●	
	2017/18		95.9%	95.8%	95.3%	95.3%		
Written Complaints - Received	2018/19	<211	14				●	
	2017/18		18	20	12	50		

1. Patient Safety Incidents (LCH only)

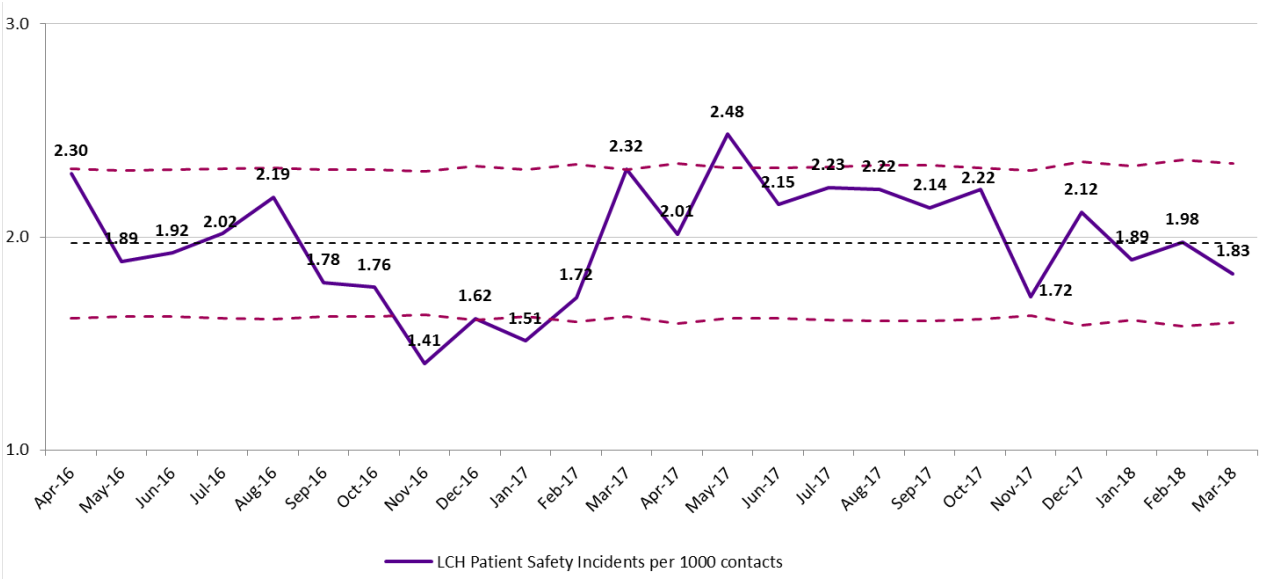
1.1 Patient safety incident data is reported to the end of April 2018 and reflected in the graphs below. Reporting on PSI's by contacts lags a month behind as it merges data from Systm1 and Datix. April data will be captured and reported on for the May Exception report.

1.2 LCH PSIs per 1000 contacts for March 2018 demonstrates the process is subject to common cause variation only. The Business Intelligence Team has improved the SPC chart which they believe is more appropriate in representing this type of data. The chart now used, is the most appropriate for displaying rates and this is called a U chart.

A U Chart is specifically used for "incidents per unit" type data. Comparison of this new chart and charts used in previous reports highlight that the main difference is seen in the upper and lower control lines which are now closer together meaning that the variation is now better appreciated. The activity shown in the chart remains unchanged.

1.3 Incidents per 1000 contacts reported in March is lower than February but the process remains subject to common cause variation only.

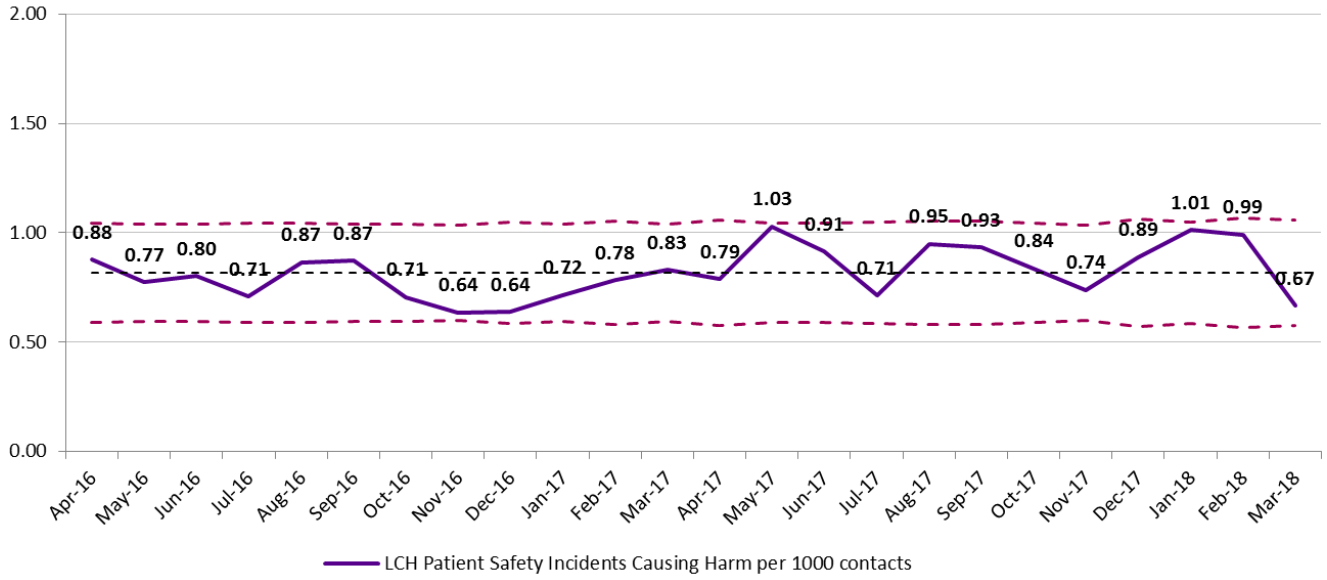
**data available to March 2018 only*



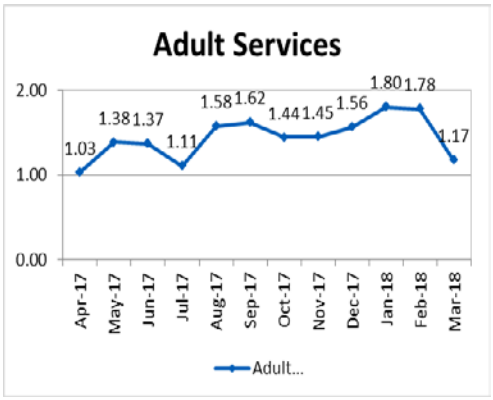
2. Incidents causing harm (LCH only)

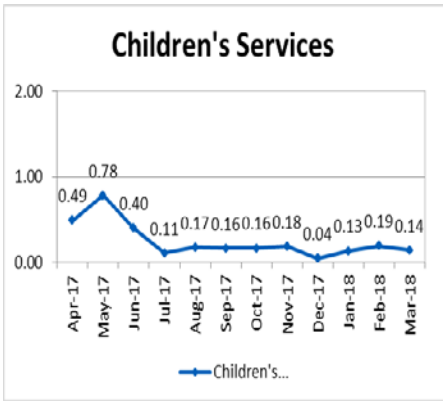
2.1 There were 116 (45.8%) LCH PSI incidents reported as causing harm during April. This is an increase on the lowest figure reported last month, but more in keeping with earlier months. There were more LCH Patient Safety incidents overall reported this month.

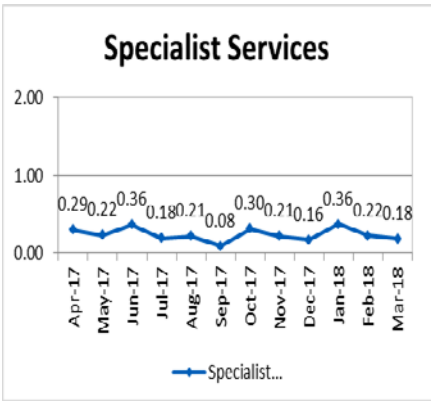
2.2 The chart below shows LCH incidents causing harm (1 month in arrears as all other SPC charts). This highlights the drop in harms reported in March; however this did not drop below the lower control level, so the process remains subject to common cause variation only.



2.2 SPC charts broken down by Business unit are not available yet. 25 points of data are required to produce a meaningful SPC chart and currently only 18 points exist. The business intelligence team propose to add a median line to the 3 business unit run charts in the May Performance Brief.







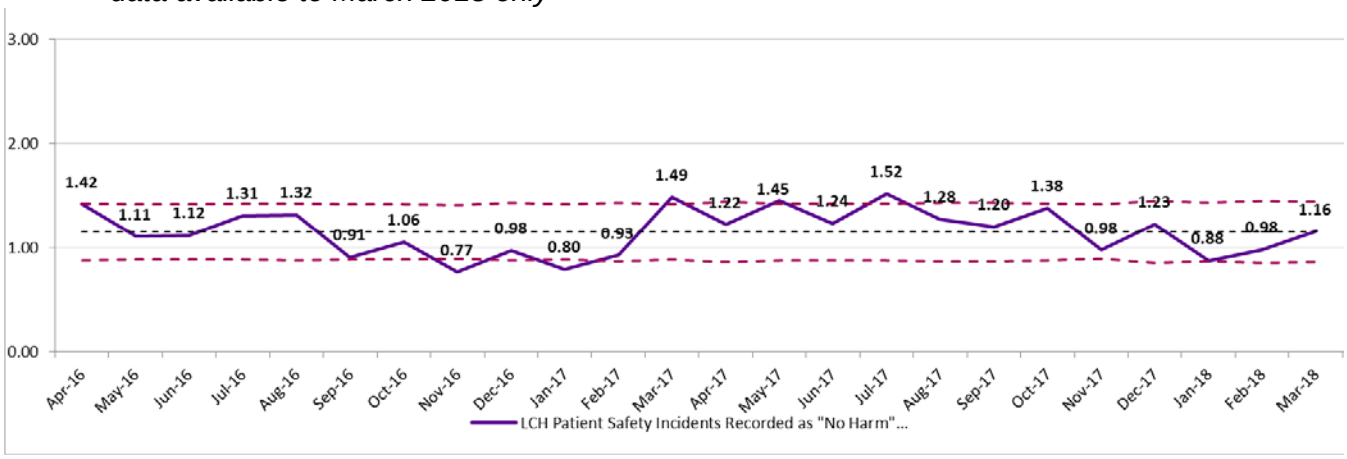
The Adult Services chart above shows that the reduction in harm incidents was attributable to the ABU as the other business units remained relatively stable.

3. No Harm incidents

3.1 The number of **LCH patient safety incidents causing no harm per 1000 contacts** has risen steadily over the previous 2 months and in March but the chart below demonstrates that the process is subject to common cause variation only.

3.2 Increases were seen in no-harm medication incidents, access/appointments & Implementation of care.

**data available to March 2018 only*



3.3 34 of 109 (31%) of reporting teams saw increase above their average reporting figures for no harm LCH PSIs in March 18, however there were three teams where reporting of these incidents had risen more than 3 points above their average. These services were Leeds Sexual Health Service (4.3); Gateway/Bed Bureau (3.8) and Neighbourhood Nights (3.6)

3.4 The ratio of moderate/major incidents to minimal/no harm incidents for LCH Patient Safety Incidents was 1:4.6 during March and in April this has dropped to 1:3.7 which is more in keeping with previous months; the rolling year data is shown below.

LCH Patient Safety Incidents by Degree of Harm

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
No injury sustained	148	202	174	198	163	151	186	140	140	119	113	133	129
Minimal Harm	68	95	89	70	81	79	62	73	66	82	62	45	64
Moderate Harm	27	47	37	23	39	39	48	36	36	51	45	32	46
Major Harm	4	4	4	5	5	6	8	4	5	4	9	7	6
Death	6	4	2	11	5	9	9	10	7	0	2	13	8
Total	253	352	306	307	293	284	313	263	254	256	231	230	253
Ratio: (moderate/major incidents : minimal/no harm incidents for LCH Patient Safety Incidents)	1:7	1:5.8	1:6.4	1:9.6	1:5.5	1:5.1	1:4.4	1:5.3	1:5	1:3.7	1:3.2	1:4.6	1:3.7

4. Overdue Incidents

4.1 There are 407 live incidents in Datix as of 08/05/2018. A total of 112 (27.5%) have breached the 15 or 30 day investigation time. Of these 45 (40.2%) are LCH Patient incidents, the remainder (67) are other patients, staff or Trust incidents.

A significant number (37) are attributable to 'patient flow services' and are mainly awaiting investigations from the Discharge Facilitators. A conversation has taken place and a decision reached between the discharge facilitators and the Adult BU Clinical Lead which should lead to a number of these non-LCH incidents being updated and finally approved/closed. This should be evident in the May and June reports.

The next highest service is Morley Neighbourhood Team with 14 overdue records and Leeds Sexual Health Service with 8 overdue records.

It has been agreed that the Clinical Governance Officer will send out weekly reminder spreadsheet with all overdue incident information to all Business Unit Clinical Leads.

As the ABU is the largest reporter of incidents and therefore also has the largest number of overdue incidents, a training session has taken place with the ABU Senior Ops admin to ensure that the internal overdue data they provide to their teams is of the same quality and accuracy as that provided by Clinical Governance.

Weekly automatic overdue reminders continue to be sent to Handlers and Investigators.

3 of the incidents that have been in Datix the longest are deaths in LCH care which have been subject to the mortality review process. An email has been sent to the ABU admin to get an update from these reviews. These records have now been updated and closed.

Contact has also been made with the EPR team regarding the staff incident which has not had a review. This has been due to staff requiring training in the use of Datix. Although booked on one of the sessions in June an office based investigation/handler session is being provided to the team in May to ensure this record can be updated and closed.

5. Never Events

There has been no Never Event reported in April 2018.

6. Safety Alerts (CAS)

There were 7 Safety alerts issued which were due to be closed in April 2018. There were no breaches in LCH response times for these alerts.

There are 2 alerts that have been identified as overdue by MHRA. These date back to March 2011 and have only been highlighted to LCH in April 2018 (March 2011 is pre LCH). One relates to the Insulin Passport Scheme and the other regarding a childs wheelchair. Clarification has been requested from MHRA as to why these records have come to light in April 2018 and not before and if any actions are required.

7. Duty of Candour

At the end of April 2018 there were 5 incidents closed where the duty of candour was applicable (verified as actual moderate + harm attributable to LCH)

4 patients have received an apology in the form as requested by the patient.

The remaining incident requires further discussion with the service to clarify level of apology provided.

Therefore LCH are currently 80% compliant.

8. Infection Prevention Control (IPC)

8.1 MRSA bacteraemia and C difficile Infection

During April there were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to LCH.

8.2 Other contractual issues and outbreaks

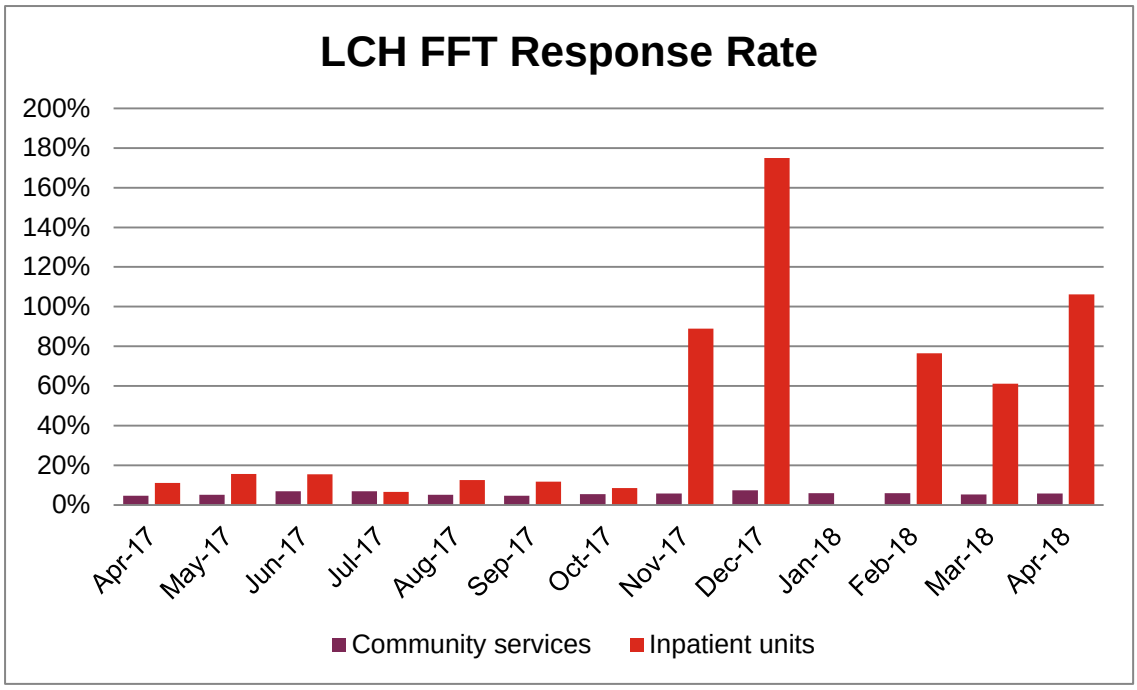
There has been one case of Measles in LS12 and incident control meetings are continuing to review the ongoing situation. There have been no other reported outbreaks reported during April.

9. Patient Experience

9.0 Friends and Family Test (FFT)

9.1 Response rates (community and inpatient)

The number of completed FFT surveys fluctuates on a monthly basis due to variation in when surveys are received in the month by the Clinical Governance Team. Overall 95.59% of Community patients and 100% of Inpatients for April would recommend LCH services. This is in line with the results for the last quarter (96% and 100% respectively).



9.2 Performance by Business Unit

Apr-18	% Recommended	Response Rate	Comments
ABU services	90.11%	4.83%	119
CBU services	97.90%	5.24%	456
CBU inpatients	100%	3.39%	3
SBU services	95.93%	6.26%	596
SBU inpatients	100%	93.75%	11

9.3 In April's data, there have been 12 surveys inputted for CICU. This has not been included in the above table. Upon further investigation, it has transpired the surveys were intended for the Leeds Sexual Health service. This has been followed up with the service manager.

9.4 Surveys for CNS Inpatient Pathway and CNS Neurology Rehabilitation have all been inputted as CNS Inpatient Pathway which has resulted in 0% feedback for CNRS. This will be fed back to the Clinical Governance team to reiterate due care and attention during survey data entry.

10. Complaints, Concerns, PALS and Claims

10.1

Item	April 2018 Received	Comments
Complaints	**14**	2 of 14 were escalated from concerns*
Concerns	**28**	No exceptions to report
PALS Enquiries	**7**	No exceptions to report
PALS Signposting	**10**	No exceptions to report
Clinical Claims	**0**	No exceptions to report
Non-clinical Claims	**0**	No exceptions to report

*Two Concerns within ABU were not resolved within agreed timeframes due to staff absence. The PE Team were not informed of the issues. This was addressed with the Service Lead and Clinical Lead.

10.2 In line with previous months, appointment and attitude, conduct, cultural and dignity issues. The majority main subject of complaints in April was clinical judgement / treatment.

10.3

Key Performance Indicators and Developments - Complaints	Status
Acknowledged within 3 days	**100%** Compliance
Responded to within 180 days	**100%** Compliance (closed complaints)
Contacts from External Agencies	**0** LTHT **0** Leeds City Council
Active PET Caseload	**34** open complaints (2 of 41 are being investigated as serious incidents) **13** open concerns
PHSO requests	**0**

Leeds Community Healthcare NHS Trust

Effective Domain Report

The measures in this domain are reported quarterly so will first appear in the Performance Brief for June 2018.

Leeds Community Healthcare NHS Trust

Responsive Domain Report

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		Target	April	May	June	Q1	Forecast	Rolling 12 Month Trend
Patient Contacts - Variance from Profile*	2018/19	0 to ± 5%	-11.6%					
	2017/18		-12.1%	-4.5%	-1.2%	-5.9%		
Patient Contacts - Variance from 2017/2018	2018/19	-	-1.4%					
	2018/19		123,965					
	2017/18		125,763	141,835	142,260	409,858		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2018/19	>=92%	96.1%					
	2017/18		99.9%	99.7%	99.6%	99.6%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2018/19	0	0					
	2017/18		0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2018/19	>=99%	100.0%					
	2017/18		96.1%	99.1%	99.5%	99.5%		
% Patients waiting under 18 weeks (non reportable)	2018/19	>=95%	98.9%					
	2017/18		98.7%	99.0%	99.0%	98.8%		
IAPT - Percentage of people treated within 18 weeks of referral	2018/19	>=95%	99.2%					
	2017/18		99.6%	100.0%	100.0%	100.0%		
IAPT - Percentage of people treated within 6 weeks of referral	2018/19	>=75%	92.5%					
	2017/18		96.5%	95.7%	96.1%	96.1%		

At the end of April 2018, 60 patients were waiting more than 18 weeks for treatment in consultant-led services. This is an increase of 26 from the previous month.

There were 14 waiters for Child Development Centres (CDC), the same number as March. 2 patients were given the first available appointment, 5 patients required a CCA assessment and the rest have either been seen or have an appointment scheduled.

There were 19 waiters for CPC (CHICS) Children's Paediatric Clinic, an increase of 15 from March, but all the patients have now had an appointment or have had an appointment scheduled.

There were 27 waiters in Paediatric Neuro Disability Service (PND), an increase of 11 from March, with most patients having now been seen or are scheduled to be seen.

Leeds Community Healthcare NHS Trust

Well Led Domain Report

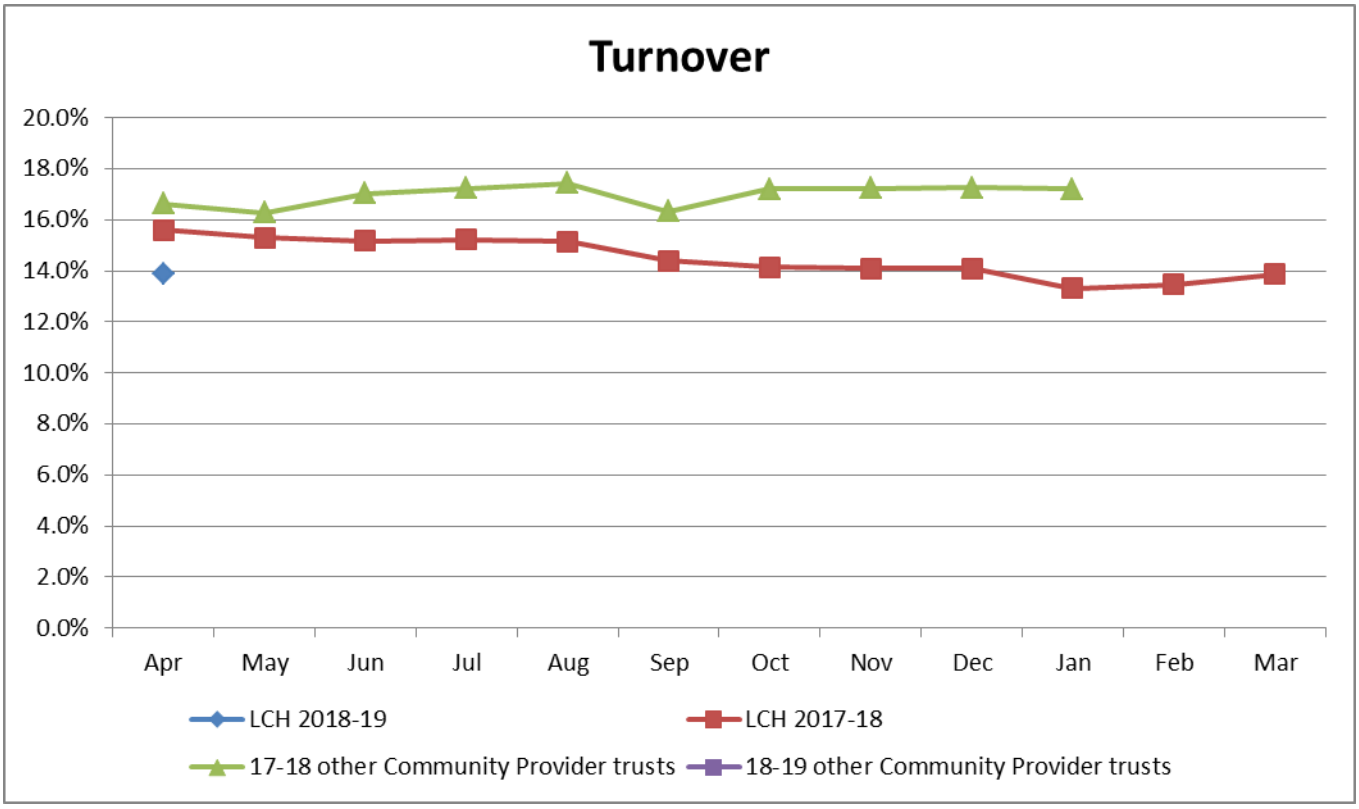
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		Target	April	May	June	Q1	Forecast	Rolling 12 Month Trend
Staff Turnover	2018/19	<=14.5%	13.9%					
	2017/18		15.6%	15.3%	15.2%	15.2%		
Reduce the number of staff leaving the organisation within 12 months	2018/19	<=20.0%	13.0%					
	2017/18		19.4%	16.2%	16.3%	16.3%		
Executive Team Turnover	2018/19	<=14.5%	0.0%					
	2017/18		0.0%	0.0%	0.0%	0.0%		
Stability Index	2018/19	>=85%	85.6%					
	2017/18		83.1%	83.5%	83.8%	83.8%		
Short term sickness absence rate (%)	2018/19	<2.2%	1.9%					
	2017/18		1.6%	2.1%	1.8%	1.8%		
Long term sickness absence rate (%)	2018/19	<3.6%	3.5%					
	2017/18		3.8%	3.4%	3.5%	3.5%		
Total sickness absence rate (%)	2018/19	<5.8%	5.4%					
	2017/18		5.4%	5.5%	5.2%	5.2%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2018/19	>=95%	81.9%					
	2017/18		87.3%	89.3%	88.8%	86.6%		
Medical staff appraisal rate (%)	2018/19	100%						
	2017/18		100.0%			100.0%		
6 universal Statutory and Mandatory training requirements	2018/19	>=95%	91.4%					
	2017/18		90.5%	90.6%	91.0%	91.0%		
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2018/19	>52.0%						
	2017/18		54.0%			54.0%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2018/19	>52.0%						
	2017/18		62.0%			62.0%		
Sustain the time between placing adverts	Qualified Nurses	<= 112 Days						
	Administration	<=83 Days						
	Police Custody	<=145 Days						
Response Rate for Staff FFT	2018/19	>22.0%						
	2017/18		22.2%			22.2%		
Response Rate for Inpatient FFT	2018/19	23.1%	27.7%					
	2017/18		11.0%	15.6%	15.4%	15.4%		
Response Rate for Community FFT	2018/19	6.8%	5.8%					
	2017/18		4.6%	5.1%	6.9%	6.9%		
Total agency cap	2018/19	£534k	£438k					
	2017/18		£563k	£474k	£507k	£1,544k		
Percentage Spend on Temporary Staff	2018/19		7.1%					
	2017/18		8.6%	7.4%	8.3%	8.1%		

1. Turnover

The rate of turnover during the rolling year has continued to steadily improve during 2017/18 and at April 2018 reports at 13.9% which is below the Trust target of 14.5%.

The number of staff leaving the trust within the first 12 months of employment has reduced from 18% at April 2017 to 13% at April 2018.

The Trust continues to report a lower turnover than other community provider trusts who reported a 17.2% turnover at January 2018.



In April 2018 there were 30 leavers across the Trust as set out below by Business Unit and staff group:

Business Unit	April 18 Leavers
Adult Business unit	12
Children's Business Unit	9
Corporate	2
Specialist Business Unit	7
Grand Total	**30**

Staff Group	April 18 Leavers
Additional Clinical Services and Scientific	8
Administrative and Clerical	4
Allied Health Professionals	6
Nursing and Midwifery Registered	12
Grand Total	**30**

The top 3 reasons for leaving were:

1. Voluntary Resignation – Promotion (9)
2. Voluntary Resignation – Work life balance (6)
3. Retirement – Age (6)

2. Retention

The Trust's turnover has seen a steady decrease from 15.6% at April 2017 to 13.9% at April 2018 and has an overall stability index of 85. 6%.

Recruitment, retention and attendance are agreed priorities for the Trust and work will continue to focus on these areas through a number of work programmes already in place eg coaching, LEAD programme and quality improvement. Work is underway to consider how we continue to create and develop leadership capability and how we develop a high performing culture.

Structurally the Quality (Service) Improvement and Organisational Development Teams have been brought together into a single, integrated team in recognition of the strong inter-relationships between the two functions. This came into effect on 1 April 2018 – the team is now known as the Organisational Development & Improvement Team.

We have confirmed our partnership with Yorkshire & Humber Improvement Academy who will work with us during 2018/19 around the following areas:

- Engaging and developing the Board's understanding of Quality Improvement
- Supporting the implementation of 4 learning Quality Improvement projects which should be confirmed in May 2018 (work has started on the Health and Wellbeing - attendance quality improvement project).
- Developing the organisation's capability in QI knowledge and skills through QI training
- Coaching and expertise around the development of an organisational approach to QI that is right for the Trust

To further support our retention work a 12 month retention plan has been agreed and work has started to progress this. Focus during May and June will be on developing an internal transfer list to enable nurses to access internal opportunities and 'itchy feet' conversations which will support this approach. We will also progress our approach to supporting our staff to retire and return and exploring flexible working options and financial planning for retirement. This work is being supported by NHS Improvement and progress will be monitored and reported on throughout the coming year.

3. Recruitment

We are carrying out further analysis of our performance data to help us in developing appropriate KPI's and are seeking feedback from candidates and managers who use the recruitment service. We now have feedback since February 18 from new starters who overall had a very good candidate experience. The following comments have been captured:

- Good experience, no issues.
- Fantastic, I was aware of my offer the same day. Interview process was good and so was the overall recruitment process, HR/Recruitment made every attempt to accommodate me.
- Generally very positive service was very informative and responded to queries quickly.
- I had a very straight forward easy recruitment process and feel everything was dealt with promptly and professionally.
- Supportive and helpful throughout.
- Good service, efficient. Always helpful when I called with questions. LCH has better recruitment processes than LTHT.

We held the last of our assessment centres for the recruitment of newly qualified nurses to the Neighbourhood teams and now have 25 who have been offered posts. We are aiming to recruit 30 in total to start from September onwards so recruitment will be done as part of the ongoing standing interview panels which are held every 3 weeks.
We are currently running a Facebook paid advertising campaign for the Custody Suites which is supporting our ongoing attraction campaign to recruit 30 Healthcare professionals (band 6

nurses/paramedics). We have offered 26 posts to date. The trusts 'Refer a Friend' scheme has been extended to this group of staff and we have had 3 members of staff access the scheme.

We are taking steps to develop stronger links with all of the Business units and Business managers to ensure we provide a proactive and responsive recruitment service and to share the approaches undertaken within the Adult business unit.

4. Staff Survey

This year there is an increased focus on understanding and acting upon feedback from staff via the annual Staff Survey.

Detailed analysis has been underway since March 2018. Feedback from the survey continues to be shared with the Business Units and Directorates and support given for working with the learning to create sustainable, relevant actions based on team priorities. Furthermore, analysis continues to understand three key areas of focus: Health & Wellbeing, Equality & Diversity and Harassment & Bullying.

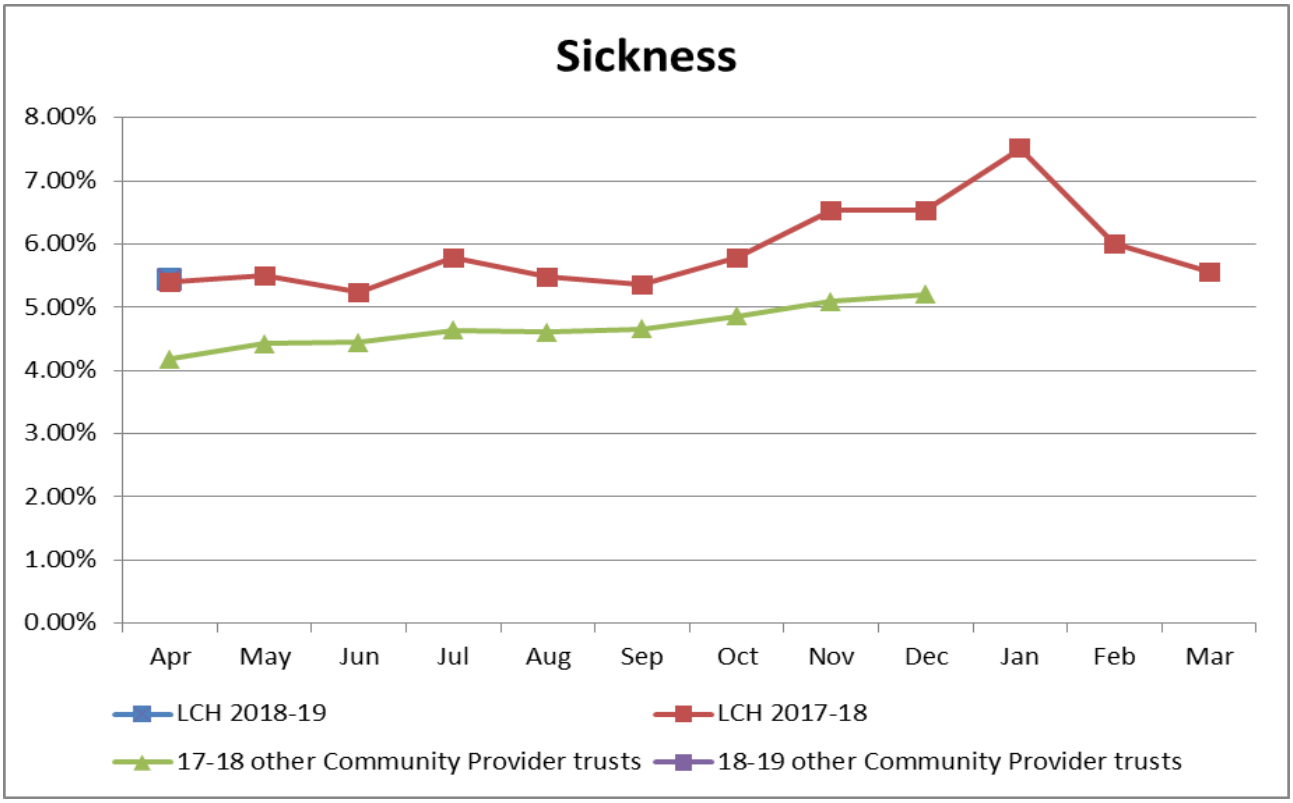
Results have also been shared with and considered in the 50 Voices forum, as well as used in the May Board development workshop to consider priority areas of focus and action.

5. Sickness absence

Sickness absence rate for April was 5.4%, a drop of 0.2% from March's figure and, notably, the same percentage figure as April 2017 - perhaps seasonal factors play some part in the reporting of this figure?

Both Children's and HQ/Corporate functions sickness percentage rates continue to decrease and they report figures below the Trust target with 4.3% and 3.5% respectively. Unfortunately, both Adults and Specialist business units have increased their percentage over the month increasing from 5.9% to 6.7% and 6.0% to 6.4% respectively. The increase in long term sickness absence of 1.1% in Specialist is the most marked increase over the month.

Business Unit	April 2018 absence rate
Adult	6.7%↑
Children	4.3%↓
Specialist	6.4%↑
Estates & Ancillary Staff (Operations) / Corporate	3.5%↓



Areas of HWB focus during May 2018 to include:

- Reviewed and updated people management policies including Special Leave and Whistleblowing
- Continued preliminary work on QI approach / framework to proposed attendance management project

6. Appraisal

As at the end of April 2018, 81.9% of available staff were registered as having had an appraisal within the last 12 months. This is below the target of 95%.

Corporate services is reporting a compliance rate of 53.99% which is concerning. Further exploration will take place and information will be triangulated with the further work being undertaken around the staff survey, to look at why this may be happening looking particularly at data from the nine questions around staff engagement which are set out in the annual staff survey.

7. Statutory and Mandatory training

The overall level of compliance for the universal statutory and mandatory training stands at 91.4% which is just below the target of 95%.

The Trust target for Information Governance has been set at 95%. Compliance for this training is 94.11% which is also just below the Trust target.

Some of the Statutory and Mandatory Training processes are currently under review. Options are being considered to improve the accessibility of the training to maximise attendance while reducing the impact on individual staff time. There are currently a number of options being evaluated to better enable e-learning and easier access to Statutory Mandatory on-line training. Other proposals being considered include the possibility of incorporating a higher percentage of the training required in to the induction before staff begin their role in the workplace.

8. Staff Friends and Family Test

The 2017 Q4 Staff FFT results have been received, collated and sent to General Managers and relevant colleagues. Overall Q4 received 571 responses, 20% response rate and 333 comments. The results indicate improvement in all areas questioned during Q4 – with the exception of involvement in decisions about changes introduced within the work area, which shows a slight deterioration.

The 2018 Q1 Survey will be launched in May.

2017	Q1	Q2	Q4
Staff likeliness to recommend LCH as a place for care/treatment	3% ↑	6% ↓	6% ↑
Staff likeliness to recommend LCH as a place to work	2% ↑	2% ↓	4% ↑
Other Questions			
I am able to make suggestions to improve the work of my team/department	1% ↓	1% ↑	1% ↑
I am able to make improvements that happen in my area of work	1% ↓	1% ↑	3% ↑
I am involved in deciding on changes introduced that affect my work area/team/department	2% ↑	3% ↑	1% ↓
I am satisfied with the support I get from my immediate line manager	1% ↑	2% ↓	3% ↑
My immediate manager gives me clear feedback on my work	2% ↑	1% ↓	1% ↑
My immediate manager asks for my opinion before making decisions that affect my work	3% ↑	1% ↓	1% ↑

Leeds Community Healthcare NHS Trust

Finance Report

Finance		Target	April	May	June	Q1	Forecast	12 Month Trend
Net surplus (-)/Deficit (+) (£m) - YTD	2018/19	-£0.2m	£0.2m				●	
	2017/18		-£0.2m	-£0.7m	-£0.9m	-£0.9m		
Net surplus (-)/Deficit (+) (£m) - Forecast	2018/19	£2.5m	£2.5m				●	
	2017/18		-£3.0m	-£3.0m	-£3.0m	-£3.0m		
Forecast underlying surplus	2018/19	£1.4m	N/A				●	
	2017/18		-£1.4m	-£1.4m	-£1.4m	-£1.4m		
Capital expenditure in comparison to plan (£k) - YTD	2018/19	£29k	£21k				●	
	2017/18		£0.1m	£0.2m	£0.2m	£0.2m		
Capital expenditure in comparison to plan (£m) - Forecast	2018/19	£3.2m	£3.2m				●	
	2017/18		£1.8m	£1.8m	£1.8m	£1.8m		
CIP delivery (£m) - YTD	2018/19	£0.3m	£0.3m				●	
	2017/18		£0.2m	£0.4m	£0.6m	£0.6m		
CIP delivery (£m) - Forecast	2018/19	£4.7m	£4.7m				●	
	2017/18		£3.4m	£3.4m	£3.4m	£3.4m		
Use of Resources Risk Rating (from Oct 2016)	2018/19	2	1				●	
	2017/18		1	1	1	1		

1. Summary & KPIs

The Trust has commenced 2018/19 with an overall position in line with the planned control total. Pay is consistent with the last quarter of 2017/18 and is marginally less than planned. The Trust is within the agency cap in April. Cost savings plans are 5% below expected levels however savings in procurement occur as the year progresses. Cash is running £0.8m less than planned. The use of resources risk rating is 1.

The major risks at this time are the uncertainty around the impact of the proposed pay- award, the £1.2m unidentified savings in respect of the CCG decommissioning plan and any shortfall in the delivery of planned cost savings.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	(£0.1m)	-	(£2.541m)	G
Remain with EFL of (£2.506m)			(£2.506m)	G
Remain within CRL of £3.241m	£0.9m	(£0.7m)	£3.241m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	100%	5%	95%	G
BPPC NHS Invoices Value 95%	100%	5%	95%	G
BPPC Non NHS Invoices Number 95%	98%	3%	95%	G
BPPC Non NHS Invoices Value 95%	99%	4%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.2m recurrent in year	£0.3m	-5%	£4.7m	A
CIP Savings £1.5m planned non recurrent in year	£0.1m	-	£0.3m	G

2. Income & Expenditure

The Trust's income and expenditure is on plan across all areas for April. The Trust has 130 wte or 4.9% less staff in post than funded in April; (95 less in March) this is after the planned vacancy factor reduction. Temporary staffing costs are £614k for the month. All un-committed reserves have been released into the position.

Table 2 Income & Expenditure Summary	April Plan WTE	April Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m
Income								
Contract Income			(11.4)	(11.4)	0.0	(136.4)	(136.4)	(0.0)
Other Income			(0.9)	(0.9)	0.0	(9.6)	(9.5)	0.1
Total Income			***(12.3)***	***(12.3)***	***0.0***	***(146.0)***	***(146.0)***	***0.1***
Expenditure								
Pay	2,637.6	2,507.4	8.6	8.6	(0.0)	101.4	103.1	1.7
Non pay			3.0	3.0	0.0	36.7	36.2	(0.5)
Reserves & Non Recurrent			0.3	0.3	(0.0)	2.9	2.5	(0.4)
Savings Requirement			0.0	0.0	0.0	0.0	(0.8)	(0.8)
Total Expenditure	***2,637.6***	***2,507.4***	***11.9***	***11.9***	***(0.0)***	***141.0***	***140.9***	***(0.1)***
EBITDA	**2,637.6**	**2,507.4**	**(0.4)**	**(0.4)**	**(0.0)**	**(5.0)**	**(5.0)**	**(0.0)**
Depreciation			0.2	0.2	(0.0)	1.9	1.9	0.0
Public Dividend Capital			0.1	0.1	0.0	0.7	0.7	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0
Impairment			0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable			0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	0.0
Retained Net Surplus	**2,637.6**	**2,507.4**	**(0.1)**	**(0.1)**	**(0.0)**	**(2.5)**	**(2.5)**	**(0.0)**
	Variance =	**(130.2)**						

2.1 Income

Both contract and non-contract income is running in line with plan. This includes accruals for CQUIN income paid in arrears. The income assumption includes the allocated STF monies for 2018/19.

2.2 Pay

Table 3 below illustrates the total pay costs by category. The underspending on substantive staff in post continues in April.

Table 3 Annual Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	8,608	7,886	(721)	
Seconded staff costs	72	88	15	
Vacancy Factor	(596)		596	
Sub-total Direct Pay	**8,084**	**7,974**	**(110)**	
Bank Staff	7	176	169	
Agency Staff	533	438	(95)	
Total Pay Costs	**8,624**	**8,588**	**(37)**	**1,676**

Prior year data has been provided as a comparator in the following table.

Table 4 Month on Month Pay Costs by Category	Jan £k	Feb £k	Mar £k	April £k
Directly employed staff	7,981	7,887	7,949	7,886
Seconded staff costs	91	101	70	88
Bank staff	139	166	200	176
Agency staff	459	442	657	438
Total Pay Costs	**8,669**	**8,596**	**8,876**	**8,588**

2.3 Non Pay

Non pay expenditure is running slightly more than planned for the first month of the year.

Table 5 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Forecast Outturn Variance £k
Drugs	65	60	(5)	
Clinical Supplies & Services	853	835	(18)	
General Supplies & Services	454	444	(10)	
Establishment Expenses	596	548	(48)	
Premises	1,037	1,092	55	
Other non pay	10	51	40	
Total Non Pay Costs	**3,015**	**3,030**	**14**	**(535)**

3. Reserves & Non Recurrent

The Trust has £2.9m in reserve at the end of April; all un-committed reserves have been released into the forecast outturn position including the £300k contingency set aside. Based on the forecast at this early point in the year the Trust will require an additional £0.8m of savings to achieve the control total agreed with NHSI for the year.

4. Service Line & Contract Performance

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m	YTD Plan Activity	YTD Actual Activity	YTD Variance Activity	Corr-elation
Specialist Services	37.1	647.0	599.4	(47.6)	3.1	2.9	(0.2)	39,115	34,718	(4,397)	•••
Childrens Services	27.6	683.5	682.9	(0.5)	2.3	2.3	0.0	29,460	26,486	(2,974)	•••
Adults Services	39.9	893.8	858.7	(35.1)	3.5	3.5	0.1	71,660	62,761	(8,899)	•••
Ops Management & Equipment	1.4	48.2	51.5	3.3	0.1	0.1	0.0				••
Service Line Totals	**106.0**	**2,272.5**	**2,192.5**	**(79.9)**	**9.0**	**8.9**	**(0.1)**	**140,235**	**123,965**	**(16,270)**	•••
Corporate Support & Estates	26.5	365.1	314.9	(50.3)	2.3	2.4	0.1				••
Total All Services	**132.5**	**2,637.6**	**2,507.4**	**(130.2)**	**11.3**	**11.3**	**(0.0)**	**140,235**	**123,965**	**(16,270)**	•••

This month operational services have 80 wte less in post than planned. The services are a net £0.1m underspent for April.

The overall activity is 11.6% behind plan, as all business units have not reached the planned levels of activity for April; however there will be some lag in recording; this will improve as records are brought up to date in the next few weeks before the freeze position

- Specialist services activities are 11.2% less than planned,
- Children's services activities are 10.1% less than planned, and
- Adult NT services activities are 12.4% less than planned.

5. Cost Improvement Plans

Table 7 has the Trust's performance against the cost savings plan for 2018/19. Overall the plan is £15k or 4.5% behind at this early point in the year. Corporate support savings have not been identified however overall corporate pay is £70k underspent at the end of April so these savings are being made. The Finance team will work with Directors to identify the specific budgets to be removed recurrently. Procurement savings are delivered I year as opportunities arise. It is anticipated actions will be taken to recover the shortfall and this is reflected in the forecast outturn.

Table 7 Savings Scheme	2018/19 YTD Plan £k	2018/19 YTD Actual £k	2018/19 YTD Variance £k	2018/19 Annual Plan £k	2018/19 Forecast Outturn £k	2018/19 Forecast Variance £k	2018/19 Forecast Variance %
Estates	58	58	0	700	700	0	0%
Admin Review	21	21	0	250	250	0	0%
Corporate Support	25	25	0	300	300	0	0%
Procurement	15	0	(15)	180	180	0	0%
Non Pay Inflation	37	37	0	440	440	0	0%
CQUIN	38	38	0	452	452	0	0%
Contribution to overheads / fixed costs	69	69	0	831	831	0	0%
Release of Reserves	6	6	0	75	75	0	0%
IT Kit	25	25	0	300	300	0	0%
Discretionary spending	42	42	0	500	500	0	0%
Decommissioning cost reduction	0	0	0	700	700	0	0%
Total Efficiency Savings Delivery	**336**	**321**	**(15)**	**4,728**	**4,728**	**0**	**0%**

6. Capital Expenditure

NHS Improvement has yet to confirm the Trust's capital resource limit for 2018/19. The Trust has planned for capital expenditure of £3.2m as below. There has been no material expenditure planned or incurred in April.

Table 8 Scheme	Annual Plan £m
Estate maintenance	0.7
Equipment/IT	0.5
Electronic Patient Records	0.5
CAMHS Tier 4	1.5
Totals	**3.2**

7. Statement of Financial Position

The Trust's statement of financial position at the end of April is ahead of plan by £18k reflecting the income and expenditure position. Trade and other receivables are £0.1m lower than plan and trade and other payables, including provisions, £0.8m lower than plan.

Trade receivables total £8.2m at the end of April. The largest debtor is Leeds City Council which owes £1.5m. Accrued income totals £3.9m, made up of £0.1m for CQUIN income, £0.2m for NHS England/CCG non-contract income and £0.6m for NHS England/CCG contract income. Non-NHS contract income made up £0.1m together with Non-NHS non-contract income of £0.1m. STF accruals for 17/18 totalled £1.8m as well as £0.1m for 18/19.

Trade payables total £11.9m at the end of April. Accrued expenditure totals £10.5m, made up of £7.9m for property charges and various other smaller accruals.

As a result of the above the cash position is £0.8m lower than planned, with cash and cash equivalents totalling £22.7m.

Table 9 Statement of Financial Position	Plan 30/04/2018 £m	Actual 30/04/2018 £m	Variance 30/04/2018 £m	Planned Outturn 31/03/19 £m	Forecast Outturn 31/03/19 £m	Forecast Variance 31/03/19 £m
Property, Plant and Equipment	29.2	29.2	0.0	27.5	29.5	2.1
Intangible Assets	0.1	0.1	(0.0)	0.0	0.1	0.0
Total Non Current Assets	**29.2**	**29.3**	**0.0**	**27.5**	**29.6**	**2.1**
Current Assets						
Inventories	0.0	0.0	0.0	0.0	0.0	0.0
Trade and Other Receivables	8.3	8.2	(0.0)	6.6	6.9	0.3
Cash and Cash Equivalents	23.5	22.7	(0.8)	20.7	24.0	3.3
Total Current Assets	**31.8**	**31.0**	**(0.8)**	**27.3**	**30.9**	**3.6**
TOTAL ASSETS	**61.0**	**60.2**	**(0.8)**	**54.8**	**60.5**	**5.8**
Current Liabilities						
Trade and Other Payables	(12.3)	(10.6)	1.8	(11.1)	(13.4)	(2.3)
Provisions	(0.4)	(1.4)	(1.0)	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.7)**	**(11.9)**	**0.8**	**(11.5)**	**(13.8)**	**(2.3)**
Net Current Assets/(Liabilities)	**19.0**	**19.0**	**(0.0)**	**15.8**	**17.1**	**1.4**
TOTAL ASSETS LESS CURRENT LIABILITIES	**48.3**	**48.3**	**(0.0)**	**43.2**	**46.7**	**3.5**
Non Current Provisions	0.0	0.0	0.0	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**48.3**	**48.3**	**(0.0)**	**43.2**	**46.7**	**3.5**
TAXPAYERS EQUITY						
Public Dividend Capital	0.3	0.3	0.0	0.3	0.3	0.0
Retained Earnings Reserve	17.4	17.4	0.0	15.6	16.2	0.6
General Fund	18.5	18.5	(0.0)	18.2	18.5	0.3
Revaluation Reserve	12.1	12.0	(0.0)	9.2	11.7	2.5
TOTAL EQUITY	**48.3**	**48.3**	**(0.0)**	**43.2**	**46.7**	**3.5**

8. Working Capital

Chart 1 reflects the Board approved financial plan submitted to NHS Improvement April 2018. The planned, actual and forecast cash positions for the year are illustrated.

The Trust's cash position is strong at £22.7m which is £0.8m less than planned.

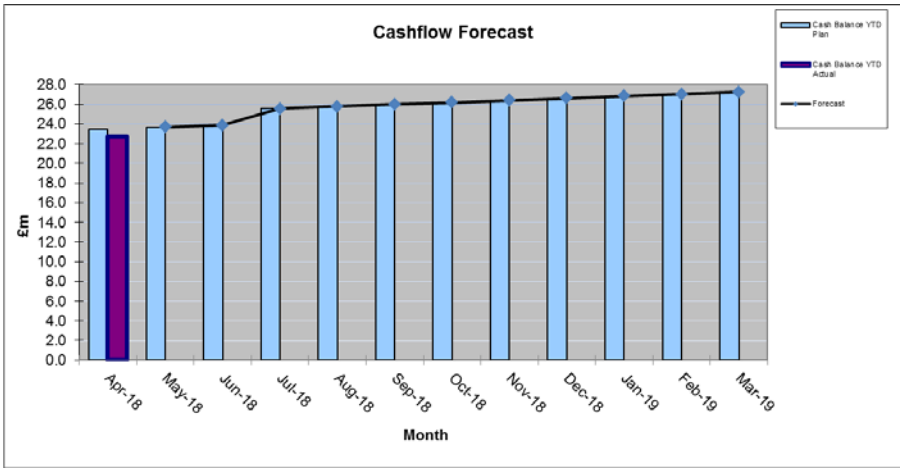


Chart 1

Table 10 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	100%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	99%	95%	G

Table 10 demonstrates the Trust's performance in respect of the Better Payment Practice Code.

9. Use of Resources Risk Rating

Table 11 reports the Trust's financial performance calculated using the single oversight framework; which has revised criteria to determine an overall use of resources risk rating.

For April the Trust overall result is 1, which is the lowest risk.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	48	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	7.7	1	20%	0.2
Underlying performance	I&E margin	2%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-18%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

10. Conclusion on Financial Performance

At this early point in the year the Trust is overall in line with the planned financial performance. CIP delivery has been good for April and pay is in line with expectations. Staffing levels are 130 wte below funded; temporary staffing is in place to mitigate service risks.

The forecast outturn demonstrates there are some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the proposed pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will be monitored closely as the year progresses.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (11a)

Meeting Trust Board 25 May 2018	**Category of paper** *(please tick)*	
Report title Serious Incidents Report Q4	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident and Assurance Manager	**For assurance**	√
Previously considered by N/A	**For information**	

Purpose of the report

This report provides the Board with an update and assurance in relation to the management of Serious Incidents (SIs). It summarises the outcomes, themes, actions and learning from SI investigations closed within the organisation during January to March 2018; as well as progress against action plans.

Main issues for consideration

A total of 22 Serious Incidents were reported and verified in January through to March 2018 taking the total for the year 2017/18 to 79 as opposed to 92 reported SI's in 2016/17. This is a 14.1% reduction overall in SI's compared to the same period in the previous year.

Nineteen (86.4%) of the SI's in this reporting period related to pressure ulcers; with two unexpected deaths and one related to an invasive procedure undertaken in the sexual health service.

Outcomes of serious incident investigations completed in January through to March 2018 are included in the report along with any themes identified through investigations. The themes remain consistent with previous reports and generally fall into three overarching categories: documentation, communication and processes.

There have been two records 'de-logged' from StEIS. This indicates there is still some learning to be had concerning identifying and categorising pressure damage and support for new staff in the organisation when identifying records that require submitting to the CCG

Recommendations

The Board is recommended to:

- note the current position of action plans and learning
- receive assurance regarding the management of Serious Incidents and handling of inquests

Serious Incidents Report

1.0 Purpose of this report

1.1 This report provides the Trust Board with an overview of Serious Incidents (SI's) managed within LCH in the period 01 January – 31 March 2018.

1.2 The report provides a summary of the outcomes, themes, learning and actions from completed serious incident investigations. An update of service improvements and actions taken to prevent recurrence of the incident is also included in the report.

1.3 The report provides an overview of Coroner's Inquests held in relation to Serious Incidents, along with the outcomes and any recommendations made.

2.0 Background

2.1 The Trust reports all incidents meeting the Serious Incident criteria, according to the NHS England Serious Incident Framework (DoH March 2015), via the Leeds CCG Strategic Executive Information System (StEIS).

2.2 Serious Incidents (SIs) are reported on StEIS within 2 working days of the incident being confirmed as a Serious Incident. They are allocated to the relevant commissioner via the StEIS report.

2.3 SI's occurring in services with additional commissioning arrangements (for example HMP Wetherby YOI, Policy Custody, Leeds IAPT) are also reported to the relevant body, such as NHS England.

2.4 A monthly summary of SIs and any exceptions is included within the monthly Clinical Governance Exception report; part of the Trust's Executive Director of Nursing's Report. This is submitted to the Quality Committee.

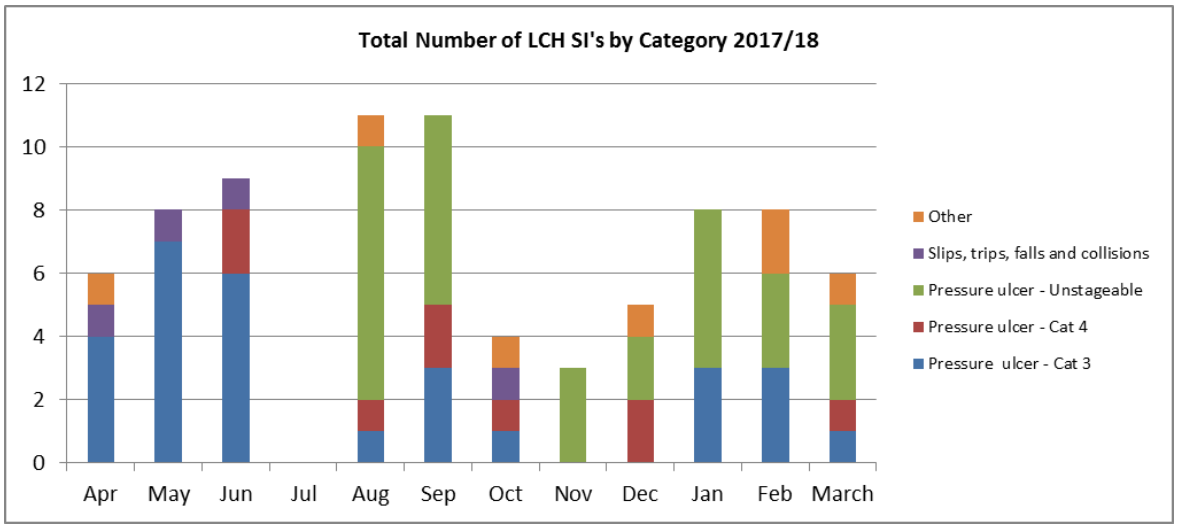
3.0 New Serious Incidents in Quarter 4

3.1 Twenty four SI's were reported to the commissioners via STEIS between January and March 2018; two were removed (de-logged) as reported in error.

3.2 The table below provides a summary of the types of SI's reported in this quarter.

2017 - 2018 - Quarter 4	Jan	Feb	March	Total
Pressure ulcer - Cat 3	3	3	1	7
Pressure ulcer - Cat 4	0	0	1	1
Pressure ulcer - Unstageable	5	3	3	11
Slips, trips, falls and collisions	0	0	0	0
Other	0	2	1	3
Total	8	8	6	22
Delogged SI's	1	1		2

3.3 Total SI's taken forward for investigations for the year are in the table below



4.0 Completed Investigations

4.1 16 SI's were due to be submitted or were to be included in the Quarter 4 pressure ulcer report to the CCG. Two records remain open and investigations ongoing.

(both records were subsequently closed in Q1 18/19)

4.2 16 SI investigations were completed. 3 were sent directly to the CCG for review, the remaining 13 all related to category 3 or unstageable pressure ulcers which are sent to the commissioners in a quarterly report.

There were no category 4 pressure ulcers closed in quarter 4

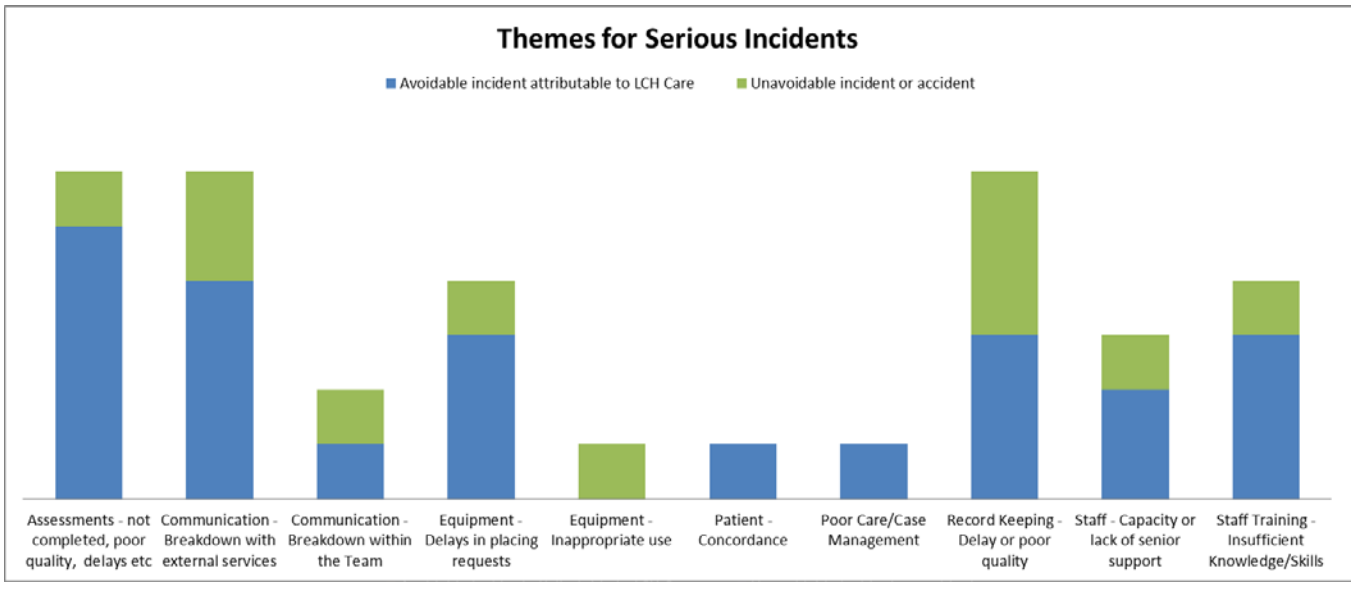
4.3 A synopsis of individual submissions is provided below:

Ref	Type	Status	Root Cause(s)
45984	Fractures sustained following fall in CRU	Unavoidable	Communication barriers – patient required an interpreter for more detailed conversations Gloves and Aprons being outside the bathroom which resulted in the carers coming into the bathroom and then leaving again to put these on.
46041	Invasive procedure	Avoidable	Patient identification error due staff not adhering to Trust policy. The doctor did not follow the agreed Trust policy on patient identification There were a number of opportunities within the pathway where consent, identify and understanding of procedure should have been checked.
47642	Unexpected Death	Unavoidable	Excessive waiting times for step 3 therapy Primary and Secondary mental health services use separate and different Electronic patient records which are not routinely shared. Therefore, important clinical risk and suitability information was not known at time of assessment.

4.3 The themes and learning from the closed investigations have been extracted and included in section 5.0

5.0 Outcomes and Themes

5.1 Themes emerging from all the SI investigation reports completed in January to March 2018 identify the areas of concern to be:



5.2 Themes are reflective of those identified in previous reports, which relates in part to the cause of the SI's being of the same theme i.e. pressure ulcers and the complexities involved in reducing these incidents.

5.3 The targeted programme of education, led by the Pressure Ulcer Steering Group, continues.

6.0 Action Plans and Learning

6.1 All SI reports require an action plan to be developed alongside completion of the investigation. Action plans are reviewed at a validation panel to ensure they are SMART and fully address the recommendations.

6.2 The Business Units provide a monthly update of progress for open action plans. These are scrutinised and monitored via Patient Safety, Experience and Governance Group (PSEGG) and any issues are escalated to the Quality Committee. Access to action plans will also support the PSEGG to triangulate learning from incidents, patient experience and inclusion along with patient, carer and public involvement and feedback from staff (via workshop meetings). The action plans are overseen by the Business Unit Quality Leads.

6.3 Outcomes and experience from the management of SI's is shared with other organisations at the regional SI network meeting. This network will be used to develop benchmarking and identify areas for improving how learning is embedded.

6.4 A Lessons Learned template for shared learning has been reviewed by the Incident and Assurance Manager and Specialist Business Unit Quality Lead. This has now available and will be shared via Community Talk, Elsie and summer edition of Risky Business. Plans are in place to involve Communications to put a flashing banner on the Elsie homepage highlighting the new template

7.0 CCG response

7.1 All SI investigations are sent to the CCG to review at a validation panel. The panel will authorise closure of an incident; or request further assurance with regards to the management of and learning from it.

7.2 The CCG requested no further assurance in relation to SI reports in quarter 4

7.3 Partnership work continues between LCH and the CCG to cross reference all open SI's to ensure consistent records are held and that all completed investigations are closed on the StEIS database.

8.0 Inquests

8.1 Two potential inquests were registered with LCH as an interested party in quarter 4.

8.2 Two inquests were held and closed in the quarter with no recommendations for the organisation.

	Synopsis	Inquest Date	Outcome	Recommendations
1	Patient had supra pubic catheter inserted as planned surgery. Patient had complained of abdominal and bladder pain on the ward however was discharged home the same day. Following day, family became concerned that patient had become unwell- paramedics were called. Patient passed away	15 March 2018	Misadventure	There were no rule 43 recommendations
2	Telephone triage to IAPT service –low risk identified. Follow-up call unsuccessful – notified that client had taken own life.	05 February 2018	Suicide	No Coroner recommendations for LCH

NB: There will be other inquests held for LCH patients. Those listed are for inquests where LCH is officially registered with the Coroner's office as a Properly Interested Party (PIP) and/or where LCH witnesses are required to provide information/evidence.

8.3 There have been no Prevention of Future Death (PFD) reports served by the Coroner to LCH under the Coroners Regulation 28 (Reg 28).

9.0 Impact

9.1 ***Quality***

9.1.1 The process of SI management has an impact on quality in the following areas:

- Quality and safety of patient care
- Meeting statutory/regulatory requirements
- Supporting services with the local governance arrangements relating to serious incidents
- The organisations reputation with external and internal stakeholders

9.1.2 These priorities are addressed by ensuring the continuation of good governance of the Serious Incident process; identifying feedback from Commissioning bodies; and ensuring the opportunity for continuous improvement is embedded the SI management process.

9.2 ***Risk and assurance***

9.2.1 All previously identified risks are being positively addressed to ensure that governance systems are in place to mitigate any risk in relation to good SI management.

10.0 Next steps – monitoring & improvements

10.1 Quality Committee will continue to receive assurance regarding SI management and learning as part of agreed monthly and quarterly reporting arrangements.

10.2 An annual themed report will be produced combining incidents (including SI's) and complaints with an interim (6 monthly) report of themes.

10.3 The Clinical Governance Team will continue to monitor the quality of SI action plans as previously advised.

10.4 The PSEGG will bring together themes, actions and learning and evidence the sharing of learning across the organisation.

11.0 Recommendations

The Board is recommended to:

- receive this report and note the current position with regards action plans and learning
- receive assurance regarding the management of Serious Incidents and handling of inquests

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018/19 (11b)

Meeting: Trust Board 25 May 2018	**Category of paper** *(please tick)*	
Report title: Annual Patient Experience, Complaints and Incident Thematic Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Clinical Governance Team	**For assurance**	
Previously considered by PSEGG - 26 April 2018 Quality Committee – 23 April 2018	**For information**	✓

PURPOSE OF THE REPORT

The purpose of this report is to provide the Trust Board with an annual review of the themes of patient experience and incidents within Leeds Community Healthcare NHS Trust (LCH) for the year 2017-18. The report incorporates the information required for the annual complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). The information used in the report has been taken from complaints, concerns and incident data and the Friends and Family Test.

MAIN ISSUES FOR CONSIDERATION

The report provides a thematic review of complaints, concerns, and feedback via the Friends and Family Test for 2017/18. It compares the data with previous years and where relevant, national data. It also provides analysis of identified themes in greater detail and triangulates information where possible to identify commonalities across all sources of intelligence.

Clinical Judgement / Poor Treatment, Appointments, Attitude, Communication and Access/Availability are the top 5 themes of complaint and concerns for the second year running. These themes are generally in keeping with what has been the national picture for complaints for more than five years.

Friends and Family Test (FFT) intelligence has previously been described as generally unreflective of the themes identified, primarily because FFT feedback is mostly positive with few true negative comments being received through this source. Where possible the FFT data has been linked to themes with the other patient feedback although it is recognised that the number of overall responses to FFT is low, hence the use and significance of FFT intelligence is limited for this type of analysis.

A summary of themes by Business Unit, taken from all sources of intelligence, is included in section 4. This forms a useful visual guide to identify commonalities and areas of focus for learning from experience across the Business Units.

Examples of Actions and Learning for all themes, sourced from Business Unit Clinical and Quality Leads are detailed in Appendix 1.

RECOMMENDATIONS

Trust Board is requested to:

- Note the themes identified and comparisons provided
- Receive information that actions and learning is in progress to address the themes identified.

Annual Patient Experience, Complaints and Incident Thematic Report

1. Introduction

The purpose of this report is to provide an annual review of the themes of patient experience and incidents within Leeds Community Healthcare NHS Trust (LCH) for the financial year 2017-18. The report incorporates the information required for the annual complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). The information used in the report has been taken from complaints, concerns and incident data and the Friends and Family Test.

2. Background

2.1 The Trust Board receives a six-monthly report on the quality of LCH services. This report includes a detailed consideration of incident, complaints and patient experience data.

Following discussion at Patient Safety, Experience and Governance Group (PSEGG), the report is shared with the Trust Board, which has corporate responsibility for the monitoring and management of quality of care. Within LCH, the Chief Executive delegates responsibility for the management of patient experience and incident management to the Executive Director of Nursing.

2.2 The Clinical Governance Team (CGT) is an arm of the Quality Professional & Development Department within the profile of responsibility of the Executive Director of Nursing. The CGT is responsible for providing overarching services for the organisation and includes:

- Quality and safety of patient care
- Meeting statutory/regulatory requirements
- Supporting services in all fields of governance
- The organisations reputation with external and internal stakeholders

Concerns and Complaints, Incidents/Serious Incidents and the Friends and Family Test (FFT) are managed alongside other governance priorities within this structure.

2.3 Annual complaints and incident reports are prepared in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This report contributes to those requirements and draws on additional available sources of feedback to gain a more complete picture of the quality of our services.

2.4 A performance summary of patient experience is provided on a monthly basis via the Performance Exception Report and a fuller analysis via the quarterly Patient Safety, Experience and Governance Group report, and Quality Governance report.

3. Lch patient feedback

3.1 The numbers

3.1.1 For the purposes of clarity throughout the paper, LCH collects patient experience feedback in two different systems. Complaints, concerns, enquiries and compliments are collected / recorded within the Datix® system held by the Trust. The Friends and Family Test (FFT) and the comments provided with it are collected via an external system provided by Membership Engagement Services (MES).

3.1.2 In 2017-18 LCH received 188 complaints which were managed under the 2009 regulations. There were also 221 concerns and a total of 107 enquiries recorded regarding LCH services. Subjects and sub-subjects are linked to complaints and concerns; for the 409 pieces of feedback considered for this element of the report, 696 subjects and 694 sub-subjects were recorded.

3.1.3 Of the complaints received, 29% were not upheld; 28% were partially upheld and 23% were fully upheld. The remainder of the caseload (38 complaints) had not yet been responded to and has been carried over into the next year. The Trust acknowledged and responded to all received complaints within the statutory timeframes (3 and 180 working days respectively) and responded to 52% of complaints received within the LCH target timeframe of 40 working days or less.

3.1.4 During the year, 11 complainants asked the Trust to re-open their complaints to look at issues again. Three referrals were made to the Parliamentary and Health Services Ombudsman; (two of the referrals were about the same complaint) none of the complaints were upheld by the Ombudsman. There are currently no LCH complaints under review or investigation by the Ombudsman.

3.1.5 A further 24 complaints were received of which 14 were withdrawn by the respective complainants and 10 were withdrawn by the Trust. The withdrawn complaints are not included in the figures noted in 3.1.2. Those re-opened by the Trust or the Ombudsman were counted when originally received and responded to and are also excluded.

3.1.6 Trust services also received 2196 compliments throughout the year with 89% of those being given by patients or carers. More information on compliments can be found in Appendix 2.

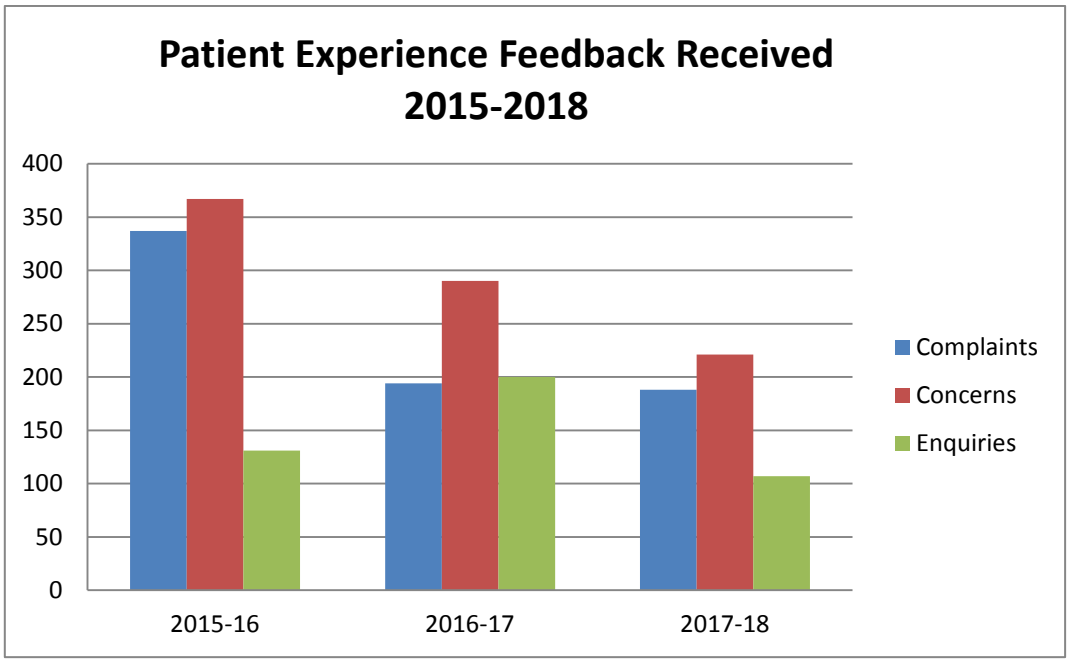
3.1.7 Over the year, 15,270 responses to the FFT were received (5.35% response rate); with 96.7% of respondents saying they would recommend LCH services. Although this represents an increase in both figures compared to last year, the response rate is lower than expected based upon results from earlier in the year and is also below the target set for 2017/18. People responding to the FFT also provided 13,915 comments about their experiences.

3.1.8 To put the feedback figures in context, the Trust made over 1.6 million patient contacts last year which is broken down by business unit below:

Business Unit	Number of patient contacts
Adult	801,529
Children's	368,918
Specialist	433,639
Total	1,604,086

Overall, the Trust received 2.5 complaints or concerns for every 10,000 patient contacts.

3.1.9 The chart below provides a comparison of the different types of feedback received 2015-2018. It is clear that there has been a decline in the numbers of enquiries, concerns and complaints received over the period. Initially, the decrease in complaints was explained through a focus on resolving concerns quickly and alterations to Trust processes. There are a number of potential reasons for the continued decrease in feedback received. It is possible that more patients are expressing their feelings about their experiences via the FFT as the number of responses to the FFT has increased. Anecdotal evidence confirms many issues that would be considered concerns are being successfully resolved by staff every day but are not being reported in Datix® either because staff do not have time or because the issues are not recognised as concerns. Information regarding the removal of benchmarking information is noted in section 3.3.



3.2 Overarching themes

3.2.1 This section provides an overview of themes during 2017/18 alongside a national and LCH comparison year on year from 2015/16 and 2016/17 for the top five subjects of complaint. The data reported for the 188 complaints and 221 concerns received have been used. In total 696 subjects and 694 sub-subjects were recorded across the 409 pieces of patient feedback.

3.2.2 Subjects of the same theme are colour coded in the table below. Due to the timing of this paper it is not possible to provide a national comparison as the national Q4 and annual data is not due to be published until June 2018.

COMPLAINTS					
	Nationally 2015/16	**LCH 2015/16**	**Nationally 2016/17**	**LCH 2016/17**	**LCH 2017/18**
1	All aspects of clinical treatment	Appointments	Communication	Clinical Judgement / Poor Treatment	Clinical judgement / Poor treatment
2	Attitude of staff	Clinical judgement / Poor treatment	Patient Care including Nutrition and Hydration	Attitude, conduct, cultural and dignity issues	Appointments
3	Communication / information to patients (written and oral)	Access and availability	Values and Behaviours (Staff)	Appointments	Attitude, conduct, cultural and dignity issues including Staff attitude and communication
4	Appointments, delay / cancellation (outpatient)	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Appointments including delays and cancellations	Communication issues with the patient (verbal and written)	Communication issues with the patient (verbal and written)
5	Admissions, discharge and transfer arrangements	Medication issues	Other	Access and availability	Access and availability

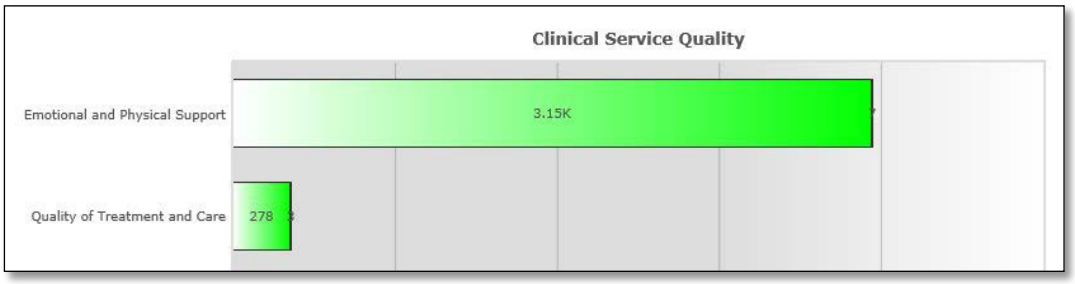
3.2.3 The top five subjects within complaints is identical to last year and has four of five of the same subjects as 2015-16. This is not unexpected as the broad themes of Appointments, Communication, and Clinical Care have been the main themes of NHS complaints nationally for more than five years.

3.2.4 The table below shows the LCH subjects for concerns for the past two years including a comparison of the first and second six months of 2017-18. This demonstrates the consistency of the issues being raised by patients; it is also noted that over the year the themes are the same as those raised within complaints.

CONCERNS				
	LCH 2016/17	LCH Apr-Sept 2017	LCH Oct 17- Mar 18	LCH 2017/18
1	Appointments	Appointments	Appointments	Appointments
2	Communication issues with the patient	Clinical judgement/ Treatment	Clinical judgement/ Treatment	Clinical judgement/ Treatment
3	Clinical judgement/ Treatment	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues
4	Attitude, conduct, cultural and dignity issues	Access and availability	Communication issues with the patient	Communication issues with the patient
5	Access and availability	Communication issues with the patient	Connected with the management of operations/ treatment	Access and availability

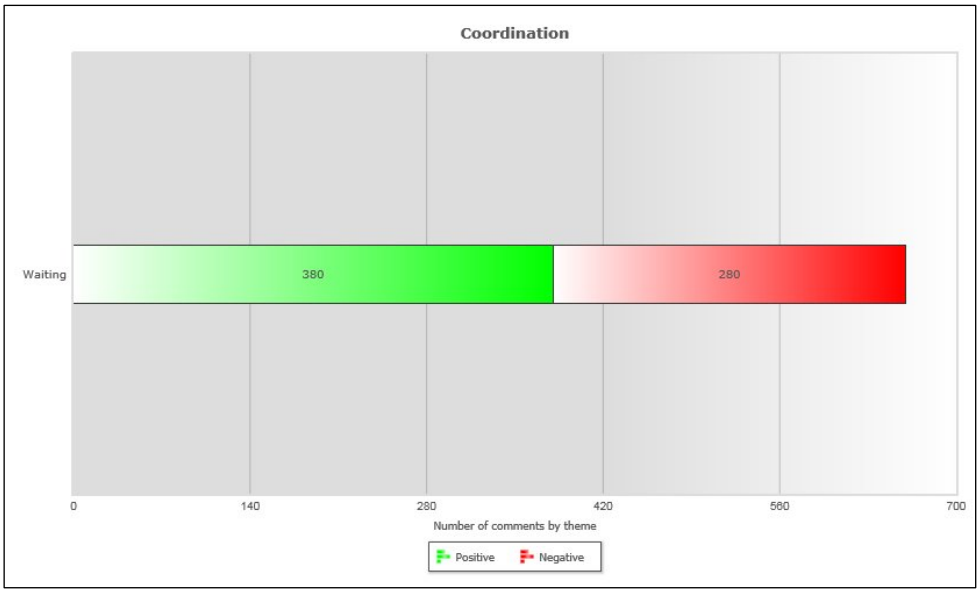
3.2.5 **"Clinical judgement / Poor treatment"** was the theme in 45% of complaints received by the Trust, although it was not necessarily the primary subject; this is a 10% increase from the position at six months. Within those complaints, this subject was recorded 131 times with the top three issues being 'Clinical / Professional Opinion', 'Clinical Judgement', and 'Poor Treatment'.

The charts below depict feedback form FFT in relation to Clinical Service Quality. It represents patient's experience of the quality of Clinical Service they received in our care. Of the two areas measured, "emotional and physical support," has the highest positive rating.



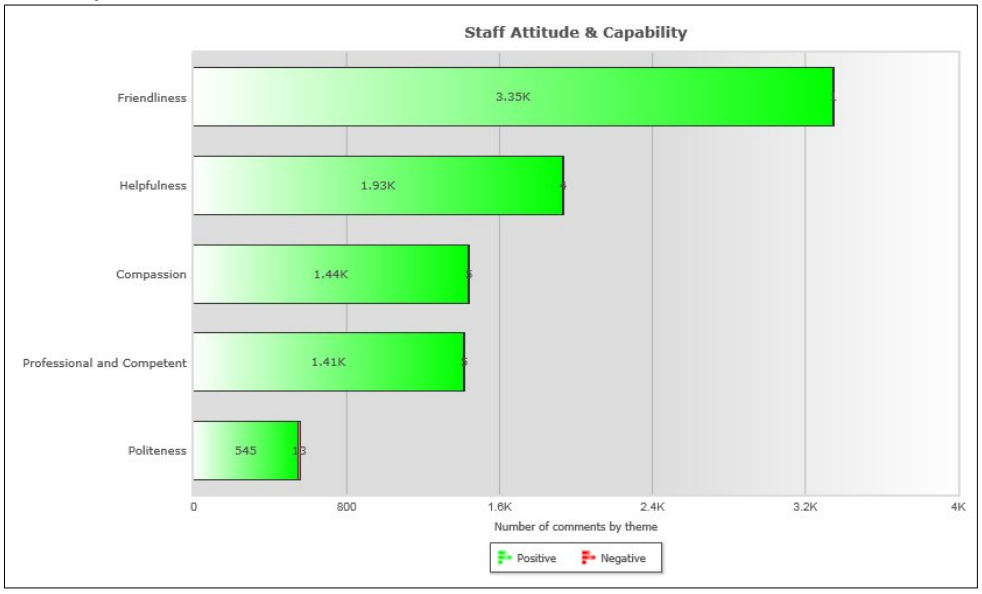
3.2.6 **“Appointments”** issues were a subject of 35% of the complaints received. The subject was reported 98 times with the top three issues being ‘Waiting time for an appointment’, ‘Unable to get an appointment’, and ‘Failure / delay in referral process’. Due to the continuous number of appointment issues received, it remains the area of most concern to patients and carers. **Appointments** remain the top theme for patients and carers across concerns and complaints.

The FFT provides insight into this theme from the perspective of waiting as the following chart demonstrates:



3.2.7 **“Attitude, conduct, cultural and dignity issues”** featured in 31% of complaints and was reported 73 times during 2017/18. This subject / category include the subcategory of “Staff attitude and communication” which was used 57 times. Other subcategories reported included “Abuse of patient by staff” and “Alleged discrimination”.

Despite this particular subcategory remaining the most reported one over the year, the following information from the FFT shows that the vast majority of feedback received about staff is positive and should be celebrated.



3.2.8 The theme of **"Communication with the patient"** was investigated in 17% of complaints with 34 mentions. The leading issue was "Verbal Communication" which in some cases could be interchanged with the "Staff attitude and communication" option. Other subcategories under this theme were "written communication" and "Issues affecting patient dignity".

3.2.9 The final theme for 2017/18 was **"Access and Availability"** which featured in 9% of complaints and was mentioned 18 times. This category is used to cover issues including problems with domiciliary visits and physical access to Trust premises.

As this category can cover a number of elements, the FFT tie in chosen is the non-clinical quality. The chart demonstrates a mixture of positive and negative comments received:

3.2.10 The subjects reported within complaints have remained stable over the three years. A review of the teams involved has shown they are spread across the business units with no clusters or areas of concern to highlight.

3.3 Benchmarking

3.3.1 Previous reports have included benchmarking information from three other community trusts that were considered to be comparable to LCH. It was identified during the preparation of the previous report (October 2017) that the trusts used were no longer completely suitable for benchmarking. Further changes to the service profile of LCH following the removal of adult in-patient services means that a review is necessary to identify which community trusts more accurately reflect LCH for benchmarking purposes. Until that work is completed it was felt more appropriate to remove the benchmarking information. National benchmarking will be possible from June 2018 when NHS Digital publishes the Quarter 4 and annual complaints data.

3.4 Incident themes

3.4.1 Incident themes for Leeds Community Healthcare have been consistent over the past 2 years and this trend has continued throughout 17/18. The top four results are reflected by other Community Trusts that report via the NRLS as shown in the table below.

3.4.2 In Q3/4 the top five incident categories reflects 87.1% (combined) of all LCH Patient Safety Incidents reported. This is a change from the previous 6 month when the top 5 combined accounted for 69% of all LCH PSIs. The top 5 patient safety incidents reported nationally between April and June 2017 accounted for 74% of all (latest data available from NHS Information).

	Incident Themes (LCH Patient Safety Incidents (PSI's) only)				
	2015/16	**2016/17**	**2017/18 Q1/Q2**	**2017/18 Q3/Q4**	**NRLS National Data April-Jun 17**
1	Accidents that may result in personal injury	Implementation of care or ongoing monitoring /review	Implementation of care or ongoing monitoring /review	Implementation of care or ongoing monitoring /review	Implementation of care or ongoing monitoring /review
2	Implementation of care or ongoing monitoring /review	Accidents that may result in personal injury	Accidents that may result in personal injury	Accidents that may result in personal injury	Accidents that may result in personal injury
3	Medication	Medication	Medication	Medication	Medication
4	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge
5	Abusive, violent, disruptive or self-harming behaviour	Abusive, violent, disruptive or self-harming behaviour	Abusive, violent, disruptive or self-harming behaviour	IG / Records	Treatment/ Procedure

3.4.3 Overarching themes exist across complaints and incidents as seen in the tables provided so far, particularly **access/appointments and clinical care**. Further analysis identifies any commonalities arising from these themes in section 3.8.

3.4.4 The only change of note in the chart above is in theme 5 which has been static for a number of years, however in this report has seen a new change to IG/Records.

A piece of work was undertaken with the Head of Information Governance in 2017 and Datix categories/sub-categories were amended to better reflect the latest IG toolkit. This resulted in the new category of IG/Records which merged and replaced the two categories of IG and Patient Information/records which also seemed to cause confusion with incident reporters.

Further analysis of this category has shown that since its inception in April 2017 numbers of LCH PSI IG/Records incidents has fluctuated between 28 and 48 in any one quarter. However there was a noticeable rise in reporting in November 2017 of 22 reports which has accounted for this category making the top 5 in this reporting period

A dive into the November records showed that this increase was related to an issue in a Neighbourhood Team and none EPR registered patients. This does not appear to have re-occurred and reported numbers in the last quarter were consistently lower month on month.

3.5 Serious Incident Themes (SIs)

3.5.1 As reported to Board on a monthly basis, there are recurring themes within reported LCH Sis.

3.5.2 The criteria for reporting SI's changed in July 2017 and as a result, unstageable pressure damage is now reported as a serious incident. Prior to being recorded on STEIS, all category 3, 4 and unstageable pressure related damage undergoes a 72 hour review and is only logged as an SI with NHS Leeds via the STEIS database if there is evidence of a possible lapse in LCH care that may have contributed to it.

3.5.3 Thirty three SI's were reported in the last 6 months, one was subsequently de-logged as on investigation, it no longer met the SI criteria. The primary SI type is now unstageable pressure damage. There has been a significant reduction in category 3 pressure damage being logged as SI's of over 52%. Avoidable category 4 figures have not reduced significantly.

3.5.4 Themes from SI investigations are detailed in the bi-monthly SI learning board report and any exceptions are highlighted monthly in the performance exception report. In brief the themes arising from investigations are consistent and relate to:

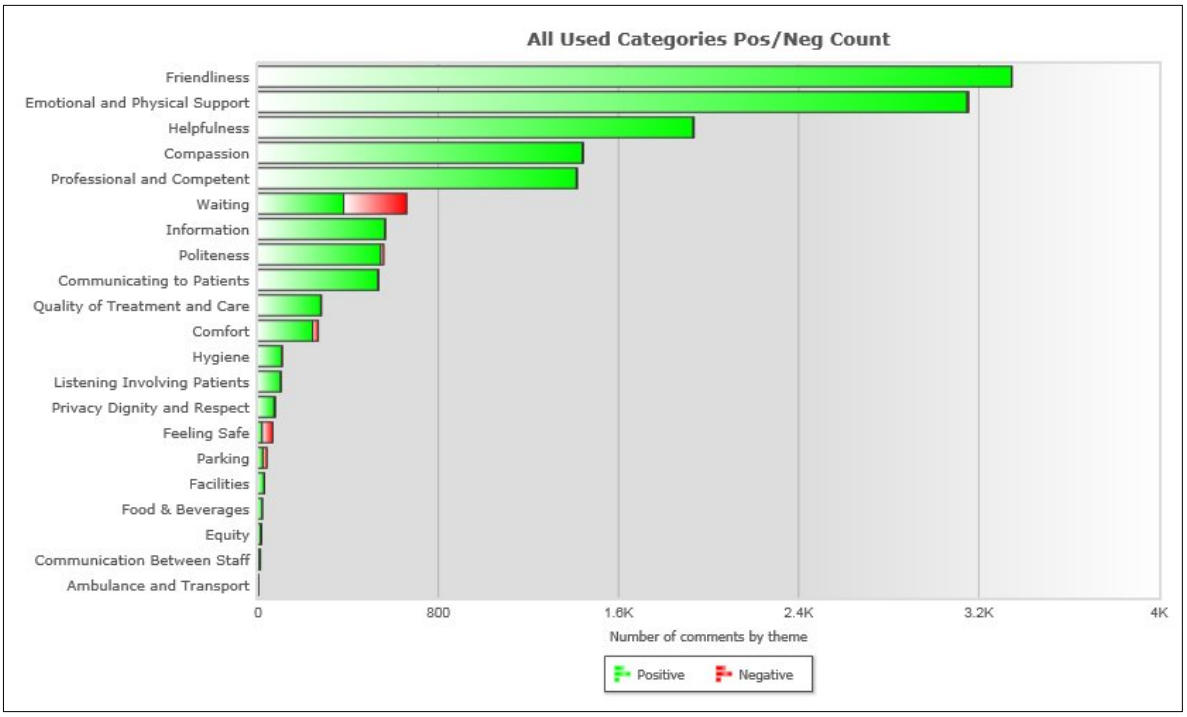
- Documentation
- Communication
- Care Delivery/Processes
- Equipment, education and training
- Patient factors including non-concordance

3.5.5 There has been a marked decrease in the number of fractured Neck of Femur incidents being SI reportable. This is due to the implementation of the 72 hour review and where required, subsequent panel meeting to determine the facts, avoid-ability and lessons learned/actions prior to reporting to STEIS.

3.5.6 'Other' Serious Incidents reported in the month have increased, 3 of these have been themed as Treatment/procedure provided by the Sexual Health Service (2) and 1 neighbourhood team. This is a significant difference and new theme in reported SI categories in the past 2 years.

3.6 Friends and Family Test

3.6.1 The FFT results for 2017/18 demonstrate an overall positive response to the FFT question with 95.51 % of community service users and 97.63% of in-patient user saying they would recommend LCH services. The chart below highlights the overwhelmingly positive nature of the comments received over the year.



3.6.2 These comments are provided from 15270 FFT surveys, which represents a lower than expected overall response rate of 5.35%. At the time of writing the last report, the Trust was on track to exceed the target set (6.8%) and had met the target at the end of Q3.

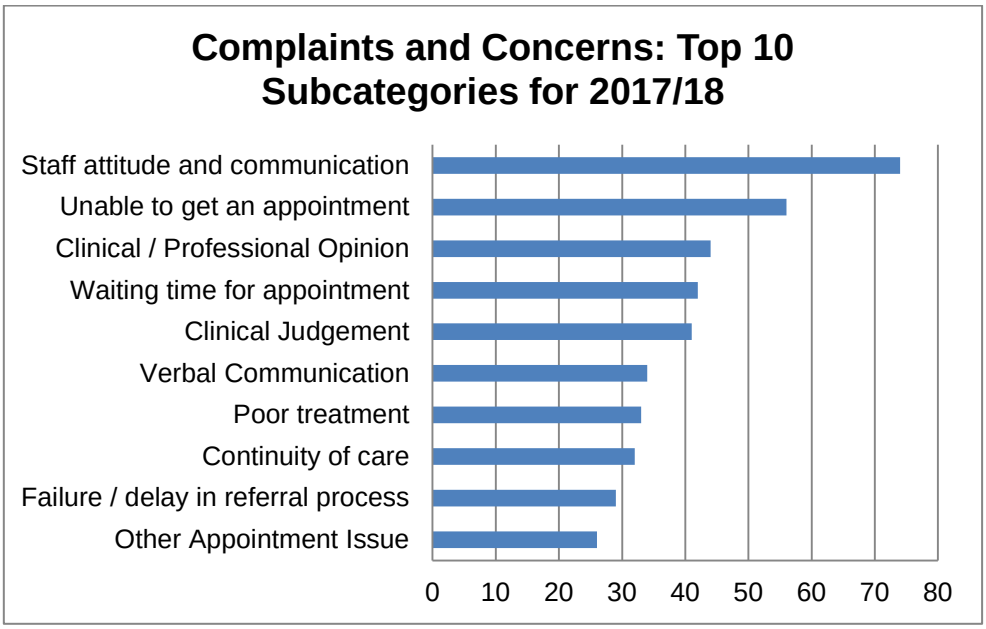
3.6.3 Negative comment responses are primarily recorded under the themes of Waiting, Politeness, Comfort, Parking and Feeling Safe which mirrors the results of the previous report.

3.6.4 The difficulties with benchmarking noted in 3.3 are further compounded for the FFT by the limited availability of published comparable data. As noted in 3.2.2 due to the timing of this paper, there is no comparable data published for last year as yet.

3.7 Complaint & Concern Sub-Subjects

3.7.1 Sub-subjects lie below the main subject of complaint within the Trust's Complaint and Concern database (C&C). They offer the opportunity for the user to select a more specific representation of the patient or carer's main issue.

3.7.2 The chart below represents the top ten C&C subcategories for the year:



3.7.3 This level of categorisation can deepen understanding of the core issues of C&C. The options presently available do not provide significant additional insight beyond the higher level category selected.

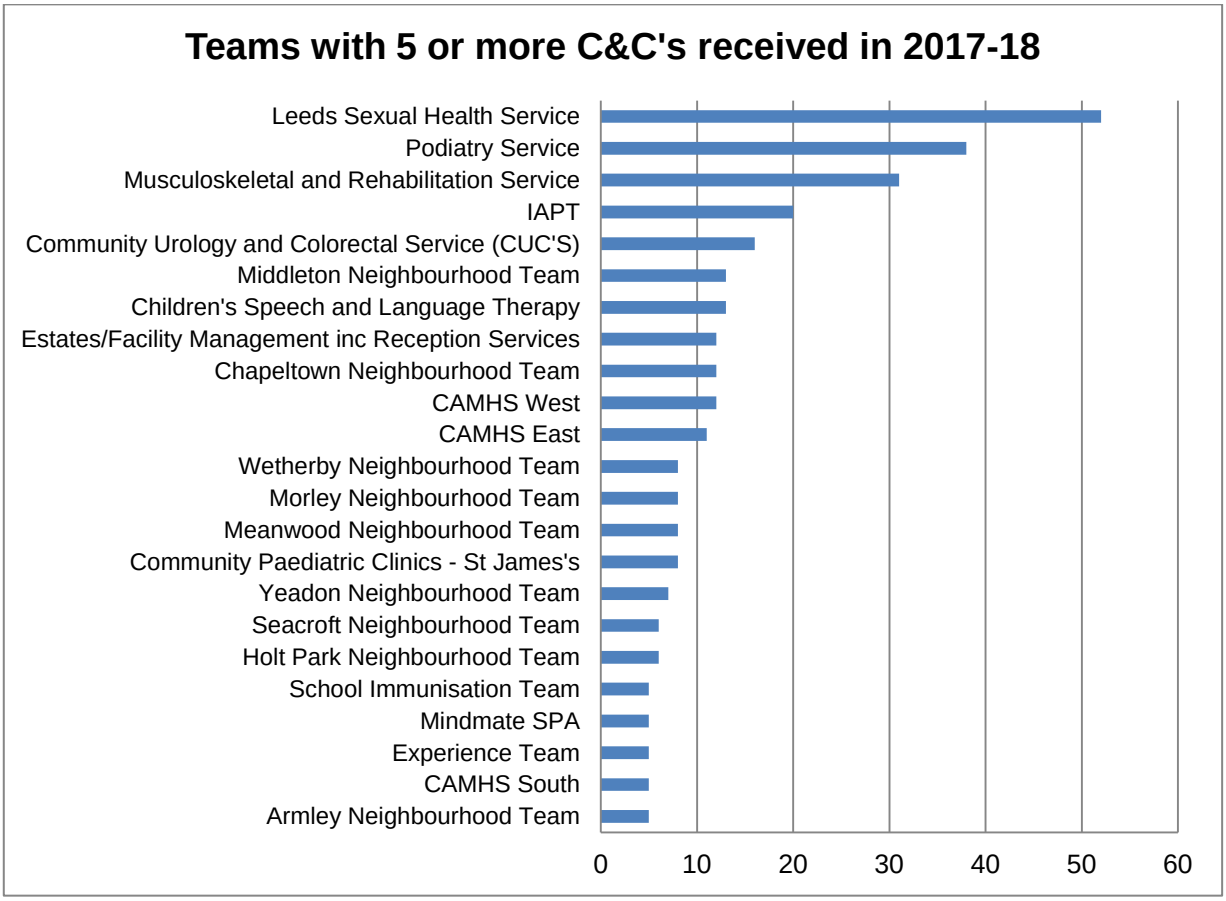
3.7.4 As noted in the previous report, a full review of the Datix® system and subject categorisation used is planned. The prioritisation of other work within the Datix® system has delayed the review which will be completed at the earliest opportunity.

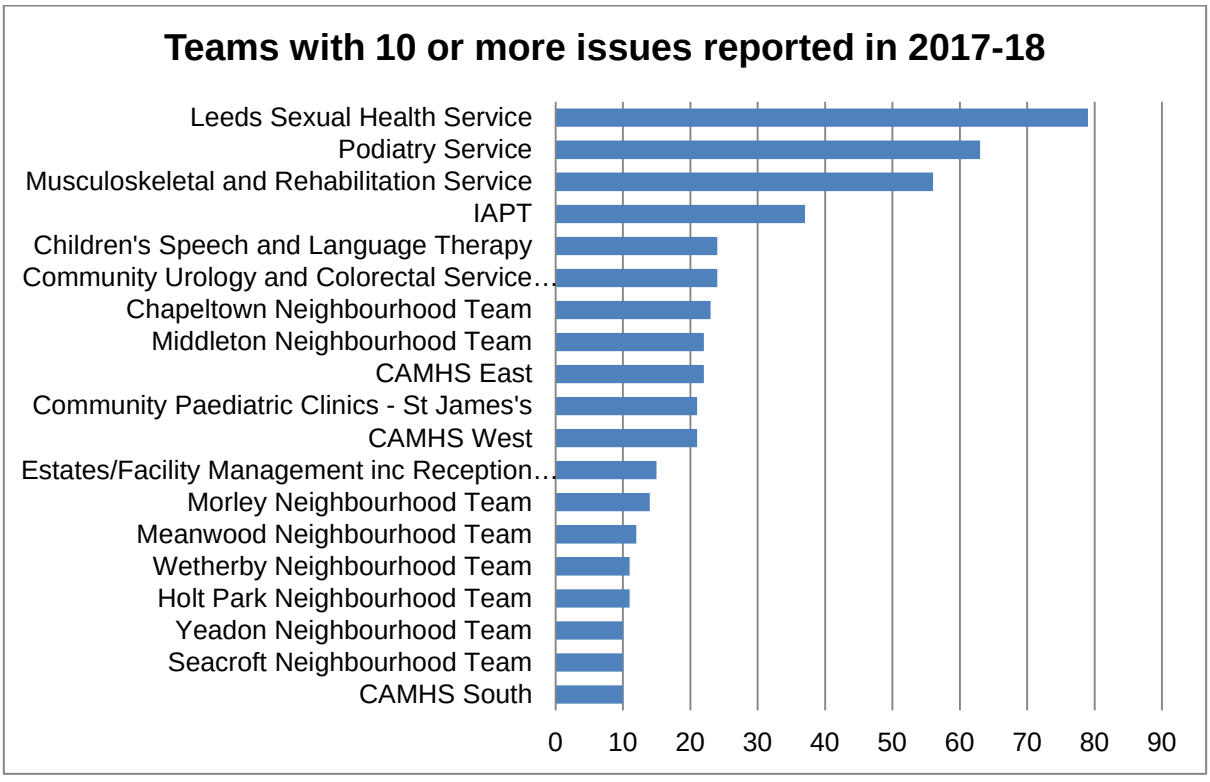
3.8 Teams with highest number of C&Cs

3.8.1 In the reporting period, the Trust has completed 1,604,086 patient contacts. The table below details how the contacts were split across the business units and the ratio of complaints per 10,000 contacts:

Business Unit	Number of contacts	Total Complaints and Concerns received	Ratio
Adult	801,529	90	1.12
Children's	368,918	110	2.98
Specialist	433,639	167	3.85

3.8.2 The two charts below illustrate the teams with 5 or more concerns or complaints received and the teams with ten or more issues within the reporting period:





3.8.3 As identified in the previous report, the teams with the most concerns or complaints are areas with high numbers of patient contacts. They also represent either services where patients receive care for a chronic condition that may be difficult to manage (e.g. MSK services) or those where there is a high level of demand for the service (e.g. Children's Speech and Language Therapy).

3.8.4 In total, 81 teams across all business units received a complaint or concern. There are no unexpected clusters identified within the reporting period.

3.8.5 The top four teams with the highest numbers of issues reported also receive the highest number of concerns or complaints. These are all services dealing with patients who may have chronic conditions or where there is high demand for the service.

4. SUMMARY OF THEMES BY BUSINESS UNIT (COMPLAINTS, CONCERNS & INCIDENTS)

4.1 The table below provides highlights a visual guide to the commonalities across Business Units. Themes from this information can be used by the Patient Safety, Experience and Governance Group (PSEGG) for future workshop focus and sharing of learning across the Trust.

The common noted themes across the 3 business units are Appointment, medication, clinical judgement/Treatment and staff attitude.

Business Unit	Complaints	Concerns	Incidents
Adults	Clinical judgement / Treatment	Appointment	Implementation of care or ongoing monitoring/review
	Appointment	Clinical judgement / Treatment	Accident that may result in personal injury
	Attitude, conduct, cultural and dignity issues	Access and availability	Medication
Children's	Clinical judgement / Treatment	Appointment	Access, Appointment, Admission, Transfer, Discharge
	Appointment	Clinical judgement / Treatment	Information Governance / Records
	Attitude, conduct, cultural and dignity issues	Communication issues with the patient	Medication
Specialist	Appointment	Clinical judgement / Treatment	Medication
	Clinical judgement / Treatment	Attitude, conduct, cultural and dignity issues	Accident that may result in personal injury
	Attitude, conduct, cultural and dignity issues	Appointment	Access, Appointment, Admission, Transfer, Discharge

5. ACTIONS AND LEARNING TO IMPROVE SERVICES

5.1 An update was requested from Business Unit Clinical Leads to evidence action and learning relating to the themes identified throughout this report and in the table above.

5.2 Appendix 1 offers assurance that all Business Units are aware of these areas for improvement; and provides examples of actions in progress to address the themes identified.

5.3 Themes by Business Unit and organisation, and actions to bring about improvement are also monitored via the monthly Exception Report and the quarterly Patient Safety, Experience and Governance Report.

6. RECOMMENDATIONS

6.1 Trust Board is requested to:

- Note the themes identified
- Receive information that actions and learning is in progress to address the themes identified

APPENDIX 1: ACTIONS AND LEARNING TO IMPROVE SERVICES

1. Adult Business Unit

The Neighbourhood Team Clinical Leadership Team monitors service user feedback on a formal basis within the Monthly Quality Metric Meeting and ABU Performance meeting on a quarterly basis. This includes a review of the themes and any causative or contributory factors that have occurred as a response to service.

Learning from this analysis of complaints, concerns and compliments is shared directly to staff on either a 1:1 or group basis. The learning is also shared via the weekly Safety Huddles and Neighbourhood Team Quality Safety Briefings.

Emerging themes will now also be shared through the Business Unit Newsletter (Neighbourhood News) and the Monthly Quality Bulletin.

1.1 Clinical judgement / Treatment

- The theme related to clinical judgement and treatment when analysed mainly relates to delivery of care rather than the skills and experience of staff provided care to Neighbourhood Team patients.
- The Adult Business Unit is developing a Clinical Delivery Framework Handbook to guide and support the quality of care being delivered and reducing any variation in clinical practice. Holistic Assessment and Wound Care Framework have been completed and are being embedded into standard clinical practice.
- ABU have created a new Clinical Skills and Competency role, the post holder delivers key clinical skills training with non-registered and registered clinicians within the Neighbourhood Teams. This support ensures that clinical staff have the required skills and have their competency assessed.
- Daily handover meetings are now fully established at caseload cluster level and the rollout of a daily safety huddle is being implemented.
- The learning from clinical incidents is routinely shared across the Neighbourhood Teams and this supports the development of clinical judgement
- The monthly case load review process is being established and it is classified as an essential activity for capacity and demand purposes.
- Community Matrons and Advanced Clinical practitioners, specialist nursing colleagues from the WPaMS and EoL Palliative Care Lead nurses all support the quality and effectiveness of the clinical care delivered by the NTs
- Additional advanced clinical practitioners posts are being created to support clinical practice across the Neighbourhood Teams

1.2 Appointments and access to services

- The Adult Business unit is committed to ensuring effective and timely access to all ABU clinical services, access and flow are being improved by developing further effectiveness and functions within SPUR. The NT referral form is now electronic and has been redesigned to improve the standard of referral information
- Access and waiting times to the Neighbourhood Teams and City Wide Adult Services such as CUCS are monitored from the SystmOne waiting list report and followed up with specific initiatives to ensure referrals are accepted onto the caseload within the required contractual timescales and to avoid long waiters.

- The access and waiting times for NT Therapy are improving with specific initiatives and focus by the NTs.
- The Neighbourhood Team Triage role supports the clinical decision making at the point of referral into the service. It informs the daily allocation of clinical visit processes and the consideration of clinical complexity and acuity
- The Neighbourhood Team Capacity and Demand Tool continues to be refined to support efficient and effective service delivery
- Regular audits cancelled and unscheduled Neighbourhood Team Visits are undertaken. This information is reviewed by the leadership team and reported to the Director of Nursing.

Attitude of staff / Communication issues with the patient

- Teams discuss and share the learning from service user feedback at a local and at service level; transferable learning is shared across the business unit.
- Staff undertake equality and diversity training and teams are focused upon adhering to the duty of candour standards of practice and developing a culture within teams that promotes empathy and unconditional positive regard. Focus has recently been offered to teams to raise awareness of unconscious bias and the impact of this on behaviour and communication.
- Teams are encouraged to use the LCH 7 Magnificent Behaviours Star to structure discussions about communication with service users and attend training on health coaching and motivational interviewing which supports staff skills to have “better conversations”.
- Staff are encouraged to attend the trusts conflict resolution training and are supporting staff with the guidance produced by the LCH Safeguarding Team on ‘Managing Clinically Related Challenging Behaviours’

Pressure damage:

- ABU clinical staff undertake pressure ulcer prevention training and all patients on admission to NT caseloads have a pressure ulcer risk screen (Purpose T). The new Neighbourhood Team Wound Care Clinical Framework provides clear guidance to staff across all Neighbourhood Teams in the management of wounds and prevention of Pressure Ulcers.

Slips, trips, falls and collisions:

- A programme of work has been developed by the Falls Steering Group, to guide staff how to work proactively with service users and reduce the incidence of preventable falls. Greater awareness and proactive management of falls risk within the Neighbourhood Teams is being supported by the rollout of the daily Safety Huddles.

Medication:

- Work has been undertaken by the Business Unit in conjunction with the Medicines Management Team to improve NT medication management, with the introduction and monitoring compliance of standard processes for the administration of insulin and medication prompts. Pharmacy Technicians are now working aligned to each NT.

2 Specialist Business Unit

On a quarterly basis the Quality lead for the Specialist Business Unit reviews the themes from complaints and concerns, producing a report that is discussed at the business unit clinical forum meeting.

The number of complaints and concerns received is within the working limits of a SPC chart with complaints received being in a ratio of 0.2 per 1000 patient contacts.

Complaints

Appointments:

- A theme in this category is the availability of appointments. A number of services have in place the option for patients to access an emergency appointment subject to clinical need.
- A single point assessment clinic has been developed in the Dental service to reduce the number of individual appointments required.
- A new foot protection service has been commissioned for people with diabetes who are classed as moderate to high risk which has significantly reduced the waiting list for this group of patients.
- Services have triage tools and online systems to ensure patient are directed to the correct service in a timely manner therefore reducing the need for multiple waits.
- In the LSH service they are undertaking a number of pieces of work to address waiting time for appointments, but also recognising there is a great demand for the service. They are currently collecting data on patients not able to be seen the day they request the appointment and will be sharing this with commissioners. Working with the commissioners to identify which patients could be redirected to GP services. Looking at the staffing rotas within the service to ensure uniform staff numbers across the week and to try and increase availability of services. And looking at repeat attendances for contraception and a policy of supplying longer prescriptions so patients come less often.
- Services have reviewed their appointment letters to ensure correct letters are chosen and sent by local admin teams.

Attitude, conduct, cultural and dignity issues (including Staff attitude and communication):

In The IAPT service they are working with OD regarding training for admin team including customer service training.

- It is practice in all services that where a complaint is related to members of staff that service managers have a conversation with the staff involved to identify any learning needs and to offer an apology where appropriate.
- In a number of cases where the concern/complaint is relating to the attitude of a member of staff this is sometimes due to the way a message or information was being delivered to the patient and the fact that the patient had not been given adequate information. All clinical staff undertake an appraisal every year. As part of the appraisal process, they are required to reflect on all patient feedback they have received and identify learning and improvements to their practice

Clinical judgement / Treatment:

- There was a complaint relating to a treatment procedure being undertaken on the wrong patient. The learning for the service was to ensure that all staff follows the Trust Patient Identification Policy.
- All complaints relating to clinical judgement are discussed with individual staff and learning identified.
- In some cases where the patients are unhappy with the wording of a letter template. Clinicians are encouraged to develop their own more person centred templates.
- Some services in the BU have introduced peer review following complaints to ensure staff concerned are following best practice.

Incidents.

Teams discuss and share learning locally, report incidents and learning within the Quality and Performance framework and transferable learning is shared across the business unit.

Medicine Management:

Medicines management accounts for 22% of incidents in the BU with the 75% of these occurring in the PCS and WYOI.

- In Police Custody there were a number of incidents involving the drop box – for the disposal of medication. There has been a process review with a new SOP implemented. Incidents related to reconciliation of drugs are dealt with each individual at the time i.e. feedback is given, training identified where needed. We have encouraged to all staff that reconciliation should occur as far as possible within the suites (still reported on datix) so there is now a growing trend of reported but resolved incidents. We plan to continue the work of training, SOP review, thematic analysis, individualised and team feedback, exploration of medication incidents through team meetings and clinical forum.
- At WYOI the service have a new dedicated onsite pharmacy team with input from a Pharmacist. They have various new initiatives which have been developed to support medicines management such as: In possession risk assessment by Pharmacy team, Cell Checking of in possession medication and adjustment to prescriptions if not concordant. Accuracy checking of prescriptions prior to dispensing both on site and at the community pharmacy. Annual refresher training of all administration staff – by Pharmacist.
- In CNRS Medication incidents are investigated and learning from incident memos created for specific cases and shared at the nurse meeting and wider where appropriate

Access appointment discharge:

- In the Police Custody service there are a number of incidents that could impact on patient care through lack of discharge information from hospital. The service has been liaising with the hospital departments involved. This has led to innovation in Humberside where an electronic discharge letter is sent to a secure team email that can then be uploaded to S1 – this is improving communication.
- At WYOI these incidents relate mainly on non-attendance to hospital due to refusal by the Prison for a variety of reasons. These are discussed with the Duty Governor and at the monthly Joint Operational Meeting.
- There are a number of incidents related to local administration errors from staff not directly managed within the services. Training is being developed by their manager relating to waiting list clock being stopped.

Implementation of Care:

- PCS are currently reviewing their care pathways which are being done in consultation with staff and as part of the mobilisation of the contract. Each case is looked at to identify whether this is a training issue – we have in response begun a skills and drills programme where any member of staff can come and 'update' their competency.

Information Governance:

- Work is being undertaken and training provided to local admin staff to ensure correct patient record identified before letters and referrals produced.

Accidents that may result in personal injury:

- There have been a number of incidents relating to sharps with both experienced staff and students. Staff are reminded of safe practice and disposal of sharps with peer review. Student mentorship package adjusted, and service specific poster updated.

Clinical Judgement/Treatment:

- There are a number of initiatives undertaken by services such as: Meet with individual staff concerned and discussed any issues and identify any learning needs. Shared the learning from a serious incident at a team brief and shared the action plan. Revised information given to patients prior to a procedure regarding use of analgesia.

Slips, trips, falls and collisions:

In the business unit most falls incidents are report in the CNRS due to the nature of the client group. In most cases these are unwitnessed falls whilst patient in own home environment. If a specific investigation has highlighted an issue or process issue then specific learning is shared at team meetings.

3. Children's Business Unit

Note: The top 3 subjects for a complaint to the CBU remain unchanged from Q1 and Q2. Access, appointment, admission, transfer and discharge are also the highest reported reason for PSIs, reported by staff. This replaces abuse, violent, disruptive or self-harming behaviour as the top category for PSIs.

- The CBU is committed to ensuring effective and timely access to clinical services, this being a priority within the LCH Children's Strategy. CBU services are sharing learning on how to manage waiting lists even better, for example;
- CSaLT sharing the lessons learnt and methodology of the Waiting List Initiative which has resulted in waiting lists being reduced to 12-14 weeks.
- CAMHS new models of service will impact waiting times along with specific initiatives to manage Autism Spectrum Condition [ASC] waiting lists. This work is being shared across services as part of the implementation of Strategic Objective 1: Agree and develop fully integrated pathways for children and young people [LCH Children's strategy].
- Improving current service specific Single Point of Access [SPAs] systems and processes especially in health visiting, our newest service specific SPA with the highest reported incidents related to Access, Appointment, Admission, Transfer, Discharge [27] and information governance [9]. The learning and improvements are being shared as part of the organisations Administration Review and the goal of the development of a single LCH

Children's Services SPA, ensuring parents and young people are able to access consistent approaches and the one contact point for all services, as described in the unit's business plan.

- The development of improved information and communication systems with parents and young people for example service leaflets and exploration of self-help materials, apps and links to local authority web based platforms. Additionally the learning from feedback and incidents is core to the development of a LCH Children's Services web page, one of the units key patient experience priorities.
- Increased provision of rapid access clinics and nurse led services as part of ICANs contribution to the unit's pathways development increasing capacity, leading to a more responsive service for children and young people.

Clinical Judgement

Learning from complaints and incidents are shared as part of 1:1 developmental reviews with named practitioners and their appraisal. Clinical supervision is in place with 80% of practitioners across the business unit reporting having supervision every 4 months, meeting the organisations target. Supervision provides an opportunity for practitioners to review clinical judgement in a safe and learning environment.

Team meetings across services have incorporated space to discuss and share learning locally, report incidents and learning within the Quality and Performance framework and transferable learning is shared across the business unit. Quality improvements supporting clinical judgement have included:

- safety huddles in Hannah House
- revising of SOPs in Healthy Child Programme services around transfer in processes
- use of skin mark template on SystmOne by services across Children's Community Nursing Services
- documentation audits, in relation to care plans
- use of health coaching and restorative practice approaches when working with children and families

Wider learning will be incorporated into the development of Business Unit pathways as part of implementation of the Children's Strategy.

Staff health and wellbeing remains a priority across children's services, with managers and clinical leads promoting the Trusts behaviours and supporting staff in maintaining emotional health and wellbeing. This was a key outcome of the units December 2017 celebration event showcasing clinical expertise.

Attitude, conduct, cultural and dignity issues

The Business Unit actively promotes personalised care, endorsing working "with" approaches in line with Child Friendly Leeds models of working. The unit has developed 3 key patient experience priorities for 2018/19;

- Website development specifically for the unit
- Development and establishment of a youth board
- Take over day activities for November 2018

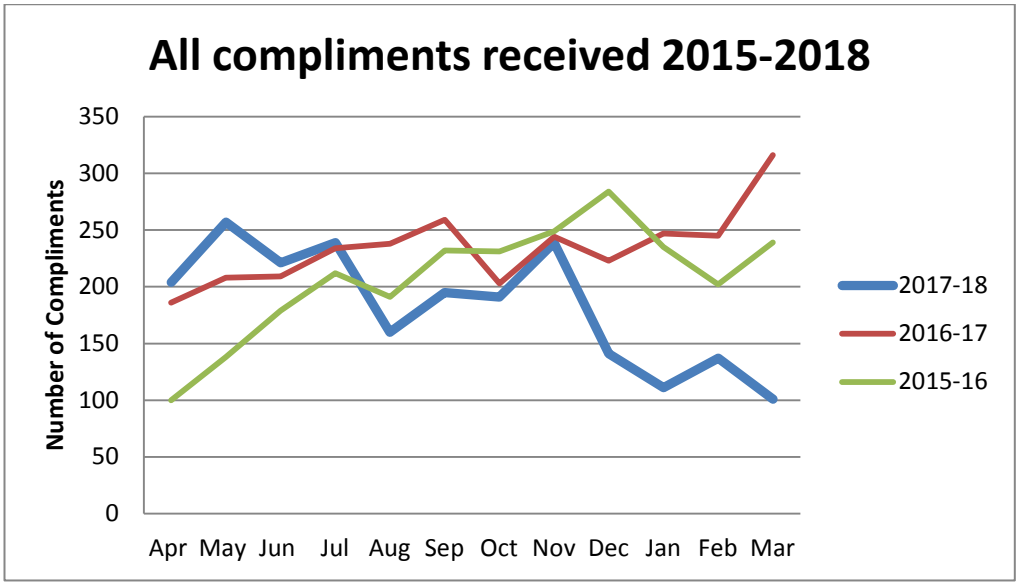
Attitude, conduct, cultural and dignity issues are also discussed in 1:1s and team meetings alongside clinical judgement learning.

Staff have undertaken equality and diversity training and bespoke unconscious bias sessions in teams.

Appendix 2: Compliments received by LCH services in 2017-18

The charts below provide further detail about the compliments received by LCH services in 2017-18.

a) The number of compliments received by LCH over three years:

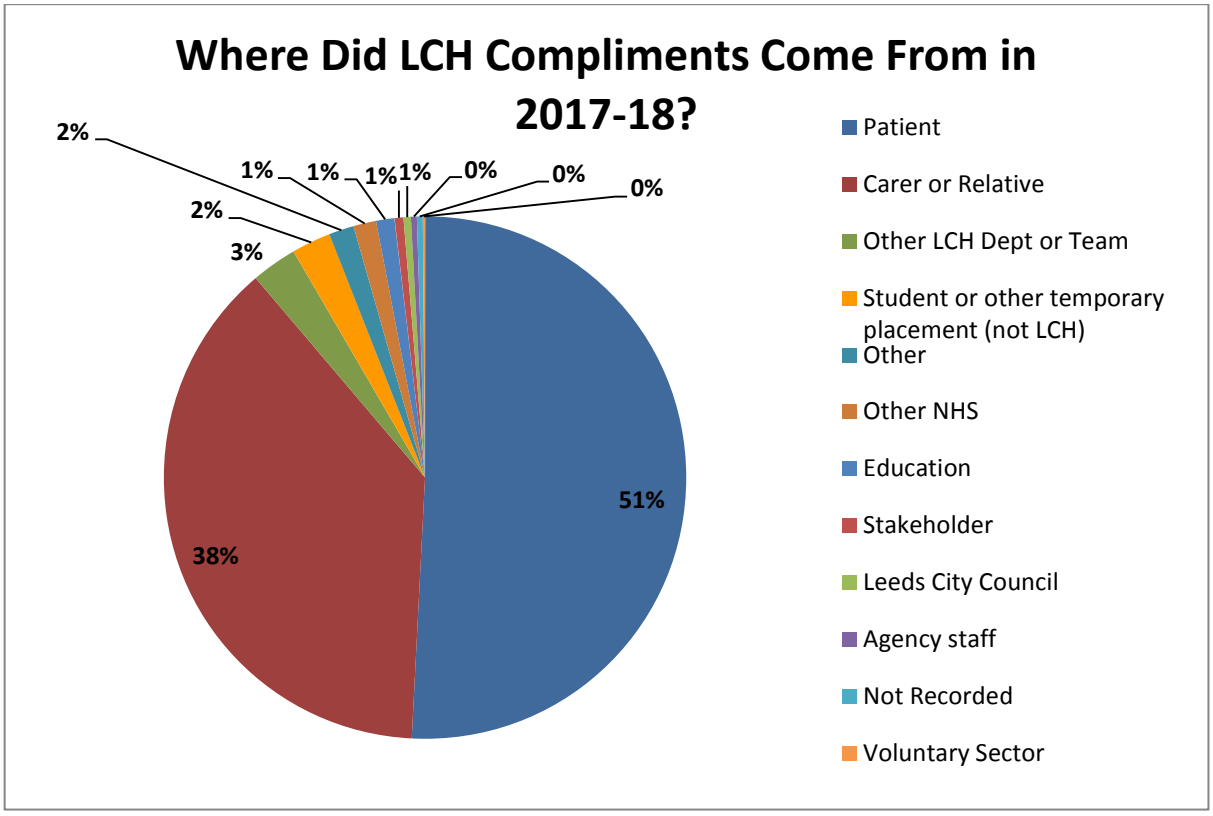


Compliments Received	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2017-18	204	257	221	239	160	195	191	239	141	111	137	101	2196
2016-17	186	208	209	234	238	259	203	244	223	247	245	316	2812
2015-16	100	138	179	212	191	232	231	249	284	235	202	239	2492

b) Compliments received by each Business Unit in 2017-18

2017-18	Compliment (or positive comment)
Adult Services	522
Children's Services	942
Specialist Services	571
Operational Support Services	36
Corporate & HQ functions	90
No Data	35
Total	2196

c) A breakdown of who provided the compliments LCH received in 2017-18?



Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (12)

Meeting: Trust Board 25 May 2018	**Category of paper**	
Report title: Annual Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director: Executive Medical Director **Report authors:** Guardian for Safe Working Hours	**For assurance**	✓
Previously considered by: Quality Committee 21 May 2018	**For information**	

Purpose of the report

This document provides a report on issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

Main issues for consideration

- This report covers the period from July 2017 to April 2018.
- In this period, Dr Turlough Mills was appointed as Guardian for Safe Working Hours in October 2017. Graham Dunn retired from Human Resources in March 2018.
- There has been one exception report in this time, submitted by a paediatric trainee. Actions to resolve issues raised are detailed in this report.
- There are gaps on the CAMHS specialty trainee rota from April 2018.

Recommendation

The Board is recommended to:

- Note the Guardian for Safe Working Hours annual report.

ANNUAL REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING

1. Introduction

This report, as required by the Junior Doctor's contract, is intended to provide the Board with an evidenced based report on the working hours and practices of Junior Doctors within the Trust, confirming safe working practices and will illustrate areas for concern. This report is written with the information available relating to data to date in the period covered.

Purpose: to report on issues affecting trainee doctors and dentists such as working hours and the accessibility of training which forms part of the rotational training programme.

2. High level data

Number of doctors / dentists in training (total): 23

Number of doctors / dentists in training employed by LCH 9

3. Annual data summary

Trainees within the Trust (May 2018)

Department	No.	Grade	Status
Adults	2	STs	Employed
CAMHS	4	STs	Employed (fulltime)
	7	CTs & FYs	Honorary
Community Paediatrics	2	STs	Employed
	6		Honorary
Sexual Health	1	ST	Employed
Dental Services	2	CTs & FYs	Honorary

4. Exception Reporting

1 report raised.

4.1 Working Hours

No exception reports raised relating to working hours in this period.

4.2 **Educational Opportunities**

One exception report raised by a paediatric trainee relating to using annual leave to complete administrative tasks, including attending supervision.

Action points:

Clinical supervisors have been contacted to request that exception reports be considered weekly in supervision.

The paediatric timetable is now under review.

5.0 Rota Gaps

5.1 **Out of Hours on call rota gaps in CAMHS**

From April 2018, there are regular rota gaps in the CAMHS 2nd on call rota.

The trust is attempting to cover these gaps as locum shifts, using both existing and external workforce. This is part of a longer term plan to develop a "bank" of suitable doctors, to safeguard against future rota gaps.

6. Guardian for Safe Working Hours

6.1 Dr Turlough Mills was appointed in October 2017.

7.0 GSWH Data Report

7.1 Fines

No fines have been levied by the GSWH.

8.0 Recommendation

The Board is recommended to:

- Note the Guardian for Safe Working Hours annual report.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018/19 12.5

Meeting: Trust Board 25 May 2018	**Category of paper**	
Report title Progress on CAMHS Tier 4 development and approval of fees	**For approval**	√
Responsible director: Executive Director of Finance and Resources **Report author:** Executive Director of Finance and Resources	**For assurance**	
Previously considered by : Business Committee, 23 May 2018	**For information**	

Purpose of the report

Approval is sought from the Trust Board to commit an estimated £1.5m of fees and associated development costs to take the CAMHS Tier 4 development to Full Business Case.

Main issues for consideration

If the scheme is approved and proceeds these costs will be met from the £13m successfully bid for. However, if the scheme is not deliverable for whatever reason these costs may be abortive and have to be met from the Trust's own revenue resources.

The report sets out an indicative timescale and the project arrangements overseeing the scheme.

Recommendation

The Board is asked to recommend to the Board that £1.5m is committed to the fees and development costs to take the CAMHS Tier 4 development to Full Business Case.

Progress on CAMHS Tier 4 development and approval of fees

1. Background

The existing 8 bed inpatient accommodation at Little Woodhouse Hall has been criticised in recent CQC reports and the Trust has been seeking suitable alternative accommodation for the service currently in Little Woodhouse Hall since 2016.

The nationally commissioned CAMHS Tier 4 review in 2014, identified significant challenges for children and young people accessing a range of CAMHS Tier 4 specialised services as close to home as possible. The review mapped the current capacity against local need and demand and concluded that there was insufficient capacity in some areas and that there was an immediate need to increase short term bed capacity for general CAMHS Tier 4 services. In 2017 NHS England, the commissioner of CAMHS Tier 4 services, identified and confirmed a model for 18 general and 4 PICU beds within West Yorkshire.

NHS England commissioned a review of options for the site of a unit to meet these requirements and concluded that the Leeds and York Partnerships NHS Foundation Trust owned St Mary's Hospital in Leeds was their preferred site.

The West Yorkshire and Harrogate Health Care Partnership supported a £13m bid for additional capital resources from the Department of Health and Social Care to fund the building of a new inpatient unit as its number one priority in November 2017 and this bid was successful.

Key benefits include:

- New purpose built 22 bed accommodation, which aims to minimise clinical risks and enhance patient and staff experience
- Creates 4 specialist CAMHS psychiatric intensive care unit beds locally
- Increases the provision of local generic CAMHS beds from 8 to 18 thereby avoiding the need for so many Children and Young people from Yorkshire and the Humber to be placed out of area
- Supports the new care model approach, where inpatient beds are utilised effectively and only as necessary
- Utilises existing NHS land on a site that has no long term NHS use, keeping a community asset in the location

The Trust has been engaged in setting up the project to deliver a new unit at St Mary's Hospital, confirming scheme approval routes with NHS England and NHS Improvement and making early contact with Leeds planning officers.

2. Timetable

The high level proposed timetable of activities on all aspects of the project from now until when the Trust Board can expect to receive the full business case (FBC) in February 2019 is set out in Annex 1.

3. Financial Assumptions

The funding for the new 22 bed building has been allocated on the assumption that the Trust will be able to build the new unit within the financial envelope of £13m. Current estimates at this early stage of development indicate this may not be deliverable.

There are options for closing this gap which include utilising some of the Trust's existing capital resource limit or in partnership with Leeds and York Partnership NHS Foundation Trust who have more flexibility as an FT.

The Trust does not currently provide CAMHS PICU services and a bed day rate for these services will need to be agreed with NHS England commissioners. It is assumed that given the commissioner support to date for the capital scheme that a suitable bed day rate will be agreed.

The existing general CAMHS bed day rate does not cover the cost of the current service provision; however the poor building design and low bed numbers mean that the service has dis-economies of scale and staffing inefficiencies.

The Trust is confident an affordable model is achievable and this will be demonstrated in the FBC.

4. Indicative Costs to FBC

The indicative costs to take the project through phase 1 to the completion of the full business case total £1.5m. An indicative split was provided to the Business Committee and is available to Board members on request.

If the scheme is approved and proceeds these costs will be met from the £13m successfully bid for. However, if the scheme is not deliverable for whatever reason these costs may be abortive and have to be met from the Trust's own revenue resources.

5. Project Management Arrangements

The project has a formal project management structure in place in line with good practice. The project is led by an experienced senior project manager on secondment from a neighbouring Trust. The project structure is included at Annex 2.

6. Procurement Method

The preferred procurement route is Procure 22. This will require the Trust to appoint a Procure 22 partner. This route is the preferred option as it:

- Should be the quickest method of achieving the new building
- Is a long standing, proven and DH&SC approved method of procuring buildings
- Is cost effective
- Negates the need for in-house specialists
- Provides certainty around the guaranteed maximum price, and
- Offers the opportunity for gain share arrangements to incentivise the contractor.

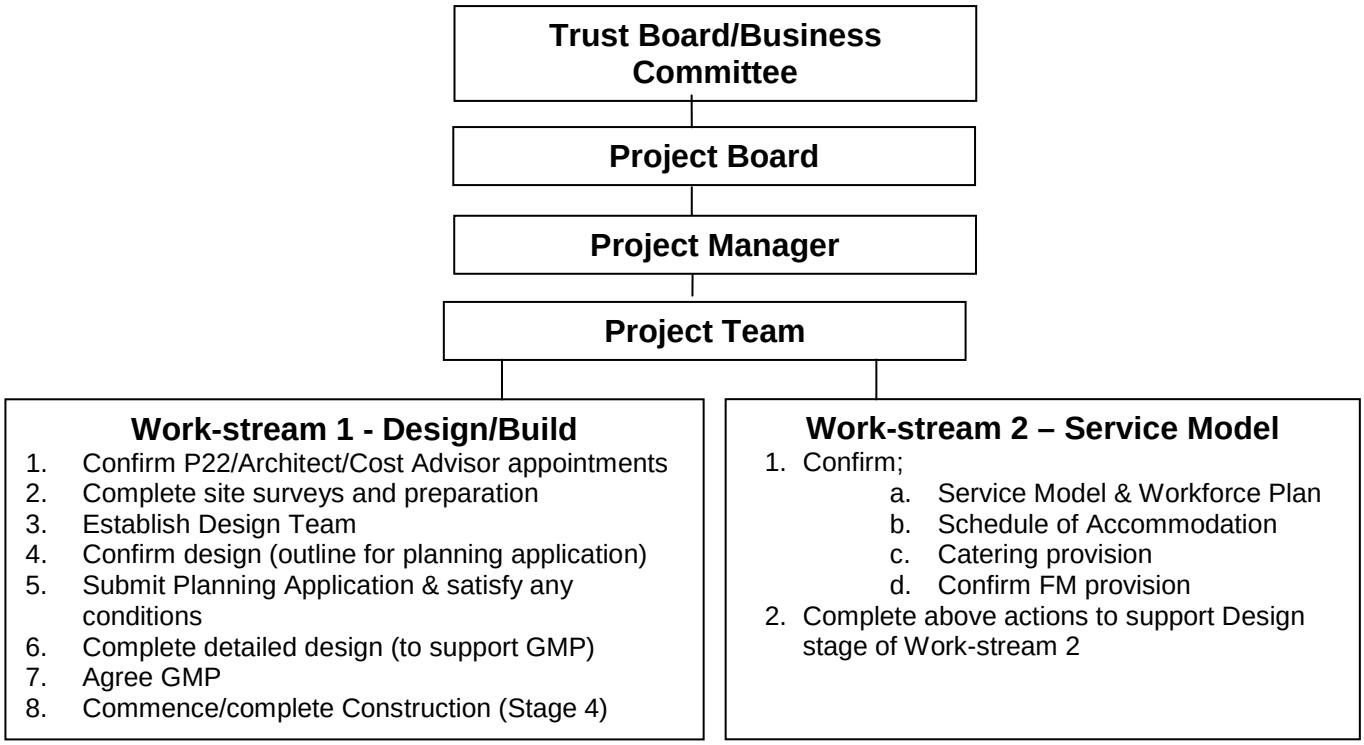
7. Recommendation

Approval is sought from the Board to commit up to £1.5m capital spend in the full understanding that if the scheme is not deliverable for whatever reason these costs may be abortive and have to be met from the Trust's own revenue resources.

Project Timescale to Full Business Case

Phase 1 Activity	**Detail**	**Timeline**
Building Design	Site appraisal & development plan	May
	Site acquisition	May
	Appoint architects	May
	Appoint procure 22 partner	May/Jun
	Develop scheme design	May/Jun
	Planning process	Jun/Aug
	Develop GMP	Jun/Nov
Develop Service Model	Review current service model	May
	Complete activity schedules	May
	Undertake site visits	May
	Complete schedule of accommodation	May
	Develop workforce model	June
	Confirm hotel services & FM	Jun/Nov
Communications	Develop communications strategy	May
	Engagement to support design etc	May/Nov
Full Business Case	Business Committee	Jan 2019
	Trust Board	Feb

Project Structure and Board and Team Membership



NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (13)

Meeting: Trust Board 25 May 2018	**Category of paper** *(please tick)*	
Report title: Significant risks and Board Assurance Framework (BAF) report	**For approval**	
Responsible director: Chief Executive **Report author:** Risk Manager	**For assurance**	√
Previously considered by: N/A	**For information**	

Purpose of the report:

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

The report provides Trust Board with the current risk profile. It details the Trust's risks currently scoring 15 or above, after the application of controls and mitigation measures. It provides an analysis of all risk movement, presents the risk profile, identifies themes, and links these material risks to the strategic risks on the Board Assurance Framework (BAF).

The Board Assurance Framework (BAF) summary advises Trust Board of the current assurance level determined for each of the Trust's strategic risks.

Main issues for consideration:

There are four risks currently scored as 'extreme', including two new risks:

- Risk 939 New CAMHS Tier 4 building
- Risk 940 Risk of delays to new CAMHS Tier 4 service model

The risks on the risk register (both clinical and non-clinical risks) have been interrogated for this report. The strongest theme continues to be about capacity: sickness absence, vacancies, retention of staff in a competitive market, and not meeting demand for service (referral rates).

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by SMT, committees, and the Board.

Recommendations

The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary

SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Introduction

1.1 This report, which is presented at Senior Management Team (SMT) monthly, and every two months to the Board provides an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures. The report also provides a description of risk movement since the last risk register report was presented to Trust Board in March 2018

1.2 The paper also provides a section detailing risks scoring 12. Whilst these do not meet the definition for inclusion in the risk register extract reported to SMT and the Board, they have been detailed as they evidence those matters of high risk and are scrutinised closely by SMT and the Board. In addition, there is a short summary of those risks scoring 8 or above, which are reported at the Quality Committee or Business Committee at each meeting.

1.3 The Board has previously agreed to the reduction in the number of in-depth risk register reports. Summary reports are received on a frequent basis, which alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report (such as this one) is received on a less frequent basis, and describes and analyses all risk movement, the risk profile, themes and risk activity.

1.4 The risk register has been analysed for this in-depth report and themes have been identified, which link these material risks to the strategic risks on the Board Assurance Framework (BAF).

1.5 This paper provides a summary of the current BAF and an indication of the assurance level that has been determined for each strategic risk.

2.0 Background

2.1 Risks showing a current score of 15 or above (extreme) are reported to the Trust's Board at each meeting. Prior to Board scrutiny, the Senior Management Team (SMT) consider and moderate the risks at 15 and above (monthly). SMT also receives a summary of risks graded 12. In exceptional circumstances, a director can request inclusion of any risk onto the register received by the Board.

2.2 The Board Assurance Framework (BAF) is a significant tool in helping the Board hold itself to account, understand the implementation of strategy and the risks that might impede delivery of its strategy and brings together:

- The Trust's strategic goals as set out in the Trust's longer term plans, its annual operational plan and the strategic priorities of business units
- Strategic risks that might prevent the Trust from meeting its strategic goals and corporate objectives; their causes and effects
- Controls and sources of assurance in place to manage risk and so support the delivery of those goals and objectives
- Actions to remedy gaps in controls or assurances

3.0 Summary of current risks scoring 15 or above

3.1 There are four risks with a current score of 15 (extreme) or above on the Trust risk register as at 4 May 2018. These are as follows:

Table 1 Extreme risks (scoring over 15)

Risk ID	Risk description	Risk score	Risk movement
Risk 224	*Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.*	16 (extreme)	
Risk 872	*Difficulties recruiting to and retaining staff within neighbourhood teams.*	16 (extreme)	
Risk 939	*New CAMHS Tier 4 building*	16 (extreme)	**NEW**
Risk 940	*Risk of delays to new CAMHS Tier 4 service model*	16 (extreme)	**NEW**

3.2 Full details of these four extreme risks are given in **appendix 1** (extreme risks).

4.0 New or escalated risks scoring 15+

4.1 Since the last report to Trust Board in March 2018, there have been two new risks scoring 15 or more.

Risk 939	Initial risk score **16**	Current risk score **16**	Target risk score **8**
Risk description: New CAMHS Tier 4 Building The Trust has been allocated £13m of public sector capital to deliver a new CAMHS Unit for 22 beds on the St Mary's Hospital site. There is a risk that the cost of the Unit cannot be contained within the £13m risking delivery of the Unit in the required timescale and requiring the Trust to identify other sources of funding that could compromise other plans. **Controls in place:** Project Board **Actions include:** Business Case to be submitted to the Board in June 2018			
Risk 940	Initial risk score **16**	Current risk score **16**	Target risk score **4**
Risk description: Risk of delays to new CAMHS Tier 4 Service Model The CAMHS Tier 4 service is currently designed to provide 8 beds at Little Woodhouse Hall. The service needs to plan to provide a service to 18 general and 4 psychiatric intensive care beds from the opening of the new building in late 2019. The risk is that an affordable service model has not been designed and recruited to in time. **Controls in place:** Project Board **Actions include:** Service model to be designed Recruitment strategy required			

4.2 There have been no risks escalated to 15 or more.

5.0 Closures, consolidation and de-escalation of risks scoring 15+

5.1 Since the March 2018 report, there have been no closed risks previously recorded at 15 or above.

6.0 Summary of risks scoring 12 (high)

6.1 High risks (scoring 12)

6.1.2 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by Trust Board is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

6.1.3 The table below details risks currently scoring 12 (high risk). There are no new risks added to this list. 4 risks have been closed and 2 risks have been deescalated below 12 since January 2018.

Table 2 High risks (scoring 12)

ID	Description	Rating (initial)	Rating (current)	Rating (Target)
924	CCG Plans to decommission £1.5m of services.	12	12	2
874	Sickness levels - Neighbourhood Teams including Neighbourhood Night Nursing Service.	12	12	6
875	Children's Community Dysphagia Service capacity to manage increased number and complexity of referrals.	16	12	3
913	Increasing numbers of referrals for complex communication assessments in ICAN service risks breaching waiting time target.	15	12	3

7.0 Summary of all risks currently scoring 8 or above

7.1 The following sections aim to apprise the Board of risks with a current score of 8 (after the application of controls and mitigations) or above.

7.2 At present, the Trust's risk register comprises of 34 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate and headquarters functions. This is the same number of risks when compared with 34 risks on the previous report.

7.3 Risks scoring 8 or above

7.3.1 The chart below shows the number of risks by area of the business, logged on the Trust's risk management database (Datix) as at 4 May 2018

Table 4 risks by area of the business

Directorate	Risks scored 8-12 High	Risks scored 15+ Extreme	Totals by directorate
Adult BU	5	1	**6**
Children's BU	12	1	**13**
Specialist BU	5	0	**5**
Operational Support Services	1	0	**1**
Corporate & HQ functions	7	2	**9**
Totals by risk severity	**30**	**4**	**34**

8.0 Current risks scoring 8 or above by theme

8.1 For this report, the current material (the 'here and now') risks have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a more holistic view of the higher level risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

8.2 Themes within the current risk register are as follows:

- Three risks relate to staff absence (absence due to sickness and maternity leave)
- Four risks concern vacancies, including difficulties recruiting staff to posts, problems in the recruitment process.
- Two risks are about the high turnover of staff
- Three risks relate to demand and capacity (high numbers of referrals, complex referrals)
- Two risks relate to cyber-attacks on LCH systems
- Two risks relate to commissioning decisions
- Two risks relate to the new CAMHS building

These themes links to the following BAF strategic risks:

- Risk 2.2 delivery of contracted activity requirement
- Risk 2.4 retain existing viable business and/or win new financially beneficial business tenders
- Risk 3.1 suitable and sufficient staff capacity and capability
- Risk 3.2 the scale of sickness absence

The emergence of material risks could mean that the controls in place on the Board Assurance Framework to manage strategic risks are not sufficiently robust. SMT has reviewed the controls for BAF risks in April 2018, as part of its annual BAF review.

9.0 Risk profile - all risks

9.1 There are 19 open clinical risks on the Trust's risk register and 46 open non-clinical risks. The total number of risks on the risk register is currently 65. This is a decrease compared to the 72 risks reported in the previous in-depth risk register report. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Table 7 Risk profile across the Trust.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	0	0	0	0
4 - Major	0	5	2	4	0	11
3 - Moderate	2	15	21	2	0	40
2 - Minor	0	4	10	0	0	14
1 - Negligible	0	0	0	0	0	0
Total	2	24	33	6	0	65

10.0 Board Assurance Framework Summary

10.1 The purpose of the BAF is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively.

10.2 Definitions:

- Strategic risks are those that might prevent the Trust from meeting its strategic goals and corporate objectives
- A control is an activity that eliminates, prevents, or reduces the risk
- Sources of assurance are reliable sources of information informing the Committee or Board that the risk is being mitigated ie success is been realised (or not)

10.3 Directors maintain oversight of the strategic risks assigned to them and review these risks regularly. They also continually evaluate the controls in place that are managing the risk and any gaps that require further action.

10.4 SMT, the Quality and Business Committees, and the Board review the sources of assurance presented to them and provide the Board (through the BAF process) with positive or negative assurance.

10.5 The BAF summary **(appendix 2)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board, in line with the risk assurance levels described in **appendix 3** (BAF risk assurance levels).

10.6 Since the last BAF summary report in March 2018, the current level of assurance for the following BAF risks has been adjusted as follows:

Positive movement (indicating an improved situation)

- BAF risk 2.1 (achieve principal internal projects) has received reasonable assurance for the admin review project and substantial assurance for the EPR project. Only limited assurance was received for the E-rostering project
- BAF risk 2.4 (retain existing viable business and/or win new financially beneficial business tenders) received reasonable assurance as good progress is being made against the 3 high-level priorities

Negative movement (indicating a worsening situation)

- No strategic risks have any negative movement

11.0 Risk management activity

11.1 An interim risk manager has been appointed to ensure that risk management continues to be integral to the organisation.

11.2 A risk management 'health check' survey of service managers, clinical leads and operational leads, was carried out in December 2017 in response to the CQC inspection report. The results of the survey have been collated and presented to the Risk Review Group on the 19 April 2018.

The aim of the survey was to:

- Determine whether risk management procedures were broadly understood across all areas of the Trust
- Identify risk management strengths and weaknesses within the services.

The results revealed that over half of service managers who returned the questionnaires were:

- not familiar with the risk appetite statement;
- had not attended the risk management training;
- not confident when updating the risk register;
- not including 'risk' as an agenda items at their team meetings.

An action plan has been developed to address the findings, additional guidance and sign-posting documents have been circulated to managers, and discussions are taking place within the individual business units at a senior level to address these areas.

A training session is scheduled to be delivered to the children's business unit service managers in May 2018.

Risk extraction training is being organised for the operations support team so that they can provide the reports required for team meeting discussions.

11.3 Support in completing risk assessments continues to be provided to staff to add risks to the risk register.

New staff receive an overview of risk management within LCH at the induction sessions.

11.4 Readership of Risky Business continues to increase, feedback regarding its contents has been positive. Articles in the recently published spring 2018 edition included:

- Examples of incorrect assumptions about medication
- An awareness of first aid training and request for volunteers across all areas
- The need for strong passwords to prevent computer hacking
- How to prevent aches and pains through Display Screen Equipment assessments.
- A reminder of how to avoid needle stick injuries

12.0 Impact

12.1 *Quality*

12.1.1 Risks recorded on the Trust's risk register are regularly scrutinised to ensure they remain current. Risk owners are encouraged to devise action plans to mitigate the risk and to review the actions, risk scores and provide a succinct and timely update statement. There are no known quality issues regarding this report.

12.2 Resources

12.2.1 Any financial or other resource implications are identified and managed by the risk owner/lead director responsible for individual risks.

12.3 Risk and assurance

12.3.1 This paper seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Evidence that risks are proactively identified and managed in the Trust can be seen in the shifting profile of the risk register, with new risks being added and subsequently updated, risk scores amended and risks being closed.

13 Next steps

13.1 A number of developments are planned to ensure that the Trust's risk management framework continues to mature.

13.2 The Risk Manager will continue to monitor risk review dates and remind risk owners of their responsibility to review and update risks appropriately.

13.3 The improvement plan formulated to address the risk management comments and recommendations made by the CQC in their inspection report continues to be actioned.

14.0 Reporting schedule

14.1 Set out below is the risk register and BAF reporting schedules to which this report conforms:

Risk register reporting schedule

		Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Meeting type	RRG		FULL		FULL		FULL		FULL		FULL		FULL
	SMT	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY
	QC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	BC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	Board		FULL		SUMMARY		FULL		SUMMARY		FULL		SUMMARY

FULL	= in depth report
Summary	= snapshot report
	= information flow

BAF reporting schedule

		Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Meeting	SMT	Summary		Summary		Full		Summary		Summary	Mid-year review	Summary	
	QC/BC					Full (extract)					Mid-year revised		
	AC				Summary			Full					Full
	Board		Summary		Summary		Summary		Summary		Summary		Summary

Full	= Complete BAF
Summary	= BAF overview
Mid-year review	= Mid-year review
	= Information flow

15.0 Recommendations

15.1 The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary

Significant risks (15+)

Appendix 1

ID	Risk Owner	Director	Opened	Description	Controls in place	Adequacy of controls	Latest update	Risk level (initial)	Rating (initial)	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Review date
Lead Directorate: Finance and Resources														
Portfolio: Corporate & HQ functions														
NEW RISK 939	Machin, Bryan	Machin, Bryan	03/05/2018	title: New CAMHS Tier 4 Building The Trust has been allocated £13m of public sector capital to deliver a new CAMHS Unit for 22 beds on the St Mary's Hospital site. There is a risk that the cost of the Unit cannot be contained within the £13m risking delivery of the Unit in the required timescale and requiring the Trust to identify other sources of funding that could compromise other plans.	Project Board. Business case to Board in June	Adequate		Extreme	16	Extreme	16	High	8	08/06/2018
Lead Directorate: Operations														
Portfolio: Adult Services														
872	Rowlands, Megan	Prince, Sam	23/11/2016	Title: Difficulties recruiting to and retaining staff within neighbourhood teams. There is a high turnover of staff within neighbourhood teams. There is a risk of not having enough staff capacity to meet the demands on the service, a risk of missed visits / delayed appointments impacting on patient safety, a risk of having a less experienced and reduced workforce causing additional pressures on remaining staff, which will impact on staff wellbeing, a risk of a reduced offer impacting on activity levels and finances, and on ability to release staff for skills and competency training. There is a particular risk and impact where there are issues with recruitment and retention of senior clinical staff who provide leadership as well as direct clinical care.	Management reports in each service area. Oversight at weekly Ops meeting, monthly Performance Panels and weekly at SMT Establishment Control process Service specification plans in place Weekly management consideration of workload. Support with prioritisation. Movement of staff between teams to offer more balanced capacity. Proactive recruitment plan in place Rolling recruitment and focused recruitment events Team coaching in place to support local leadership team with issues relating to staff morale Key clinical skills training matrix and enhanced training support in place Sourcing short term support via CLASS	Adequate	Actions continue: Sourcing short term support via CLASS continues. Subcontract in place from November 2017 supporting five NTs with additional capacity over winter= now extended to end June 2018. Future options being considered in discussion with SMT. Rolling recruitment and focused recruitment events for community staff nurses - successful in recruiting additional staff. improved fill rate for community staff nurses due to new starters progressing with induction and preceptorship - time delay to be fully confident and competent to deliver full range of duties. Lack of capacity continues to impact on service delivery. Turnover remains relatively high. Considering skill mix options to support delivery. Ongoing action required to reduce risk rating. (Updated 29/03/2018)	Extreme	20	Extreme	16	Low	3	31/05/2018

Portfolio: Children's Services														
NEW RISK 940	Prince, Sam	Prince, Sam	03/05/2018	Title: Risk of delays to new CAMHS Tier 4 Service Model The CAMHS Tier 4 service is currently designed to provide 8 beds at little Woodhouse hall. the service needs to plan to provide a service to 18 general and 4 PICU beds from the opening of the new building in late 2019. The risk is that an affordable service model has not been designed and recruited to in time.	Project Board	Limited		Extreme	16	Extreme	16	Medium	4	29/06/2018
Lead Directorate: Workforce														
Portfolio: Corporate & HQ functions														
224	Hobson, Ann	Hobson, Ann	01/01/2012	Title: Prevalence of staff sickness: Due to current high levels of staff sickness absence across the Trust, there is a risk of greater reliance on agency cover and a risk of remaining staff being under pressure to manage an additional workload. The impacts are the financial cost of agency cover and an effect on staff morale and wellbeing	Regular monthly reporting by individual team to managers.Monthly discussion of absence by teams at business unit performance meetings.Monthly discussion of absence by Business unit at operational performance meetings, SMT, Business Committee and Board.Health and wellbeing team in place to support managers. Greater scrutiny within business units re compliance with return to work interviews. New Managing Attendance Policy.	Limited	Sickness absence continues to be closely monitored on a monthly basis at the Business Committee. Additional elements being explored include, a review of compliance with the sickness absence policy, an analyst reviewing the information at a very granular detail and review of staff survey results around this area. the Trust continues to promote staffs health and wellbeing. Whilst sickness absence levels have reduced slightly, there is not sufficient trend to lower the risk level at this time. (updated 06/04/2018)	Extreme	16	Extreme	16	Medium	6	28/06/2018

Board Assurance Framework (summary) 2018-19

Appendix 2

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score									
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	Current Level of Assurance (denoted by ◆). No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	MP	QC	4	4	16	⟺			◆		Quality Committee received only limited assurance as there was no evidence presented of the number of completed clinical audits.	
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships.	MP	QC	2	4	8	⟺				◆	Quality Committee received an update on Hannah House. Whilst some improvements are being made, the service has received two recent complaints. The Committee was only provided with limited assurance by this information. The mortality surveillance update report provided reasonable assurance on progress being made.	
	RISK 1.3 If the Trust does not maintain and continue to improve the quality of all services, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	MP	QC	2	3	6	⟺				◆	The Quality Improvement Priorities quarter four progress report received reasonable assurance from Quality Committee. The actions completed in the first year of the Quality Strategy provided reasonable assurance, although the Quality Committee thought the actions could be smarter.	
	RISK 1.4 If the Trust does not achieve external and internal quality priorities and targets then this may cause damage to reputation and loss of income.	MP	QC	3	2	6	⟺			◆			
Provide sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects (integrated neighbourhood teams, EPR, E-rostering) then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	3	4	12	⟺			◆		The Business Committee heard how the admin review project is on track, providing reasonable assurance. EPR presentation to Business Committee provided substantial assurance about the benefits being realised. E-rostering continues to provide limited assurance whilst awaiting the project initiation document.	⇒
	RISK 2.2 If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	4	3	12	⟺			◆			
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of accurate performance information, then it may fail to retain a competitive market position.	SP	BC	3	4	12	⟺				◆		
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12	⟺				◆	Business development update to Business Committee provided reasonable assurance that good progress was being made against the 3 high-level priorities.	⇒
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8	⟺				◆	Business Committeee recognised that the Trust has met or exceeded all of its financial targets for the year.	

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	AH	BC	4	4	16						Quality Committee was reasonably assured by the Professional Strategy update which described the progress made against its aspirations. Business Committee was provided with an update on the OD strategy, and plans to remedy recruitment issues. This update, whilst helful, provided only limited assurance.	
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	AH	BC	4	4	16						Business Committee recognised a number of measures were in place to try improve sickness levels, however the forecast is 'red', therefore it only offered limited assurance.	
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	4	3	12							
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing .	SP	BC	3	3	9							
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC	3	3	9							
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	3	4	12							
	RISK 4.3 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage.	MP	QC	2	3	6							
	RISK 4.4 If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered.	TS	BC	3	3	9							
	Risk 4.5 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships.	BM	BC	3	3	9						New strategic risk: no sources of assurance are currently being received at committee level.	

Appendix 3

Glossary- BAF risk assurance levels

Risk assurance levels	Definition
Substantial	Substantial assurance can be given that the system of internal control and governance will deliver the clinical, quality and business objectives and that controls and management actions are consistently applied in all the areas reviewed.
Reasonable	Reasonable assurance can be given that there are generally sound systems of internal control and governance to deliver the clinical, quality and business objectives, and that controls and management actions are generally being applied consistently. However, some weakness in the design and / or application of controls and management action put the achievement of particular objectives at risk.
Limited	Limited assurance can be given as weaknesses in the design, and/or application of controls and management actions put the achievement of the clinical, quality and business objectives at risk in a number of the areas reviewed.
No	No assurance can be given as weakness in control, and/or application of controls and management actions could result *(have resulted)* in failure to achieve the clinical, quality and business objectives in the areas reviewed.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (14)

Meeting: Trust Board 25 May 2018	**Category of paper**	
Report title: Corporate Governance Report	**For approval**	√
Responsible director: Chief Executive **Report author:** Company Secretary	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This paper covers a number of corporate governance requirements for consideration.

Main issues for consideration

The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust. In the main, these are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

Adherence to this governance framework enables the organisation to demonstrate it is well governed and meets the requirements of corporate governance codes.

In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met.

This paper covers a number of annual requirements, including:

- Board and Committees' effectiveness review (section 3)
- Audit Committee annual report 2017-18 (section 4)
- Committees' terms of reference review (section 5)
- Statement of NHS provider licence compliance (section 6)
- Amendments to standing orders and standing financial instructions (section 7)
- Details of use of the Trust's corporate seal (section 8)

Recommendations

The Board is recommended to:

- Note the outcome of the annual review of Board and Committees' effectiveness
- Receive the Audit Committee's annual report 2017/18
- Approve changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions
- Approve the revisions to the standing orders/standing financial instructions
- Ratify use of the corporate seal and to note content of the register of sealings

1 Purpose of the report

1.1 The purpose of the report is to provide a number of requirements for consideration on an annual or infrequent basis in relation to the effective corporate governance of the Trust.

2 Background

2.1 The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust.

2.2 In the main, these statutes, regulations and guidance are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

2.3 Adherence to this governance framework enables the organisation to demonstrate that it is well governed and meets the requirements of corporate governance codes.

2.4 In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met. This paper deals with a range of related assurances.

3 Annual review of Board and Committees' effectiveness

3.1 At all levels in the NHS, boards are encouraged to periodically review their own performance in order to build on strengths and to identify areas where there is room for further development in order to draw out the full benefits of the NHS unitary Board model.

3.2 The report at **Appendix A** provides a summary of the outcomes from an exercise to review the effectiveness of the non-executive and executive contribution to the Board, Board sub-committees and the wider Trust.

4 Committees' annual reports 2017/18

4.1 The terms of reference of the Trust's Audit Committee require that the committee has oversight of Board sub-committees annual effectiveness process and reviews the adequacy of the governance of the sub-committees. This assurance is given through the provision of an annual report from Board sub-committees to the Audit Committee.

4.2 In turn, the terms of reference for each committee require that the committee's chair submits an annual report to the Audit Committee which demonstrates how the committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and committee's work plan. The reports provide an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference.

4.3 At the Audit Committee on 20 April 2018, the annual reports for 2017/18 for the following committees were received:

- Quality Committee
- Business Committee
- Charitable Funds Committee
- Nominations and Remuneration Committee

4.4 Each report had been reviewed by the committee's chair and executive lead and by the relevant committee. The reports provided an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference. Sections within each annual report described:

- Duties of the committee
- Membership and attendance
- Review of committee's activities
- Review of effectiveness
- Areas for future development

4.5 In order to complete this cycle of review, the Audit Committee's annual report for 2017/18 is attached at **Appendix B** for receipt by the Board and demonstrates that the committee has operated in lines with its terms of reference and has undertaken a review of its effectiveness.

5 Committees' terms of reference

5.1 The Trust's Board has appointed five sub-committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically (as recorded in standing orders). In March and April 2018, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

5.1 The tables in **Appendix C** summarise the changes made in order to amend and update content (the changed text being shown in red). Once approved, an electronic version of the full amended document will be made available to Board members, managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

5.3 In order to reflect the best distribution of Board membership across the committees so that they are able to fully discharge their respective responsibilities, committee membership for 2018/19 is shown in the table below.

	Non-executive directors	Executive directors
Audit Committee	Jane Madeley (chair) Richard Gladman Prof Ian Lewis	
Quality Committee	Prof Ian Lewis (chair) Dr Tony Dearden Neil Franklin	Chief Executive Executive Medical Director Executive Director of Nursing
Business Committee	Brodie Clark (chair) Dr Tony Dearden Richard Gladman	Chief Executive Executive Director of Finance & Resources **Executive Director of Operations (change approved by Trust Board 31/03/2018)**
Charitable Funds Committee	Brodie Clark (chair) Neil Franklin	Executive Director of Finance & Resources Executive Director of Nursing
Nominations and Remuneration Committee	Neil Franklin (chair) Brodie Clark Jane Madeley	

5.4 In addition, the Quality Committee has a number of sub-groups, one of which, the Mental Health Act Governance Group, is chaired by a non-executive director; this function rests with Prof Ian Lewis.

6 Compliance with NHS provider licence: self-certification

6.1 The Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence. Although NHS trusts (which are not NHS foundation trusts) are exempt from holding the NHS provider licence (as required for foundation trusts), NHS Improvement is required to ensure that NHS trusts comply with the licence conditions as it deems appropriate. NHS Improvement's single oversight framework bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including condition G6 and condition FT4) and must self-certify under these licence provisions.

6.1 In particular, providers need to self-certify against the following two conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (condition **G6**) (self-certification required by 31 May 2018)
- The provider has complied with required governance arrangements (condition **FT4**) (self-certification required by 30 June 2018)

6.3 The document attached at **Appendix D** is a tabulation showing an assessment of compliance with the provider licence's conditions; including the two conditions (G6 and FT4) against which the Trust is required to self-certify. It should be noted that a limited number of conditions are not applicable as they apply to foundation trusts only.

6.4 When reviewing the document, the Board will note that the Trust is recording compliance against all applicable conditions.

7 Changes to standing orders, standing financial instructions and scheme of reservation and delegation of powers

7.1 NHS trusts are required to adopt standing orders and standing financial instructions and to establish a schedule of powers reserved to the Board and a scheme of delegation.

7.2 Standing orders and standing financial instructions are essential foundations for the good governance of the Trust and set out:

- Mechanisms for how the Trust Board conducts its business
- Decision making powers delegated from the Board
- Expectations of the Trust as to the conduct of individuals entrusted with public resources
- Principles and procedures that direct financial conduct

7.3 On 20 April 2018, a review of the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers was completed and reported to the Audit Committee. The Audit Committee noted and approved the amendments in line with the summary of changes. The table shown at **Appendix E** summarises the changes to be made in order to amend and update content.

8 Use of the corporate seal

8.1 In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. During 2017/18 the seal has been used on a small number of occasions. The details are contained within a copy of the register attached as **Appendix F.**

9 Recommendations

9.1 The Board is recommended to:

- Note the outcome of the annual review of Board and committees' effectiveness
- Receive the Audit Committee's annual report 2017/18
- Approve changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions
- Approve the revisions to the standing orders/standing financial instructions
- Ratify use of the corporate seal and to note content of the register of sealings

Leeds Community Healthcare NHS Trust
Reviewing Board and Committees' effectiveness

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the comments received from the review, by Board members, of the effectiveness of the non-executive and executive contribution to the Board, the Board's sub-committees and the wider Trust.

1.2 The sections below provide anonymised information gathered from a Board effectiveness diagnostic exercise and the conclusions from a Board effectiveness workshop held on 2 March 2018.

2.0 Background

2.1 By way of context, the purpose of NHS Boards is to govern effectively and in doing so to build patient, public and stakeholder confidence that health and health care is in safe hands *(The Healthy NHS Board 2013).* In meeting this purpose the Board has three key roles, to:

- Formulate strategy
- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of controls are robust and reliable
- Shape a strong culture for the Board and the organisation

2.2 The Trust Board reflects on an annual basis how non-executive and executive colleagues can further develop as a team to:

- Ensure strong and effective leadership at Board level and throughout the Board sub-committees
- Develop a culture of full and proper personal accountability
- Maintain a strategic perspective
- Ensure the Trust identifies the necessary operational changes to meet the quality and financial sustainability challenge
- Balance risk and opportunity
- Work in a partnership environment

2.3 Two questionnaires were completed by Board members; one related to Board effectiveness and the second was applicable to committees' effectiveness. The questionnaires comprised 20 statements grouped under the headings of *leadership and accountability* and *strategy development and operational delivery* (Board questionnaire) and *capacity, capability and ways of working* and *conduct of business and effectiveness of decision-making* (committees' questionnaire).

2.4 The questionnaires asked for ratings on a scale of 1 (strongly disagree) to 5 (strongly agree); plus narrative comment on opportunities for change. Responses in the questionnaires remain anonymous and have only been used to distil themes to facilitate discussion.

3.0 Board self-assessment: summary of responses

3.1 The Board scored itself highly on the following areas:

- The Board was assessed as being high quality, with a complimentary mix of members.
- The Board was regarded as 'well-led' with strong, visible leadership.
- There is an effective means of escalating issues from committees
- There is a strong grip on assurance that challenges (risks) to quality and financial objectives are being managed
- The Board demonstrate the Trust's values and behaviours in the conduct of its business

3.2 The Board had mixed feelings about some areas; however these areas generally scored highly:

- Whether the Board had achieved the right balance between operational and strategic and if discussion was sufficiently focused on the most strategic as opposed to operational issues
- If there sufficient focus on key topics – and should these be within Board meetings or in workshops?
- Whether all reports to the Board are easily understood, if they generally have sufficient analysis and proposals for solutions, which lead to an informed discussion at Board and if they provide sufficient early warnings. Board members (particularly non-executive colleagues) also indicated that there was often a considerable volume of data, without enough focused analysis and realistic and achievable actions.

3.3 The Board viewed the following areas as possible scope for improvement, as although these areas scored above average, they achieved the lowest scores:

- Promoting the Trust and engaging with external stakeholders and other organisations
- Keeping everyone up to speed with the ever-changing bigger picture and ensure strategies are aligned and forward-thinking enough. There was some consideration amongst Board members about the alignment of strategies and whether enabling strategies were fully aligned to service strategy
- There was some reflection on whether the alignment of skills and expertise was appropriately matched to the priorities of the Trust and whether the expertise of non-executives was always capitalised on to the best effect.

3.4 The Board workshop event on 2 March 2018 provided an opportunity to review the information in the self-assessments. Following a summarised presentation of the main strengths, weaknesses and any conflicting views that the self-assessment information provided, the Board agreed that the main areas for it to focus improvement on were:

- Quality of Board and committee reports
- Aligning Trust strategy with the wider health economy strategic direction
- Effective communication of new and changing partnership arrangements and improved stakeholder engagement

3.5 These improvement areas will be the subject of Board workshops in 2018/19 and in specific projects using quality improvement methodology.

4.0 Audit Committee self-assessment: summary of responses

4.1 The Audit Committee scored highly in all areas of the self-assessment, including core purpose, membership, work planning, and standard of papers. The Information Governance Group is developing and escalating appropriate issues to Audit Committee.

4.2 Recommended areas for improvement included a more structured hand over of items for the attention of the committees and the tracking of progress of internal audits and the coordination of receipt of these by each committee. This has been added to the Audit Committee's action log.

5.0 Quality Committee self-assessment: summary of responses

5.1 The members of the Quality Committee agreed that the Committee/Board relationship is strong. Agenda planning meetings are taking greater account of links between items. The service spotlight presentation linked to a subsequent patient story at Board works well.

5.2 There were areas identified for improvement including ensuring all attendees are engaged in the meeting, which is a challenge as membership is very broad. Whilst work plans of the Quality Committees subgroups are now maturing, key issues to be escalated are not highlighted in subgroup minutes. Some papers are too long, important points are not always considered and data could be better interrogated with business intelligence support. There was also room to improve the knowledge base around quality issues and outcomes.

5.3 The Quality Committee has reviewed its format and flow of business. The above information was used to inform the Committee's revised format and work plan.

6.0 Business Committee self-assessment: summary of responses

6.1 The Business Committee scores highly in all areas of the self-assessment and agreed that members have increasing confidence and willingness to contribute on non-portfolio areas. The relationship between the Business Committee and the Board is strong and there is a well-established flow of business.

6.2 The quality of reports, including the receipt of adequate and appropriate information, has improved from the previous year. The Committee will continue to review the quality of papers; ensuring data is supported by analysis, conclusions, clear recommendations and improvement trajectories.

7.0 Charitable Funds Committee self-assessment: summary of responses

7.1 The Charitable Funds Committee recognised that it had clear leadership and feedback is provided to members. Its papers are well prepared and relevant.

7.2 The Committee felt that clarity and agreement is needed on aims, direction of travel and ownership of actions. It agreed that the charity is not being promoted effectively and progress is limited by capacity for delivery.

7.3 The Committee will review the Trust's capacity to deliver the committee's objectives. It will also review and develop measurable milestones and performance indicators (including fundraising targets) to support the charitable funds development as well as looking to establish collaborative approaches with other local NHS charities and consider marketing opportunities to enhance charitable funds development plan.

8.0 Nominations and Remuneration Committee self-assessment: summary of responses

8.1 The core purpose and main objectives of the Committee were felt to be clear and members thought the Committee was working well. Members felt that they had the requisite skills and knowledge and, given the specific role of the Committee, the membership was appropriate.

8.2 The Committee recognised that there were significant time gaps between meetings and limited sight of actions being completed between meetings. There was concern about important items not being raised at the Committee and that agenda setting needed to be more robust.

8.3 The Committee has set itself actions to make improvements, including reviewing the agenda setting process and the frequency of meetings, improving the quality of papers and providing sufficient information to the Board through the chair's assurance report.

Appendix B

Leeds Community Healthcare NHS Trust
Audit Committee: Annual Report 2017/18

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the Audit Committee's activities during 2017/18.

1.2 The terms of reference for the Committee require that the Committee's Chair submits an annual report which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2.0 Background: Duties of the Committee

2.1 The Audit Committee is one of five committees established as sub-committees of the Trust's Board and operates under Board approved terms of reference.

2.2 The Committee is well established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the Committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives
- **Internal audit:** ensuring that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud, managing security and shall review the annual plan and outcomes of work

- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work
- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the board of directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation

2.5 In February 2017, the Committee approved the establishment of the Information Governance (IG) Group. The Group meets every two months and discharges a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference. The IG Group is responsible for ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. Approved minutes from the Group are received by the Audit Committee.

3.0 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership, which is as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience (one of which serves as the chair of the committee and one as the deputy chair)
    - Jane Madeley (Chair and providing financial experience)
    - Richard Gladman (Deputy Chair)
    - Elaine Taylor-Whilde (up to 30 June 2017) then Ian Lewis (from 1 July 2017)

3.2 In addition to the membership, the following participants are required to attend meetings:

- Executive Director of Finance and Resources
- Company Secretary
- Internal audit representative (including counter fraud specialist)
- External audit representative

3.3 The Chief Executive attends to discuss the process for assurance that supports the annual governance statement, the annual report and accounts and the draft internal audit plan.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally six times in the last 12 months and has been quorate on all occasions. In addition, there was one informal meeting. A table recording attendance is shown below.

Attendee	28 April	12 May (informal)	26 May	21 July	13 Oct	8 Dec	16 Mar	Total (7)
Jane Madeley	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Richard Gladman	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Elaine Taylor –Whilde (until 30 June 2017)	No	Yes	No	N/A	N/A	N/A	N/A	1/3
Ian Lewis (from 1 July 2017)	N/A	N/A	N/A	Yes	No	Yes	Yes	3/4
Bryan Machin*	Yes	Yes	Yes	Yes	Yes	No	No	5/7

- Executive Director in attendance

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting.

4.0 Review of Committee's activities

4.1 The Audit Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasional further items that have arisen as a result of specific issues brought to the Committee's attention from internal or external sources.

4.2 *Governance, risk management and internal control*

4.2.1 The Committee reviewed the annual governance statement for 2017/18 prior to it being submitted for approval by the Board. In considering the statement, the Committee reviews assurances from a range of sources including the Head of Internal Audit opinion which it expects to receive in April 2018.

4.2.2 Annual reports have been received from internal audit, counter fraud, security management and Board sub-committees.

4.2.3 The Committee considers the process for, and the nature of reporting risks contained within the board assurance framework (BAF) twice per year. In 2017/18, the Committee reviewed the BAF in July and December 2017.

4.2.4 Updates in relation to information governance and performance against the information governance toolkit were considered by the Committee in July and December 2017. The reports describe any matters related to non-compliance with information governance policy. The Trust has received a positive audit and has submitted a self-assessed level 2 compliance score for the end of March 2018.

4.3 *Internal audit*

4.3.1 The Audit Committee has delegated authority to ensure the Trust has an effective internal audit function. The Internal Auditors provide an essential part of the Trust's system of internal control. The Trust's internal audit service is currently provided by TIAA Ltd.

4.3.2 The Committee reviewed and agreed an annual internal audit plan for 2017/18, which proposed 26 audits. In completing the audit plan, the Committee has reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and overseen progress. Topics have included a broad mix of financial, corporate governance and quality topics.

4.3.3 The Audit Committee shared the outcome of internal audits with the relevant Board committee, which provided the opportunity to consider the robustness of actions to address recommendations and the associated timescales.

4.3.4 The Committee closely monitored progress against the internal audit plan in order to avoid slippage and over running toward the end of the financial year. The Committee has expressed its disappointment that despite this monitoring there has been slippage in the completion of the audit programme. The Committee has received assurance that planning for 2018/19 is designed to avoid a repetition in the coming year.

4.3.5 In addition to monitoring progress of the audits, the Committee also monitored progress against internal audit management actions. The Committee receives further explanation and background on the priority 1 and 2 recommendations from the audits which have been agreed to be delivered by a certain date but not completed..

4.4 *Counter fraud and security management*

4.4.1 The Committee received the local counter fraud annual report and the security management annual report in July 2017. There have been regular updates on progress against the counter fraud plan for 2017/18, which have noted local counter fraud activity, and introduced lessons learnt from fraud incidence from elsewhere.

4.5 *External audit*

4.5.1 The ISA 260 external audit opinion was presented in May 2017, detailing the external auditors' work in relation to use of resources and the 2016/17 annual accounts.

4.5.2 In July 2017, the External Audit Manager presented KPMG's annual audit letter for 2016/17. It stated that the auditors' had issued an unqualified opinion on the Trust's 2016/17 financial statements and concluded that there were no matters arising from KPMG's 2016/17 audit work.

4.5.3 Regular technical updates have been provided by KPMG to the Committee to highlight those issues that impact on the NHS and to which the Trust should be aware. These include for example, changes made for off-payroll workers, the importance of cyber security, and checks to be completed following the tragic events at Grenfell Tower.

4.6 ***Financial reporting and annual accounts review***

4.6.1 The Committee (with the Chief Executive in attendance) reviewed the annual report and accounts in detail in May 2017 prior to recommending the annual report and accounts to the Board for approval.

4.6.2 The Committee reviewed the charitable funds annual report and accounts in May 2017 prior to approval by the Charitable Funds Committee.

4.6.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.7 ***Standards of business conduct***

4.7.1 The Committee noted a number of waivers to tendering procedures, reviewed the reference costs process, and reviewed the register of gifts and hospitality.

4.8 ***Data security***

4.8.1 The Committee pursued evidence of compliance with data security requirements and received regular reports concerning data security, including information about the status of serious information governance incidents reported to the Information Commissioners Office.

4.8.2 A key objective for the Committee was to ensure that the Trust was not vulnerable to cyber-attack. System penetration testing, which tested the Trust's ability to repel cyber-attacks, was completed in February 2017, and the Committee received an update report at its April 2017 meeting. The report contained five high, six medium and 15 low-level recommendations which were considered in detail.

4.8.3 The Committee had previously noted the limited assurance given for the SystmOne service resilience internal audit (2016-17 internal audit programme) and monitored progress against the actions detailed in the report that related to the robustness of business continuity plans. The Committee noted in May 2018 that the initial set of recommendations provided in the internal audit report had been actioned and there was a greater confidence in the SystmOne resilience business continuity plan.

4.8.4 Some NHS trusts were left vulnerable in a global ransomware attack in May 2018 because cyber-security recommendations were not followed. The Committee was keen to ensure relevant future Trust audits and cybersecurity

test exercises should consider whether learning from this cyber-attack had been implemented where appropriate. In addition, the Committee requested that team based business continuity plans should be updated in light of the 'lessons learnt' from the cyber-attack.

4.8.5 In response to this request, a cybersecurity emergency planning exercise took place in the neighbourhood teams during June and July 2017. The findings were reported back to the Committee, indicating that overall the teams had felt confident that they would be able to maintain essential service delivery but consideration should be given to the time required to recover from the impact of an incident and the time to return to full service delivery.

4.8.6 The Committee received updates on progress against the guidance issued for the General Data Protection Regulation (GDPR), which will be introduced in May 2018 The Committee also noted that the Trust would need to ensure that the implications were thoroughly considered and necessary changes made to reflect the new arrangements. The Committee reviewed the GDPR action plan in March 2018.

4.8.7 The Committee monitored information governance/data security training compliance across the Trust and regularly received up to date information on the percentage of staff that had completed training.

5.0 Assessment of Committee's effectiveness

5.1 All members of the Committee were invited to complete a self-assessment questionnaire in January 2018, including rating elements of performance. The main points raised were as follows:

5.2 The Committee scored highly in all areas, it scored particularly well in leadership, core purpose, participation and agenda setting/minutes.

5.3 The Committee members reflected on the improvements they could make. These being:

- A more structured hand over of items for the attention of the committees
- Tracking of progress of internal audits and coordination of receipt of these by each committee

6.0 Future developments

6.1 Whilst acknowledging that there is an existing work plan for 2018/19, the following changes are to be implemented:

Action	***Actionee***	***Date***
Devise tracking method to ensure that all completed internal audit reports are received and noted by the relevant committee	Company Secretary	31/05/2018

Appendix C

Leeds Community Healthcare NHS Trust
Changes to committees' terms of reference

The tables below summarise the changes made in order to amend and update content (the changed text being shown in red bold).

Quality Committee	
Section	**Change**
3.1	• **Seek assurance** on quality, safety and excellence in patient care • **Seek assurance** on effective evidence-based clinical practice • **Identify and prioritise** quality and clinical risks and issues and assure the Board that risks and issues are being managed in a controlled and timely manner • **When the Trust is entering into new collaborative partnership arrangements, oversee the quality governance and reporting arrangements to assure the Board of the provision of safe, high quality services** • **Oversee development and implementation** of the quality strategy • **Review and approve** the annual quality account

Business Committee	
Section	**Change**
4.2	Membership to include **Executive Director of Operations** (previously an attendee), with Director of Workforce to become an attendee (previously a member). This change was approved in principle at Trust Board 29/03/2018.

Leeds Community Healthcare NHS Trust
NHS Provider Licence: compliance assessment

Section 1: general conditions

Condition	**Compliance**
G1: Provision of information *The Licensee shall furnish such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports as NHS Improvement may require.*	Compliant. The Trust has systems and processes in place to ensure compliance with all information requests whether routine, regular or ad-hoc in such form as requested and in a timely manner.
G2: Publication of information *The Licensee shall comply with any direction from NHS Improvement to publish information about health care services, in a manner that is accessible to the public.*	Compliant. The Trust determines that it is compliant with this condition as a wide variety of routine information published on website and in hard copy documents, including: Board and associated papers; annual reports and information and advice to the public and referrers about services. The Trust is committed to openness and making information available in accessible formats.
G3: Payment of fees to NHS Improvement *The Act gives NHS Improvement the ability to charge fees, the Licensee shall pay all fees to NHS Improvement in each financial year of such an amount as NHS Improvement may determine.*	Not applicable. Fee requirement did not transfer from Monitor to NHS Improvement The Trust pays all other fees as due (eg to the Care Quality Commission and to NHS Resolution).
G4: Fit and proper persons *The Licensee shall ensure that no person who is unfit may become or continue as a governor (FTs only) or as a director.* *The Licensee shall not appoint as a director any person who is an unfit person.*	Compliance with requirements reported to Board 25 May 2018. On appointment and annually thereafter, all directors are subject to a fit and proper persons' declaration process. Information is validated externally where possible. All directors complete an annual declaration of interests' statement.
G5: NHS Improvement guidance *The Licensee shall at all times have regard to guidance issued by NHS Improvement.*	The Trust complies with this requirement and has full regard to guidance as promulgated. Guidance notified to the Trust is reviewed on receipt by the relevant director and a lead is assigned in accordance with subject matter to enact the guidance as appropriate.

Condition	Compliance
G6: Systems for compliance with licence conditions and related obligations *The Licensee shall take all reasonable precautions against the risk of failure to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution, including: processes and systems to identify risk and guard against occurrence and regular review of the effectiveness of these processes and systems* ***The Licensee must self-certify that:*** *'Following a review, the directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*	Compliant. The Trust is compliant with requirements to take all necessary steps to manage the risk of failure to comply with conditions; there are robust processes are in place to identify and manage risks to compliance. The Trust utilises the Datix® risk management system to create and populate its risk registers. Strategic and operational risks are scrutinised at each meeting of the Trust Board and at Board sub-committees, as well as regular review at executive director and service level. The Audit Committee scrutinises the risk management process and provides assurance to the Trust Board. Risk management training is provided to all staff at induction, and ongoing training and support is provided by a full-time, qualified and experienced risk manager. Additional risk management resources are available for staff on the Trust intranet and in the production of a quarterly risk management newsletter. The Trust reviews and revises its board assurance framework annually and mid-year to ensure continued alignment with the operational plan and strategic goals. The board assurance framework includes: identification of strategic risks that would otherwise impede delivery of Trust's objectives, the level of risk in terms of likelihood and consequence, controls to mitigate the risks and the sources of assurance available for committee oversight and assessment. The Trust Board receives board assurance reports at each meeting which provides details of the current assurance level for each strategic risk. The Trust has an up to date risk management policy and procedure which is accessible to all staff via the policy library on the Trust's intranet. The Trust's risk appetite statement is appended to the risk management policy and procedure and describes parameters within which risk is managed. The risk appetite statement is reviewed annually by the executive team.

	The effectiveness of risk management and assurance processes was audited during 2017/18 and gained an opinion of reasonable assurance.
G7: Registration with the Care Quality Commission *The Licensee shall at all times be registered with the Care Quality Commission.*	Compliant. The Trust is registered without conditions. Current rating, published in August 2017, is 'Good'. The Trust has a quality governance approach including quality assessment visits which is fully aligned to the Care Quality Commission's domains.
G8:Patient eligibility and selection criteria *Licence holders are required to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.*	Compliant. Service information is published on the Trust's website and in patient information material. Service eligibility and selection information is detailed in service specifications and is available readily to 'Choose and Book' referrers. The Trust investigated the potential for extending service information published on NHS Choices and this is not to be pursued. Published material is comparable to that available from other trusts.
G9: Application of Section 5 (continuity of services) *The condition applies where the Licensee is subject to a contractual obligation to provide a commissioner requested service and relates to maintenance of continuity of services.*	Compliant. The Trust is aware of services which the commissioners deem to be commissioner requested services; also known as essential services. The Trust achieves a good level of compliance with commissioned contractual requirements. Contract management arrangements between the Trust and its commissioners provide oversight of service delivery in line with contractual requirements.

Section 2: Pricing

Condition	**Compliance**
P1: Recording of information *The Licensee shall obtain, record and maintain sufficient information about costs of providing services.*	Compliant. Finance systems and processes are set up to meet all internal and external reporting requirements. Board approved annual budgets and financial plan in place. Reference costs are reported annually.
P2: Provision of information *The Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require.*	Compliant. Trust complies with all requests to supply information as requested. The information collected and recorded in relation to condition P1 is made available as requested.

P3: Assurance report on submissions to NHS Improvement *If required by NHS Improvement, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to the accuracy of costing and pricing.*	Trust will fully comply with any such request as and when the requirement arises. Third party assurance provided periodically for example by internal audit on reference costs in 2017/18.
P4: Compliance with national tariff *The Licensee shall only provide health care services for the NHS at prices which comply with, or are determined in accordance with, the national tariff.*	This condition is not generally applicable to community trusts. The Trust only provides one service which is part of the national tariff with which it is fully compliant.
P5: Constructive engagement concerning local tariff modifications *The Act allows for local modifications to prices. The Licensee shall engage constructively with commissioners to reach agreement locally.*	Not applicable. The Trust operates under a block contract. Only one service is subject to national tariff and is supplied at national tariff.

Section 3: Choice and competition

Condition	**Compliance**
C1: The right of patients to make choices *The Licensee shall ensure that at every point where a person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by commissioners, he or she is notified of that choice and told where information can be found.*	Compliant. The Trust offers choice where applicable. Choice and 'choose and book' approaches in place in relation to applicable services, namely those described as 18 week reportable services.
C2: Competition oversight *The Licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting completion in the provision of health care.*	Compliant. The Trust would pursue service opportunities within statutory and accepted procurement, bidding and contracting practices; this ensures that competition is not prevented, restricted or distorted by the Trust. Procurement and contract bid processes have been the subject of internal audits. No compliance issues identified.
Section 4: Integrated care	

Condition	Compliance
IC1: Provision of integrated care *The Licensee shall not do anything that would reasonably be regarded as against the interests of people who use health care services for the purposes of the NHS to be integrated with the provision of such services.*	Compliant. The Trust is a significant leader in the development of integrated care approaches as reflected by the role played in the West Yorkshire Health and Care Partnership, Leeds Health and Care Plan, the development of new models of care and initiatives to effect closer integration. Key initiatives, service and pathway developments are captured in the Trust's operational plan 2018/19. Stakeholder engagement underpins the development of integrated approaches.

Section 5: Continuity of services

Condition	Compliance
COS1: Continuing provision of commissioner requested services *The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any commissioner requested service except where permitted to do so in the contract.*	Compliant. Contract management arrangements in place between the Trust and its commissioners; any material changes agreed through contract management board. Trust achieves good level of compliance with commissioned contractual requirements including those services deemed to be commissioner requested services. Contracts and service specifications are in place and as agreed with commissioners.
COS2: Restriction on the disposal of assets *The Licensee shall establish, maintain and keep up to date, an asset register of assets relevant to commissioner requested services and have due regard to consent before disposal.*	Compliant. No issues identified in the disposal of assets related to commissioner requested services without consent of NHS Improvement. Asset register processes have been the subject of scrutiny by internal and external audit.
COS3: Standards of corporate governance and financial management *The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:*	Compliant. The Trust has robust systems for corporate and financial management including standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2018). Compliance is monitored through Audit Committee, recorded in the annual

(a) suitable for a provider of the commissioner requested service provided by the Licensee, and *(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.*	governance statement and 'going concern statement' and has been subject to internal and external audit.
COS4: Undertaking from the ultimate controller *The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee.*	Not applicable.
COS5: Risk pool levy *The Licensee shall pay any sums required to be paid in consequence of any requirement imposed on providers by way of a levy.*	Not applicable. No NHS Improvement risk pool levy system in place. The Trust would comply with this condition when any requirement arose. The Trust participates in NHS Resolution's clinical negligence scheme for trusts.
COS6: Co-operation in the event of financial stress *The Licensee shall provide such information as NHS Improvement may direct and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.*	The Trust would comply with this condition as and when any requirement arises.
COS7: Availability of resources *The Licensee shall at all times act in a manner calculated to secure that it has, or has access to the required resources.*	Compliant. Evidenced through: annual contract negotiations, approval of operational plan for 2018/19 and associated financial plan and annual budgets, approval of going concern statement and regular monthly monitoring of performance against plan.

Section 6: NHS foundation trust conditions

Condition	**Compliance**
FT1: Information to update the register of NHS foundation trusts *The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:* *(a) the current version of the Licensee's constitution;* *(b) the Licensee's most recently published annual accounts and any report of the auditor on them, and* *(c) the Licensee's most recently published annual report*	Compliant where applicable. All information as required to be supplied to NHS Improvement from NHS trusts supplied in accordance with requirements. Constitution applies to foundation trusts only.
FT2: Payment to NHS Improvement in respect of registration and related costs *The Licensee must pay NHS Improvement a fee in respect of NHS Improvement's exercise of its functions.*	Applicable to foundation trusts only.
FT3: Provision of information to advisory panel *The Licensee shall comply with any request for information or advice made of it.*	Not applicable. Advisory panel provisions apply to governors of foundation trusts only.

Condition	**Compliance**
FT4: NHS foundation trust governance arrangements 1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health services to the NHS.*	Compliant. The Trust develops an annual governance statement which is scrutinised by Board sub-committees prior to Board approval (29 March 2018). The annual governance statement is reviewed by internal and external auditors as part of the process for finalising the Trust's report and accounts. The Trust has satisfactory opinion reports from the Head of Internal Audit (TIAA Limited) and from the Trust's external auditors (KPMG) The Trust operates at all times within a framework of standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2018) and approved policies and procedures.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	Compliant. The Trust's governance arrangements are developed with due regard of all guidance as issued by NHS Improvement from time to time. The Trust also regularly reflects on guidance information provided by the Good

	Governance Institute. Governance arrangements are reviewed annually, including a review of the standing orders, reservation and delegation of powers, and standing financial instructions.
3. The Board is satisfied that the Licensee has established and implements: *(a) Effective Board and Committee structures* *(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees* *(c) Clear reporting lines and accountabilities throughout its organisation.*	Compliant. The Trust has a fully constituted Board and five sub-committees. The terms of reference for all committees have been reviewed in early 2018; ensuring appropriate membership, lines of accountability and clear areas of delegated responsibility. The Board and committees operate to annual cycles of business. Board and committee effectiveness is reviewed annually (and reported to Audit Committee and the Board). Each committee produces an annual report. There is a robust process for recording assurances provided by committees to the Board against matters contained in the board assurance framework. Details of the Trust's governance arrangements are displayed on the intranet, accessible to all staff. A number of sub-groups have been aligned with an appropriate committee. Each sub-group escalates issues to committees as necessary.
4.The Board is satisfied that the Licensee has established and effectively implemented systems and/or processes: *(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively* *(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations* *(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions* *(d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern* *(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making*	Compliant. The Board gains assurance that the Trust operates efficiently, economically and effectively through its standing orders and financial instructions, schemes of reservation, delegation of reporting to Board and its sub committees and the following established organisational processes: The review and approval of The Trust's operational plan 2017/18 involved consideration of key areas of risk in respect of quality of services, financial performance (as recorded in board assurance framework), national and local standards and requirements and delivery of key strategies. Areas of risk have been reported to Board through risk assurance reports and monitoring of delivery of the operational plan; the latter having been considered in detail by the Trust's Quality and Business Committees. Assurances are provided by committees to the Board against matters contained in the board assurance framework. Performance management framework allows the timely monitoring of main operational, quality, workforce, contractual and financial indicators. Performance reporting is fully aligned to the Care Quality Commission's five

(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery* *(h) To ensure compliance with all applicable legal requirements.*	domains. Monthly performance data (quality, activity, contractual and financial) is reported to the sub-committees and Board for scrutiny. There are also regular reports on key issues (eg patient safety, clinical effectiveness, patient experience, demand and capacity, recruitment and retention etc). Monthly finance reports track actual performance against plan. The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that the plan is adhered to. An annual 'going concern' review is undertaken by Audit Committee and approved by Board (29 March 2018). Quality priorities are recorded in the Trust's Quality Strategy. Annual Quality priorities are agreed as part of the annual planning process aligned to the operational plan. Actions to enhance quality are contained in improvement plans; performance against which is monitored by Quality Committee and Board. The Trust is registered with the CQC without conditions. The Care Quality Commission inspected the Trust in January 2017 and concluded an overall rating of 'Good'. To ensure compliance with standards set by regulators of health care professionals the Trust has the following arrangements: • On appointment of new staff, status checks are completed with professional bodies. • Periodic checks are made to ensure registrations are renewed appropriately • There is ongoing monitoring of clinical supervision to ensure staff access this. • The Trust has a system of medical revalidation. • Annual appraisals are monitored and cover the professional standards set by the relevant governing body. • The Trust supports continual professional development. Monthly performance and finance reports are scrutinised by Business

	Committee and Trust Board. The Audit Committee provides oversight of systems of internal control including efficacy of financial reporting. The risk appetite statement and board assurance framework were reviewed in 2018. The board assurance framework was updated in 2018 to align with the Trust's operational plan 2018/19. Timely and robust risk reporting processes are in place with scheduled reports to committees and Board. A programme of internal and external audit is in place aligned to strategic risks. An annual business planning cycle produces operational plans aligned with the Trust's key strategies, system plans (West Yorkshire and Harrogate Health and Care Partnership Plan and the Leeds Health and Care Plan) and commissioner plans. Business Committee and Board receive progress reports on delivery of plans. The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.
5. The Board is satisfied that the systems and/ or processes referred to in paragraph 4 (above) should include but not be restricted to systems and /or processes to ensure: *(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided* *(b) That the Board's planning and decision making processes take timely and appropriate account of care considerations* *(c) The collection of accurate , comprehensive, timely and up to date information on quality of care* *(d) That the Board receives and takes into account accurate , comprehensive, timely and up to date information of the quality of care* *(e) That the Licensee, including its Board, actively engages on quality of care with patient, staff and other relevant stakeholders and takes into account as appropriate views*	Compliant. The Board has strong complementary skill sets amongst non-executive and executive Board members. There is a clear distinction of 'portfolios' whilst remaining fully operational as a unitary board. The 2017 CQC inspection report described the Trust as having 'stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these. Leaders were visible and accessible'. Essential leadership of the quality agenda is provided by medical and nursing directors. Board approved quality strategy sets out strategic action areas enacted through action plans and monitored through quality and safety reports to Quality Committee and Board. Annual Quality priorities are agreed as part of the annual planning process.

and information from these sources **(f)** *That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate*	Quality Committee receives a comprehensive monthly Director of Nursing report. Quality account, quality challenge+ and clinical audit programme all require measurement, evaluation and reporting of essential quality data. These are scrutinised by the Quality Committee, which communicates the level of assurance these provide to the Trust Board. Internal audit investigations on data quality have indicated reasonable assurance in all instances. There is an active programme of Board members engagement with patients and staff through visits and leadership initiatives. All Board meetings include a 'patient story', which involves a patient and or a carer attending a Board meeting to provide their account of the quality of care they have experienced. The Trust has multiple means to raise concerns related to quality of care including communicating issues to the patient experience team, stakeholder meetings, staff forums and 'freedom to speak up' activities. The Trust engages with Healthwatch and other key stakeholders in developing and agreeing Quality priorities and the Quality Account A revised Quality Impact Assessment process was agreed in-year to be completed for all service changes that have potential to impact on patient care, including service and pathway improvement, service development and transformation and service offers developed in response to tenders.
6. *The Board is satisfied that there are systems in place to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the NHS provider licence.*	Compliant. Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Trust has a fully constituted Board and committees each with full and active membership. Ongoing Board development **i**ncludes workshops, networking events and training opportunities. Full line management structure linked to each executive director's portfolio. The Chief Executive is subject to formal review by the Chair. Executive

	Directors are subject to annual appraisals by the Chief Executive, and Non-Executives are subject to annual appraisals by the Chair, these will inform individual development plans for all Board members. All appointments to senior management positions are subject to rigorous and transparent recruitment processes. The Trust develops its leadership capability through its coaching strategy which supports the development of staff. Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. Trust Board is fully apprised at each meeting of key quality, workforce and financial indicators. Workforce indicators include compliance with safe staffing ratios, vacancy rates, staff turnover, retention, agency staff deployment, sickness absence, appraisal rates, professional revalidation and training compliance. Business Committee has oversight of workforce issues; extensive consideration of areas of challenge (eg recruitment and retention in clinical services) through a suite of reports including the performance brief and the risk register report, which are received at each meeting. Business Committee communicates the level of assurance these provide directly to the Board.

Leeds Community Healthcare NHS Trust
Summary of changes to standing orders and standing financial instructions

<table>
<tr><th>Section</th><th>Change</th></tr>
<tr><td>All sections</td><td>References to former NHS Litigation Authority removed and replaced with ’NHS Resolution’</td></tr>
<tr><td>All sections</td><td>Removal of ‘Care Quality Commission Essential Steps of Quality and Safety (CQC March 2010) and replaced with ‘Care Quality Commission Fundamental Standards guidance (CQC March 2015)’.</td></tr>
<tr><td>All sections</td><td>Removal of reference to ‘National Patient Safety Agency (NPSA)’ and replaced with ‘NHS Improvement’</td></tr>
<tr><td>All sections</td><td>Insertion of correct, current policy titles</td></tr>
<tr><td>All sections</td><td>Amend ‘Department of Health’ to ‘Department of Health and Social Care’</td></tr>
<tr><td>13.2.1
Scheme of Delegation</td><td>To include “authority to commit expenditure” clarifying that this is delegated along with a budget to budget holders</td></tr>
<tr><td>4.8.6
Committees established by the Trust Board</td><td>Details of Mental Health Collaborative Committees in Common added (as described in the memorandum of understanding and terms of reference).</td></tr>
<tr><td>Section C
Schedule of reservation and scheme of delegation.</td><td>Decisions/duties delegated by the Board to committees now include details of Mental Health Collaborative Committees in Common decisions/ duties as contained in the memorandum of understanding and terms of reference. This includes an approval limit of £500K.</td></tr>
<tr><td>11.1.1
Audit Committee</td><td>Amended to include:
Consider the appointment of the external auditors in line with the regulations governing the appointment (discharged through an appointed auditor panel).</td></tr>
<tr><td>13.2.1
Budgetary Delegation</td><td>
<table>
<tr><th>Approval Limits</th><th>£ Revised Mar 2018</th><th>£ Original October 2016</th></tr>
<tr><td>Chief Executive/Director of Finance</td><td>1,000,000</td><td>1,000,000</td></tr>
<tr><td>Other Directors</td><td>100,000</td><td>100,000</td></tr>
<tr><td>General Manager/Asst. Director</td><td>30,000</td><td>50,000</td></tr>
<tr><td>Head of Service</td><td>20,000</td><td>25,000</td></tr>
<tr><td>Budget Holder (higher level)</td><td>10,000</td><td>10,000</td></tr>
<tr><td>Budget Holder (other)</td><td>5,000</td><td>5,000</td></tr>
<tr><td>Senior Team Leader</td><td>2,000</td><td>2,000</td></tr>
<tr><td>Team Leader</td><td>500</td><td>500</td></tr>
<tr><td>Requisitioner</td><td>0</td><td>0</td></tr>
</table>
Section amended to include the delegated limits for approving invoices as above. These limits are set up in the general ledger. Amendments are to bring approval limits more into line with the previously agreed changes to the tender and quotation limits.
</td></tr>
</table>

14.3 Annual accounts and reports	Manual for Accounts replaced with **Group Accounting Manual**
17.9 (b) Competitive tendering and competitive quotations	Correction of error to reflect quotation limit is **£5,000** – was wrongly stated as £20,000
20.4.1, 20.4.2 Processing Payroll	Director of Finance replaced by Director of **Workforce** for some items to reflect split responsibilities for processing payroll

Please note: actual text changes are highlighted in bold in the schedule of changes above.

Leeds Community Healthcare NHS Trust
Register of affixing of corporate seal 2017-18

Deed of surrender relating to 54 -72 York Street Leeds	St Anne's Community Services Leeds Community Healthcare NHS Trust	Executive Director of Finance and Resources Executive Director of Operations	04.04.17
Tenancy at will: Dental Practice, Chapeltown Health Centre **(signed only)**	Leeds Community Healthcare NHS Trust Whitecross Dental Care Limited (t/a mydentist)	Executive Director of Finance and Resources	05.07.17
Lease relating to: Dental Practice, Chapeltown Health Centre, Spencer Place, Leeds, LS7 4BB	Leeds Community Healthcare NHS Trust Whitecross Dental Care Limited	Chief Executive Executive Director of Nursing	23.08.17
Sale of: Garforth Clinic, Lidgett Lane, Garforth LS25 1LJ	Leeds Community Healthcare NHS Trust Pinnacle View Homes Ltd	Executive Director of Finance and Resources Deputy Director of Finance	06.09.17
Tenancy at will: Shaftesbury Medical Centre, 482 Harehills Lane, Leeds LS9 6NG **(signed only)**	Leeds Community Healthcare NHS Trust NHS Property Services Limited	Executive Director of Operations	18.09.17
Counterpart lease: Third floor, Stockdale House, Headingley Office Park, Leeds LS6 1PF	Leeds Community Healthcare NHS Trust EPISO 3 Tree Development Properties S.a.r.l	Executive Director of Operations Director of Workforce	18.09.17
Counterpart deed of variation: Second floor, Stockdale House, Headingley Office Park, Leeds LS6 1PF	Leeds Community Healthcare NHS Trust EPISO 3 Tree Development Properties S.a.r.l	Executive Director of Operations Director of Workforce	18.09.17

Counterpart deed of variation: First floor, Stockdale House, Headingley Office Park, Leeds LS6 1PF	Leeds Community Healthcare NHS Trust EPISO 3 Tree Development Properties S.a.r.l	Executive Director of Operations Director of Workforce	18.09.17
Counterpart licence: Car parking spaces, Headingley Office Park, Leeds LS6 1PF	Leeds Community Healthcare NHS Trust EPISO 3 Tree Development Properties S.a.r.l	Executive Director of Operations Director of Workforce	18.09.17
Side letter relating to car park resurfacing and lining, Stockdale House, Headingley Office Park, Leeds LS6 1PF (pursuant to renewal of lease). **(signed only)**	Leeds Community Healthcare NHS Trust EPISO 3 Tree Development Properties S.a.r.l	Executive Director of Operations	17.10.17
Renewal of lease: an ambulance standby point at Kirkstall Lane Medical Centre, Leeds	Leeds Community Healthcare NHS Trust and Yorkshire Ambulance Service NHS Trust	Chief Executive Executive Director of Finance and Resources	30.01.18

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (15)

Meeting Trust Board 25 May 2018	**Category of paper**	
Report title West Yorkshire Mental Health Services Collaborative: committees in common memorandum of understanding	**For approval**	
Responsible director Chief Executive **Report author** WY MH Programme Director & Company Secretaries/Governance Leads	**For assurance**	
Previously considered by Trust Board in private 29 March 2018	**For information**	✓

Purpose of the report

This report provides the Board with a copy of the signed memorandum of understanding for the committees in common, which is a governance mechanism to support the West Yorkshire Mental Health Services Collaborative (WYMHSC).

Main issues for consideration

The West Yorkshire Mental Health Services Collaborative (WYMHSC) is the coming together of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care Foundation Trust, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership Foundation Trust) to work collaboratively to ensure high quality, sustainable mental health services now and into the future.

At its meeting in March 2018 the Boards of the four organisations agreed the Memorandum of Understanding (MoU) subject to a number of points of clarification. These points were clarified with the members of the Committees in Common and at its meeting on 30 April 2018 the Chairs of the four organisations signed the MoU. The final version is attached for information.

The Board is reminded that the MoU is not a legal contract, but is a formal agreement between all of the partners. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

Recommendation

- The Board is asked to formally receive the signed WYMHSC MoU

WEST YORKSHIRE MENTAL HEALTH SERVICES COLLABORATIVE

DATE

30 April 2018

1. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**
2. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
3. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING FOR WEST YORKSHIRE MENTAL HEALTH SERVICE COLLABORATIVE (WYMHSC)

No	Date	Version Number	Author
1	15/11/17	01 -	Trust Company Secretaries / Governance leads
2	29/11/17	0.2	Trust Company Secretaries / Governance leads
3	4/12/17	0.3	Trust Company Secretaries / Governance leads
4	15/01/18	0.4	Trust Company Secretaries / Governance leads
5	7/03/18	0.5	Trust Company Secretaries/Governance lead
6	15/03/18	0.6 Incorporating comments from audit committee chairs	Trust Company Secretaries/Governance lead
7	25/04/18	0.7 Incorporating comments from Boards	Trust Company Secretaries/Governance lead

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire, Bradford, West Yorkshire, BD18 3LD;

(2) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(3) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(4) **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

(each a **"Party"** and together the **"Parties"**).

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the West Yorkshire and Harrogate Health and Care Partnership (STP) (**"WYHHCP"**).

(B) The Parties together form the West Yorkshire Mental Health Services Collaborative (**"WYMHSC"**) and have agreed to collaborate in delivering region-wide efficient and sustainable acute and specialist mental health services for patients. The Parties have formed Committees in Common (**"WYMHSC C-In-C"**) which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire (WY). The intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the **"WYMHS Collaborative Programme"**).

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYMHSC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the WYMHSC service area.

(D) The Parties recognise the different levels of provision of acute and specialist mental health services in portfolios of services and this will be reflected in any agreements the collaborative makes and managed through the Gateway Decision Making Process.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3. a reference to a **"Party"** is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to **"Parties"** is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for acute and specialist mental health services in WY. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYMHSC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the WYMHSC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the WYMHS Collaborative Programme in line with the Key Principles as set out in Schedule 1 (the **"Key Principles"**).

3.2. The Parties acknowledge the current position with regard to the WYMHSC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the WYMHS Collaborative Programme (the **"Principles of Collaboration"**):

4.1.1. address the vision - in developing WYMHSC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable acute and specialist mental health services for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider WYHHCP and the WYMHSC service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues or opportunities relating to WYMHSC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the WYMHS Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7. manage stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.8. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the WYMHS Collaborative Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYMHS Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYMHS Collaborative Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYMHSC:

WYMHSC Committees in Common ("WYMHSC C-In-C")

6.1. The WYMHSC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;
6.1.2. decisions required by the WYMHSC C-In-C;
6.1.3. issues and risk being managed;
6.1.4. issues requiring escalation to the WYMHSC C-In-C; and
6.1.5. progress planned for the next period.

Under a standing agenda item, WYMHSC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Programme Director will provide a summary for sharing in the public domain.

WYMHSC Programme Executive

6.2. The WYMHSC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the WYMHS Collaborative Programme via the WYMHSC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYMHS Collaborative Programme in line with the Key Principles:

WYMHSC Committees in Common

7.1. The WYMHSC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the WYMHS Collaborative Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2. The WYMHSC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

WYMHSC Executive Group

7.3. The WYMHSC Executive Group will provide assurance to the WYMHSC C-In-C that the key deliverables are being met and that the development of the WYMHS Collaborative Programme is within the boundaries set by the WYMHSC C-In-C. It will provide management at programme and workstream level.

8. DECISION MAKING

8.1. The Parties intend that WYMHSC C-In-C individual Members will each operate under a model scheme of delegation whereby each WYMHSC C-In-C individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the WYMHSC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;
- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the WYMHSC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the WYMHSC C-In-C.

8.2. The Parties intend that WYMHSC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the WYMHSC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the WYMHS Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYMHSC, the matter shall be promptly referred to the WYMHSC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYMHS Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYMHS Collaborative Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYMHS Collaborative Programme but it is intended that other providers to the WYMHSC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYMHSC C-In-C as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement/Monitor and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the WYMHSC C-In-C shall take place 12 months after the date of implementation of this MoU (1st April 2018) or sooner if deemed as required by the Parties.

13.2. The WYMHSC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the WYMHS Collaborative Programme and individual workstreams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on 1st April 2018 (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYMHS Collaborative Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYMHSC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and
14.4.2. the affected Party is first given the opportunity to address the WYMHSC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by)

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

BRADFORD DISTRICT CARE NHS FOUNDATION TRUST)
) DATE: 30 April 2018

SIGNED by)

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title: CHAIR

LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST)
) DATE: 30 April 2018

SIGNED by NEIL FRANKLIN)

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

LEEDS COMMUNITY HEALTHCARE NHS TRUST)
) DATE: 30 April 2018

SIGNED by)

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title: Chair

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST)
) DATE: 30 April 2018

SCHEDULE 1

THE KEY PRINCIPLES

1. The continued challenge of ensuring the quality and financial sustainability of mental health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in WY making best use of the collective resources.

2. Through the WYMHS Collaborative Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective acute and specialist mental health services across WY, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

   2.1. Achieving the clinical and financial stability across the WYMHSC service areas.

   2.2. Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

   2.3. The approach to collaboration:

   - The Parties will work on the greatest challenges together to ensure high quality, sustainable mental health services now and in the future.
   - Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in WY.
   - Take a collaborative approach to the delivery of acute/specialist mental health services via clinical pathways and networked services (rather than individual place/provider led developments).
   - Developing 'centres of excellence' for the more specialist mental health services e.g. forensic services, Child and Adolescent Mental Health Services (CAMHs) Tier 4, adult eating disorders,
   - Delivering economies of scale in mental health service support functions
   - Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing
   - Ensure there is appropriate public engagement on those matters which need to be communicated more widely.

SCHEDULE 2

WYMHS COLLABORATIVE PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to reduce variation and deliver sustainable acute and specialist mental health services to a standardised model which is efficient and of high quality. In developing this programme the Parties will be designing services over a wider NHS footprint (the WYMHSC service area), thinking of different models of care and making collective efficiencies where the potential exists.

2. The WYMHS Collaborative Programme Approach

The Key Principles and five key steps to developing the WYMHS Collaborative Programme approach are set out in Schedule 1.

3. WYMHS Collaborative Programme Priorities

The WYMHS Collaborative Programme priorities are expected to be generated as a result of the following internal and external drivers;

- WYMHS clinical and operational sustainability priorities.
- WYMHS analysis of variation.
- West Yorkshire & Harrogate Health and Care Partnership (formerly STP).
- Regulatory requirements.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at 1st April 2018):

Urgent & Emergency Care and Liaison: • Mental health liaison • 24/7 crisis services	• 40% reduction in unnecessary A&E attendance • 50% reduction of Section 136 Place of Safety • 24/7 crisis services
Suicide Prevention	• A zero suicide approach to prevention (10% overall reduction in suicides by 2020/21 and 75% reduction in targeted services by 2022)
Care Closer to Home (Out of Area Placements): • Adult acute • Psychiatric Intensive Care Unit (PICU) • Locked rehab and learning disabilities	• Elimination of out of area placements for non specialist acute care within 12 months • Shared bed management function
Specialist Services: • Child and Adolescent Mental Health services (CAMHS) tier 4 • Low / medium secure forensic - Adult eating disorders	• Elimination of out of area placement for children and young people • Development of new care models
Autism Spectrum Disorder (ASD) / Attention Deficit Hyperactivity Disorder (ADHD)	• Reduction in waiting times for autism assessment

4. Key Workstream Stages

4.1 Workstream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2 The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and Clinical Senate involvement
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3 The WYMHSC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4 Each workstream will have a WYMHSC Director (identified by the WYMHS Collaborative Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments
- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement
- Governor engagement

4.5 The WYMHSC Executive and WYMHSC C-In-C will make decisions on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some WYMHSC projects developed under the workstreams will have the potential to disproportionately benefit participating WYMHSC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective WYMHSC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYMHSC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the WYMHSC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

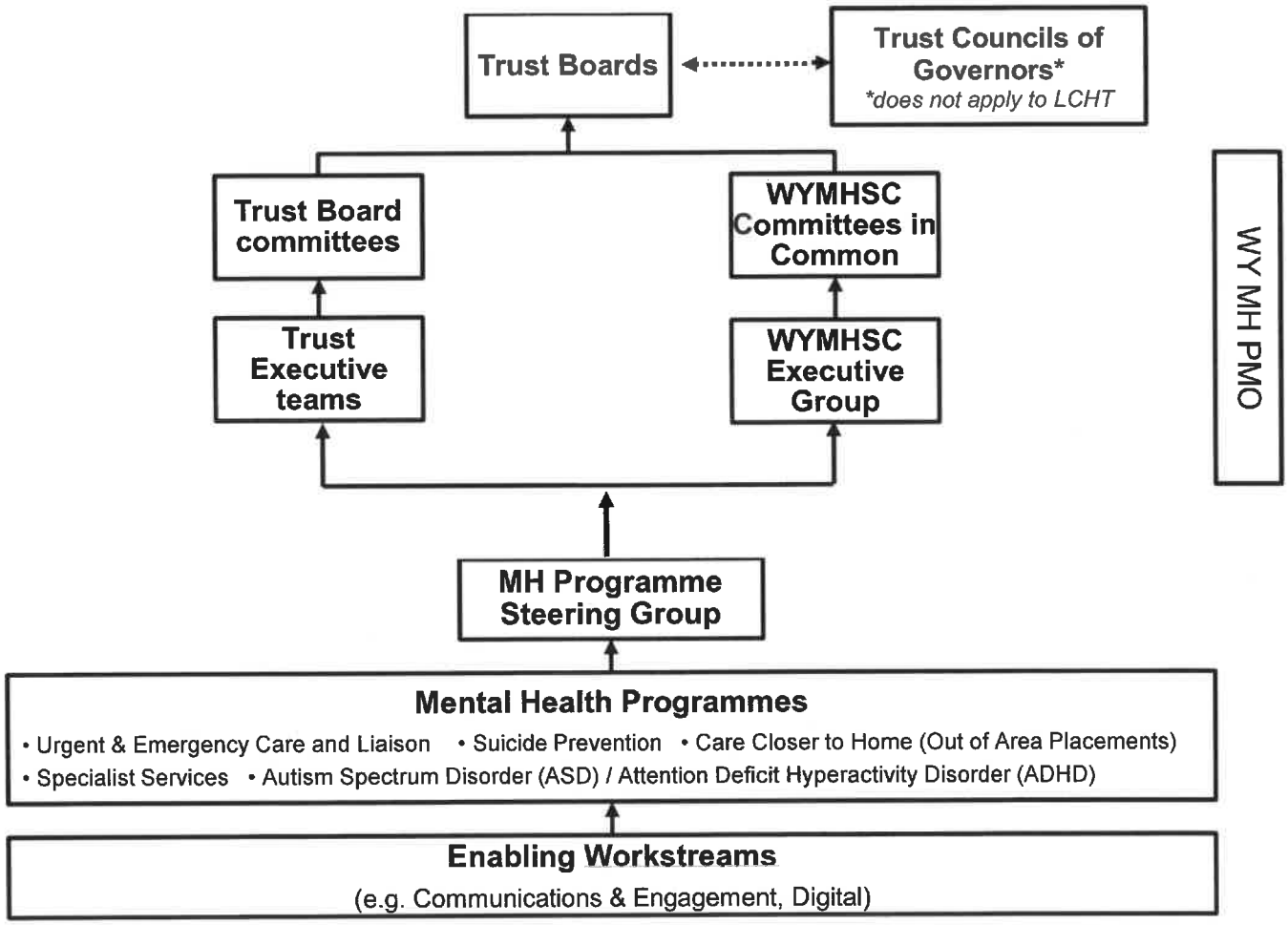
- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the West Yorkshire and Harrogate Health and Care Partnership (previously STP), is shown below:



SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the WYMHS Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the WYMHSC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYMHSC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYMHSC C-In-C for resolution.

1.5 The WYMHSC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYMHSC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in paragraph 2.4 of the MoU and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYMHSC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the WYMHSC C-In-C reached in accordance with the above, it shall inform the WYMHSC C-In-C within 10 Business Days and request that the WYMHSC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the WYMHSC C-In-C, on a "Best for Meeting the Key Principles" basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYMHSC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYMHSC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

WYMHSC CIC DECISION MAKING

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the WYMHSC Committee in Common (WYMHSC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the WYMHSC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the WYMHSC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The WYMHSC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the WYMHSC C-In-C will require a detailed case for change. At this stage the WYMHSC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6. The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the WYMHS Collaborative Programme.

8. Bilateral and Tripartite Agreements between Individual Trusts

8.1. The WYMHSC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYMHS outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other WYMHS trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the WYMHS Collaborative Programme.

8.2. Recognising that being part of the WYMHSC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

8.3. Parties may wish to invite other organisations to be party to initiatives agreed by the WYMHSC C-In-C.

9. Forum for engaging with the wider system

9.1. The WYMHSC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the WYHHCP) on specific issues.

SCHEDULE 5

WYMHSC Committees in Common -TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE WYMHSC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

1.1. The WYMHSC C-In-C will be responsible for leading the development of the WYMHS Collaborative Programme and the workstreams in accordance with the Key Principles, setting overall strategic direction in order to deliver the WYMHS Collaborative Programme.

2. Standing

2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the WYMHSC C-In-C

3.1. The general responsibilities of the WYMHSC C-In-C are:

(a) providing overall strategic oversight and direction to the development of the WYMHS Collaborative Programme;

(b) ensuring alignment of all Parties to the vision and strategy;

(c) formally recommending the final form of the collaborative programme, including determining roles and responsibilities within the workstreams;

(d) reviewing the key deliverables and ensuring adherence with the required timescales;

(e) receiving assurance that workstreams have been subject to robust quality impact assessments

(f) reviewing the risks associated with the performance of any of the Parties in terms of the impact to the WYMHS Collaborative Programme- recommending remedial and mitigating actions across the system;

(g) receiving assurance that risks associated with the WYMHS Collaborative Programme are being identified, managed and mitigated;

(h) promoting and encouraging commitment to the Key Principles;

(i) formulating, agreeing and implementing strategies for delivery of the WYMHS Collaborative Programme;

(j) seeking to determine or resolve any matter referred to it by the WYMHSC Programme Executive or any individual Party and any dispute in accordance with the MoU;

(k) approving the appointment, removal or replacement of key programme personnel;

(l) reviewing and approving the Terms of Reference of the WYMHSC Programme Executive;

(m) agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4. Members of the WYMHSC C-In-C

4.1. Each Party will appoint their Chair and Chief Executive as WYMHSC C-In-C Members and the Parties will at all times maintain a WYMHSC C-In-C Member on the WYMHSC C-In-C.

4.2. Each WYMHSC C-In-C member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYMHSC C-In-C Member is not personally present and do all the things which the appointing WYMHSC C-In-C Member is entitled to do.

4.3. Each Party will be considered to be one entity within the collaborative.

4.4. The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYMHSC C-In-C Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYMHSC C-In-C.

5. Proceedings of WYMHSC C-In-C

5.1. The WYMHSC C-In-C will meet quarterly, or more frequently as required.

5.2. The WYMHSC C-In-C shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYMHSC members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYMHSC C-In-C into the Parties' Trust Boards.

5.3. The Parties will select one of the Parties' Chairs to act as the Chair of the WYMHSC C-In-C meetings on a rotational basis for a period of twelve months. There shall also be a Deputy Chair nominated. The Deputy Chair will be the succeeding chair of the C-In-C at the end of the incumbent Chair's term.

5.4. The WYMHSC CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.5. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYMHSC C-In-C Member present.

5.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

5.7. A meeting of the WYMHSC C-In-C may consist of a conference between the WYMHSC C-In-C Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.8. Each WYMHSC C-In-C Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYMHSC Collaborative Programme.

5.9. The WYMHSC C-In-C will review the meeting effectiveness at the end of each meeting.

6. Decision making within the WYMHSC C-In-C

6.1. Each WYMHSC C-In-C Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

6.2. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYMHSC C-In-C Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

6.3. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYMHSC C-In-C Members reaching an agreed consensus decision in common in accordance with the Key Principles.

6.4. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYMHSC Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at WYMHSC C-In-C meetings

7.1. The WYMHSC C-In-C shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYMHSC C-In-C.

8. Administration for the WYMHSC C-In-C

8.1. Meeting administration for the WYMHSC C-In-C will be provided by the WYMHSC Programme Office, maintaining the register of interests and the minutes of the meetings of the WYMHSC C-In-C.

8.2. The Company Secretary/Governance lead of the incumbent Chair will have responsibility for providing governance advice and finalising agendas and

minutes with the Chair.

8.3. The agenda for the meeting will be agreed by the WYMHSC C-In-C Chair. Papers for each meeting will be sent from the Programme Office to WYMHSC C-In-C Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Programme Director will provide a summary for sharing in the public domain.

9. Review

9.1. The WYMHSC C-In-C will review these Terms of Reference at least annually for approval by the Parties.

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (17)

Trust Board public workplan 2018-19
Version 5 16 May 2018

Topic	Frequency	Lead officer	29 March 2018	25 May 2018 (revised from 1 June 2018)	3 August 2018	6 October 2018	4 December 2018	1 February 2019
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	EDN	X (Children's SLT)	X (MSK)	X	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X
Care Quality Commission inspection reports	as required	EMD				X		
Quality account	annual	EDN		X				
Staff survey	annual	DW	X					
Safe staffing report	2 x year	EDN			X			
Seasonal resilience	annual	EDO	X CEs report			X CE's report		
Serious incidents report	4 x year	EDN		X	X	X		X
Patient experience: complaints and incidents report	2 x year	EDN		X Annual report			X Six monthly report	
Freedom to speak up annual report	annual	CE			X			
Guardian for safe working hours report	4 x year	EMD		X Annual report	X		X	X
Strategy and planning								
Operational plan including financial plan	2 x year	EDFR	X	X End of year report		X		
Service strategy	as required	EDFR	X Chidren's strategy					
Quality strategy	annual	EDN						X
Professional strategy	annual	EDN					X	
OD strategy	2 x year	DW		X Deferred	X		X	
Research and development strategy	annual	EMD			X			
Other strategic service developments	as required	EDO						
Reports								
Equality and diversity report	annual	EDN					X	
Safeguarding annual report	annual	EDN				X		
Infection prevention control annual report	annual	EDN				X		
Emergency preparedness and resilience report and major incident plan annual report	annual	EDO				X		
Governance								
Medical Director's report: doctors' revalidation	annual	EMD			X			
Nurse revalidation	annual	EDN			X			
Well-led framework (in CE's report)	2x year	CS			X		X	
Annual report	annual	EDFR		X				
Annual accounts	annual	EDFR		X				
Letter of representation	annual	EDFR		X				
Audit opinion	annual	EDFR		X				
Audit Committee annual report	annual	CS		X				
Standing orders/standing financial instructions review	annual	CS	X Deferred	X				
Annual governance statement	annual	CS	X					
Going concern statement (part of corporate governance update)	annual	EDFR	X					
NHS provider licence compliance	annual	CS		X				
Committee terms of reference review	annual	CS		X				
Board and sub-committee effectiveness	annual	CS		X				
Register of sealings	annual	CS		X				
Declarations of interest/fit and proper persons test (part of corporate governance update)	annual	CS	X					
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X
Corporate governance update	as required	CS						
Decisions for ratification	as required	CS		X Cyber security				
Board workplan	every meeting	CS	X	X	X	X	X	X
Minutes (for noting)								
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board (for noting)	every meeting	CS	X	X	X	X	X	X
Additional items								
West Yorkshire Mental Health Services Collaborative	as required	CE		X MoU				
West Yorkshire and Harrogate Health and Care Partnership	as required	CE						

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
EMD	**Executive Medical Director**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required

Leeds Community Healthcare NHS Trust

Audit Committee

Boardroom, Stockdale House, Headingley Office Park, Victoria Road, Leeds, LS6 1PF
Friday 16 March 2018
12.30 am – 3.30pm

Agenda item 2018/19 (18a)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
	Ian Lewis (IL)	Non-Executive Director
In Attendance:	Cherrine Hawkins	Deputy Director of Finance and Resources
	Diane Allison	Interim Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Beric Dawson	Counter Fraud Specialist (TIAA Limited)
	Claire Partridge	External Audit Partner (KPMG)
	Richard Slough	Assistant Director Business Intelligence, Systems & IT (For Item 58)
	Jayne Cowell	Interim GDPR Project Manager (For Item 58)
Apologies:	Bryan Machin	Executive Director of Finance and Resources
	Matthew Moore	External Audit Manager (KPMG)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2017-18 (57)	**Welcome, introductions and preliminary business** The Chair welcomed members and others in attendance.	
2017-18 (57a)	**Apologies** Apologies were received from the Executive Director of Finance and Resources and Matthew Moore, External Audit Manager, KPMG.	
2017-18 (57b)	**Declarations of interest** There were no declarations of interest.	
2017-18 (57c)	**Minutes of the previous meeting 8 December 2017** The minutes of the meeting held on 8 December 2017 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the previous meeting held on 8 December 2017.	
2018-18 (57d)	**Matters arising and actions' log** *Item 48b: External audit technical update* The Deputy Director of Finance and Resources confirmed that the Trust had received the Sustainability and Transformation Fund monies for Q2 and Q3. All other actions had been completed or were covered by the agenda and there were no further matters arising from the minutes.	

2017-18 (58a)	**General Data Protection Regulation: action plan** The Assistant Director of Business Intelligence, Systems and IT presented the report and action plan which set out the Trust's approach to ensuring compliance with the General Data Protection Regulation (GDPR) which comes into effect from 25 May 2018 and the Data Protection Bill currently awaiting Parliamentary approval. He explained that the action plan was aligned with the Information Commissioner's Office (ICO)'12 steps' guidance. The Committee noted the approach and governance arrangements which had been established and agreed that reasonable assurance had been received particularly through the discussion around the presentation of the plan. The Chair of the Committee requested that a further paper be provided to the next meeting specifically to provide assurance that completion of the action plan would ensure a satisfactory compliance position by 25 May 2018 and also to provide assurance that outstanding actions and timescales would be regarded as sufficient by the ICO. She also asked that the paper include an update on progress on the establishment of a network of information asset owners. **Action: A paper to be presented at the next Committee meeting on 20 April 2018 to provide:** • **assurance that completion of the action plan would ensure a satisfactory compliance position by 25 May 2018** • **assurance that outstanding actions and timescales would be regarded as sufficient by the ICO** • **an update on progress on the establishment of a network of information asset owners.** **Outcome:** The content of the report was noted.	**Deputy Director of Finance and Resources**
2017-18 (59a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and action plan. He explained that a number of factors had impacted on the timetable for completion of the remaining audits for 2017/18 including resourcing issues at TIAA Limited which were being addressed. He advised that four audits had been completed since the Committee's last meeting on 8 December 2017. There were three audits with a reasonable assurance opinion and one was an advisory opinion on part 1 of an operational review of the Trusts self-assessment of its compliance with the IG Toolkit. These reports were received by the Committee. <u>Progress against the annual plan for 2017/18</u> The Internal Audit Manager introduced the report; particularly noting the progress already made on the remaining reports due by the end of quarter four. The Committee reviewed progress against the 2017/18 internal audit plan and raised concerns about it in anticipation of the year-end reporting timetable and the assurance required. The Internal Audit Manager updated the Committee on the current status of the outstanding audits, anticipated completion and reporting dates. He advised that all completed audits already in the draft report stage would be finalised in time for the next Committee meeting on 20 April 2018. He advised that the majority of audits still in fieldwork would be sufficiently complete to assess the level of assurance to be reported.	

	The Chair of the Committee remained concerned that there was a significant amount of work to progress during March and April 2018 to ensure that the outstanding reports would be finalised on time. The Chair of the Committee referred to the section in Appendix A which contained provisional assessments for the draft reports that had been issued. She particularly asked for more information about the payroll audit, which was anticipated as a limited assurance opinion. The Internal Audit Manager explained that he was still awaiting management comments on the draft report but did not expect the assurance opinion to change. He added that there were no priority one recommendations in the report and the majority were priority two. The Deputy Director of Finance and Resources advised that the recommendations focused on the lack of standard operating procedures and guidance to underpin the payroll processes. In addition she said that the regular quarterly meetings with the external payroll provider which formed part of the service level agreement had been postponed and acknowledged that this did not demonstrate robust control of the contract arrangements. In response to a question from a Non-Executive Director (RG), the Internal Audit Manager said he felt that the issues raised in the report could be quickly resolved. The Committee received assurance that the findings in the report did not raise fundamental control issues around payroll, which might give concern for year-end reporting. The Deputy Director of Finance and the External Auditor confirmed that other work their teams had undertaken in the payroll area supported that conclusion. The Committee discussed the executive summary and management action plans for the audits finalised since the last meeting. *Key financial systems* Referring to Recommendation 4, the Deputy Director of Finance and Resources confirmed that the Audit Committee would be formally asked to approve the invoice and purchase order authorisation levels. **Action: To update the invoice and purchase order authorisation levels in the standing orders and standing financial instructions.**	**Deputy Director of Finance and Resources**
	Staff recruitment and retention The Chair of the Committee asked that the responsible officer for all audits be the Executive Director. **Action: All audit recommendations to be assigned to appropriate executive director.**	**Internal Audit Manager (TIAA)**
2017-18 (59b)	**Internal audit recommendations update** The Deputy Director of Finance and Resources presented the report. She referred to the summary report for all internal audit recommendations that had an agreed implementation date by 31 January 2018 and the more detailed report on the outstanding actions. She noted that there were seven recommendations to report that had not been completed by the due date and these were reported in detail with an update on progress from the responsible manager.	

	The Committee discussed the overdue recommendations. Referring to the audit of the Neighbourhood Teams Capacity and Demand, a Non-Executive Director (IL) noted that four recommendations relating to the audit had a revised deadline of 30 September 2018. In particular he was concerned about the clinical risks associated with the delay in implementing the recommendations relating to allocation processes and caseload reviews. He asked for a report to be made available to the Quality Committee about how the clinical risks associated with these processes were currently being managed. **Action: A report to be made available to the Quality Committee about the management of the clinical risks associated with the delay in implementing the recommendations related to the allocation processes and caseload reviews.** **Outcome:** The internal audit update report was received and the contents noted. Including progress against the internal audit recommendations.	**Interim Company Secretary**
2017-18 (59c)	**Head of Internal Audit interim opinion** The Head of Internal Audit introduced the draft year-end report and stated that the draft opinion was that reasonable assurance could be given and that there was a generally sound system of internal control, designed to meet the organisation's objectives and that controls were generally being applied consistently. However, some weaknesses in the design and/or the inconsistent application of controls put the achievement of particular objectives at risk. This conclusion was based on the current audit findings; maintaining the level of assurance contained in the draft opinion was dependant on the outcome of outstanding audits and evidenced progress with high priority recommendations. **Action: Final internal audit year-end report to be presented at the next Committee meeting in April 2018.** **Outcome:** The Head of Internal Audit opinion was noted.	**Internal Audit Manager (TIAA)**
2017-18 (59d)	**Draft internal audit annual plan 2018/19** The draft internal audit annual plan for 2018/19 was presented by the Internal Audit Manager. He advised that during March 2018, meetings had been arranged with all the executive directors to discuss and review the plan and input from the Business and Quality Committees had been requested. A final version would be presented for approval at the Audit Committee meeting on 20 April 2018. The Committee reviewed the plan and felt that an information/ cyber security audit should feature on an annual basis from now onwards to reflect the heightened and increasing risk that this posed for all organisations. The Committee also made some recommendations about the BAF / Risk management, which had been audited on an annual basis, and suggested that a 'deep dive' approach to two selected strategic risk areas would be beneficial for the 2018/19 audit. The Committee suggested that an audit considering the changing landscape of partnership working should also be included, because of the level of exposure to this risk. For practical planning purposes, the Committee noted that the Executive Directors would need to consider ownership of the audits that were assigned to the Medical Directorate in the 2018/19 plan. **Action: The Internal Audit Manager to make changes to the draft plan for 2018/19 in response to feedback from all subcommittees of the Board and bring back to April meeting for approval.**	**Internal Audit Manager (TIAA)**

2017-18 (60a)	**External Audit** **External audit technical update** The External Audit Manager presented the technical update for March 2018. She drew the Committee's attention to the item on the reduction in pensions tax thresholds and the need to ensure that employees understood the implications of breaching the standard annual allowance of £40,000. She added that pensions tax issues were beginning to affect recruitment and retention within the NHS and understanding who was or might be affected was becoming increasingly important for trusts. The Deputy Director of Finance and Resources agreed to explore what actions the Trust was taking to identify staff affected by the pensions tax and assess the impact. **Action: An update to be provided on actions the Trust was taking to identify staff affected by the pensions and assess the impact.** **Outcome:** The Committee received and noted the update	**Deputy Director of Finance and Resources**
2017-18 (61)	**Counter Fraud and security management** **Counter fraud: Risk Assessment and strategic work plan 2018/19** The Local Counter Fraud Specialist presented the fraud risk assessment and strategic workplan for the Trust for 2018/19. The fraud risk assessment was split into several key areas where fraud could occur and included an analysis of the Trust specific fraud risks (RAG rated) alongside the TIAA portfolio and national policy issues. The strategic workplan is a three year rolling plan, cross-referenced to the fraud risk assessment as well as to the NHS Counter Fraud Authority Standards for providers. In response to a question from a Non-Executive Director (RG), the Local Counter Fraud Specialist advised that one risk had scored higher than last year but there was no significant movement on other risks. The Committee discussed the risks associated with cyber security. The Local Counter Fraud Specialist alerted the Committee to a cybersecurity maturity assessment, which could be performed for the Trust to provide a snapshot of the Trust's current position. The Committee asked that this should be undertaken in 2018/19. **Action: A cybersecurity maturity assessment to be added to the fraud risk assessment and strategic work plan for 2018/19** The Chair of the Committee asked if the Trust had assessed the value/need of undertaking its own test phishing exercise. The Deputy Director of Finance and Resources agreed to seek a view from the Executive Director of Finance and Resources and Assistant Director Business Intelligence, Systems and IT as to whether it would be beneficial for the Trust to undertake such an exercise. **Action: The Deputy Director of Finance and Resources to raise the possibility of the Trust undertaking a phishing exercise with the Executive Director of Finance and Resources and Assistant Director of Business Intelligence, Systems and IT.** **Outcome:** The Committee received and approved the fraud risk assessment and counter fraud annual work plan.	**Local Counter Fraud Specialist (TIAA)** **Deputy Director of Finance and Resources**

2017-18 (62a)	**Annual report and accounts** **Annual reports and accounts timetable and progress report** The timetable for the production of the Trust's annual report and accounts was received. The Deputy Director of Finance and Resources said that all aspects were being completed to timescale. The Chair of the Committee referred to the remuneration disclosures and observed that the Nominations and Remunerations Committee should have the opportunity to review the disclosures before they were presented to the Board as part of the accounts on 25 May 2018. She asked that a teleconference be arranged for members of the Nominations and Remuneration Committee to review the remuneration disclosures ahead of the meeting of the Audit Committee on the 12 May 2018. **Action: The Interim Company Secretary to arrange for the Nominations and Remuneration Committee to review the remuneration disclosures before the Audit Committee meeting on 12 May 2018.** **Outcome:** The detailed annual report and accounts timetable was noted.	**Interim Company Secretary**
2017-18 (62b)	**Going concern consideration** The Deputy Director of Finance and Resources presented the going concern paper for consideration by the Committee. **Outcome:** Based on the paper the Committee recommended to the Board that when approving the annual accounts it does so in agreement that the Trust is a going concern.	
2017-18 (62c)	**Annual governance statement** The Interim Company Secretary introduced the draft annual governance statement for 2017/18 which would form part of the annual report and accounts and would be available for external auditors to review as part of the process to finalise the annual accounts. The Committee members reviewed the statement and made a number of observations: • some text to be included on the Care Quality Commission inspection and conclusions relating to governance under the well-led domain • the sub-committees to be involved earlier in the process of developing the annual report for 2018/19 • BAF internal audit opinion – revision of the wording on page nine **Action: Revisions to be made to the annual governance statement to reflect the Committee's comments.** **Outcome:** The Committee reviewed and commented on the draft annual governance statement prior to consideration by the Board.	**Interim Company Secretary**
2017-18 (63a)	**Financial controls** **Tender and quotations waiver report** The Deputy Director of Finance and Resources introduced the report. She advised that the report represented an extract from the 2017/18 register of waivers completed during the financial year. She noted there had been a total of 21 waivers to the end of February 2018; the report contained details of the five waivers completed since the last report to the Committee.	

	Outcome: The Committee received the report and the content was noted.	
2017-18 (63b)	**Losses, compensation and special payments report** The Deputy Director of Finance and Resources presented the report which covered any such transactions made between December 2017 and February 2018. The Chair of the Committee noted that the total value for the reporting period was £88,346.82 relating to the write off of historic debts, including 2 significant amounts associated with the decision to terminate one specific contract which the Board were well sighted on. **Outcome:** The losses, claims and special payments report was received and noted by the Committee.	
2017-18 (63c)	**Over and under payments of salary and off payroll payments** The Deputy Director of Finance and Resources presented the report which provided details of under and over payments of salary for the period to 31 January 2018. **Outcome:** The Committee received and noted the report and the current position.	
2017-18 (63d)	**Receivables and Payables** The Executive Director of Finance and Resources presented the report which provided details of aged trade receivables (debtors) and payables (creditors) individually over £5,000 in value as at 28 February 2018, subsequent transactions and actions to clear the balances. **Outcome:** The Committee received and noted the report and the current position.	
2017-18 (63e)	**Review of investment policy** The Deputy Director of Finance and Resources reported that the Executive Director of Finance and Resources had reviewed the policy and no changes were proposed. **Outcome:** The Committee noted that no changes were proposed to the Investment Decision Making Policy.	
2017-18 (64)	**Internal Audit: appointment of internal auditors** The Deputy Director of Finance and Resources reminded members that at the meeting on the 8 December 2017 the Committee had agreed in principle that the internal audit and counter fraud contract be awarded to TIAA Limited for two years with the option for a one plus one year extension. This was subject to final agreement being sought from the Chair of the Committee following the meeting. The Chair of the Committee confirmed that she supported the decision made in principle on 8 December 2017. **Resolved:** That the internal audit and counter fraud contract be awarded to TIAA Limited for two years with the option for a one plus one year extension. **Outcome:** The Committee ratified the decision made in principle on 8 December 2017 to award the internal audit and counter fraud contract to TIAA Limited.	
2017-18 (65)	**Minutes for noting** The minutes of the Information Governance Group on 12 December 2017 were presented. **Outcome:** The minutes were noted.	

2017-18 (66)	**Audit Committee work plan** There were no matters removed from the workplan. One change needed to be made to the entry under the counter fraud annual report: self- review toolkit to remove reference to a specific year **Action**: **The workplan to be amended in relation to the entry under counter fraud annual report: self-review toolkit to remove the reference to a specific year.** **Outcome:** The workplan was noted.	**Interim Company Secretary**
2016-17 (67)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to be referred to Board colleagues: • Action plan for GDPR and request for further assurance at next meeting • Internal audit and shared responsibility for conclusion of the outstanding work and reports in time for the year-end reporting • Counter fraud – a cyber assurance maturity assessment had been requested	
2016-17 (68)	**Any other business** A Non-Executive Director (RG) briefed the Committee on a recent event he had attended where Bradford District Care Trust presented a briefing on their recent Care Quality Commission well-led assessment.	
	Date and time of next meeting Friday 20 April 2018 9.00am- 11.30am, Boardroom, Stockdale House Leeds Community Healthcare LS61PF	

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Leeds Community Healthcare NHS Trust

Item 2018/19 (18b)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Friday 16 March 2018 (1.00 – 4.00 pm)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD)
	Bryan Machin	Executive Director of Finance & Resources
	Ann Hobson	Interim Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Debra Gill	Head of Service (in attendance for item 93 only)
	Emma Williams	Lead Nurse (in attendance for item 93 only)
	Janet Addison	HoS for SLT & Project Manager for Children's Strategy (in attendance for item 94a only)
	Caroline Schonrock	Business Planning Manager (in attendance for item 96a only)
Observer:	Graham Hyde	Head of Business Intelligence
Apologies:	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Diane Allison	Interim Company Secretary
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(92)**	The Chair welcomed everyone to the meeting. **92a - Apologies**: As above. **92b - Declarations of Interest**: None recorded. **92c - Minutes of last meeting:** The public and private minutes of the meeting dated 21 February 2018 were approved by the Committee. **92d – Matters arising from the minutes and review of actions:** No further actions were noted; all actions on the action log due for completion by 16 March 2018 were completed.	
2017/18 **(93)**	**Service area focus: School immunisation team presentation** The Chair welcomed representatives from the school immunisation team. The service representatives spoke positively about achievements, issues, challenges and successes. They expressed concern about the service going out to tender at the same time as 0-19 service tender.	

	The Committee heard that the immunisation service was the second most effective public health intervention next to clean water. The school immunisation team offered immunisations to all children and young people in Leeds in accordance with the national childhood immunisation schedule. The team worked on the basis of the academic year in a school based programme as opposed to the financial year and had an excellent partnership working within schools based on a tight framework to fit sessions into school holidays, exams, etc. The Chair asked about digital technology and its implementation, particularly if this was a requirement of potential tenders. The Head of Service said that the digital technology costings would be incorporated into the response to the tenders, and that work was underway to produce a business case for a high quality service. A Non-Executive Director (TD) asked about the outcome measures of people immunised within the contract. The Head of Service said that in terms of commissioner feedback the outcome was based on different targets because of the influenza immunisation service being commissioned separately. The human papilloma virus (HPV) vaccine had two immunisations within it and people had to have both in order to achieve the 90% target. Feedback to commissioners on both doses had been provided within a tight timeframe of six months. The Chair thanked the team for the presentation and noted the tender-ready work programme. **Action:** The Executive Director of Finance & Resources agreed to visit the school immunisation team for a service visit. **Outcome:** The presentation by the school immunisation team was well received by the Committee. The team had over achieved on all targets for the previous year and were proud for the recognition of winning team of the year in that year.	BM
2017/18 **(94)**	**Strategy development and implementation** **94a – Children's services strategy** The Executive Director of Operations introduced the final children's services strategy that the Committee had received previously in different stages of development. She said there had been some minor changes since the last Committee meeting in February 2018. There had been further discussion outside the meeting between the Chair of the Business Committee, the Chair of the Quality Committee and the Executive Director of Operations about the positioning of the strategy in the city. The Executive Director of Operations asked the Committee for their final comments on the document within the next twenty-four hours before the internal strategy had to be submitted for signing off at the Trust Board meeting on 29 March 2018 for implementation. A Non-Executive Director (TD) was pleased to note that the strategy was more ambitious in terms of scope and prevention and focusing on outcome.	

	Outcome: The Committee gave its approval for submission to the Trust Board meeting in March 2018.\	
2017/18 **(95)**	**Project management** **95a – Projects' highlight reports** The Executive Director of Finance & Resources introduced the projects' highlight report for the Committee to note the progress against the project plan for electronic patient record (EPR) and patient administration review. *Patient administration review* The Executive Director of Operations said that the patient administration review was progressing to plan. There had been a number of staff engagement events within the children's business unit about the administration review to assess staff's anxiety levels from one to four and noted that there had been a fairly consistent distribution of ratings across the four areas. The Executive Director of Operations said that a meeting with a Non-Executive Director (RG) had taken place on 20 March 2018 to discuss the design principles. *Electronic patient record (EPR)* The Executive Director of Operations said that the EPR project was on track. No further comments were noted. **95b – E-rostering** The Executive Director of Finance & Resources provided a verbal update on the e-rostering project. He said that the Programme Board was continuing to develop the project initiation document (PID) and that engagement with staff using the system was underway to gather their views. The Executive Director of Finance & Resources said that at the next Programme Board meeting on 12 April 2018 the PID was to be launched for implementation on a phased basis starting with the neighbourhood teams and bank staff supported by 'Allocate' (the software provider) before the system would be rolled out across the organisation. The Interim Director of Workforce said that two further sessions with Allocate were planned and a visit to Derbyshire Community NHS Trust had been arranged to see the system in operation. **Outcome:** The e-rostering Programme Board on 12 April 2018 to consider the launch of the PID and the business case, followed by further discussions at SMT meeting and the Business Committee in April 2018.	
2017/18 **(96)**	**Business planning** **96a – Operational plan 2018/19** The Executive Director of Finance & Resources presented the Trust's draft 2018/19 operational plan to review prior to submission to the Trust Board for approval on 29 March 2018.	

	The 2018/19 priorities had been developed in consultation at the Trust Board workshops and comments received from the February 2018 Business Committee. The draft 2018/19 operational plan reflected continuity from the 2017/18 operational plan and alignment with the West Yorkshire and Harrogate Health and Care Partnership Plan and Leeds Health and Care Plan. The Committee was assured that the priorities for 2017/18 had been progressed; some 2017/18 Trust priorities were now indicated as key focuses supporting the delivery of the 2018/19 priorities. The priorities for 2018/19 had been re-assessed by the executive team and confirmed as being deliverable in full. The Executive Director of Finance & Resources said that the operational plan was also being presented to the Quality Committee on 19 March 2018 before Board approval on 29 March 2018. He said in terms of the financial plan an abridged version would form part of the operational plan. The Chair referred to the significant number of priorities reflected both in the Trust priorities and Quality Account priorities and said that the Board was interested in the top level commitments. The Executive Director of Finance & Resources agreed that the key focuses included operational detail that was not appropriate to include in the plan. The Executive Director of Finance & Resources said that the final plan would be amended to reflect this. The Chair suggested adding timeframes for implementing the priorities which would give assurance about deliverability of the plan. He added that he believed that a number of the success measures were indications, rather than specific measures of success. The Executive Director of Finance & Resources agreed to produce timelines for implementing the priorities and reflect on the comments received. He said further work was planned to define success measures in SMART terms and Quality Account priorities. A Non-Executive Director (TD) said he was concerned about some of the objectives in priority 6 'Continue to improve compliance within two years with the National Institute for Health and Care Excellence'. The Executive Director of Operations said that there was still some scoping to complete. **Outcome:** The Committee reviewed the draft 2018/19 operational plan. It recommended further consideration on a number of points. **96b – 2018/19 financial plan** (Please see private minutes) **96c – CAMHS new care model** The Executive Director of Finance & Resources said that in May 2017, Leeds Community Healthcare NHS Trust (LCH) submitted a successful proposal to NHS England to become a New Model of Care Child and Adolescent Mental Health Services Tier 4 (CAMHS T4) pilot site. The Trust was delegated with a £9m budget for the project. The due diligence on the 2016/17 data assessment assured the Trust that there would be an achievable savings from set up money and from a separate bid for crisis money into the organisation.	

	The Executive Director of Finance & Resources said that the £9m included cohort of patients managed under the transforming care partnership agreement which had reduced the delegated budget from £9m to £7.57m. The reduction in budget reduces the savings, and potentially takes the financial position to a deficit. It was noted that this would be recovered during next year by the carry forward of the set up money and the crisis bid money. The 2017/18 due diligence confirmed that the identifiable savings were achievable; this view was supported by an under spend of £800k in NHS England's books in 2018/19. Outcome: The Trust was taking lead provider responsibility for the West Yorkshire NCM from 1 April 2018.	
2017/18 **(97)**	**Performance management** **97a - Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports. The main issues for consideration were as follows: *Safe* The Trust was currently achieving most of its targets within the safe domain for the year to date. The exception was avoidable category 4 pressure ulcers recorded for the year to date. *Caring* All indicators remained as expected rated green at year end. The percentage of inpatients recommending care (friends and family test - FFT) in February had been noted as at 100%. *Effective* Clinical Audits measure forecast remained rated as green for the year but a number of Audits had been abandoned from the programme due to reconfiguration of services (7 audits). Other contributing factors included resource within teams/services reduced due to capacity and that some audits were no longer necessary or relevant to their service. *Responsive* The Trust continued to perform well in its indicators relating to waiting lists. *Well Led* Total sickness absence remained above target but was rated amber for short term sickness (2.4%). Long term sickness (3.6%) was improving and was rated green for February 2018. There had been an improvement in the agenda for change staff appraisal rate (80.3%) but remained rated as red. A Non-Executive Director (TD) noted that the three main domains for the clinical audit effectiveness had a disparity between clinical audit in the summary cover paper rated as green and amber in the report. The Executive Director of Operations said that clarification on the clinical audit measure would be provided at the Quality Committee meeting on 19 March 2018.	

	Outcome: The Committee noted the levels of performance across areas of challenge. *Finance* Trust finances were in line with forecast and expected to hit the control total at year end. **97b – Draft key performance indicators (KPIs)** The report described the changes to the high level indicators to be used to assess the Trust's performance in the performance brief for 2018/19. The Executive Director of Finance & Resources said that some of the proposed measures required development for implementation during 2018/19. The Chair commented on the 5% reduction in falls resulting in harm being discontinued. It was noted that the Quality Committee would be reviewing that indicator and also the safe and effective domain measures, and in the responsive domain the discontinued or removed indicators. The Executive Director of Operations said that the indicators that were in the quality account previously were not being continued this year. A new measure, data quality maturity index score to be re-assessed to determine whether this was part of safe domain. The Interim Director of Workforce said that she had refreshed the targets in the routinely provide updates for the well led domain in the quarterly performance report. A new target of 14.5% for staff turnover was the same as the NHS Improvement plan for recruitment and retention. Reducing the number of staff leaving the organisation within twelve months was set at 22%. The Interim Director of Workforce said that this target fluctuated but she agreed to review the current performance target of 12% for the corporate objectives. In the next workforce quarterly report due in April 2018, the Interim Director of Workforce said that she would be able to report on efficiency and effectiveness of the recruitment processes. A detailed discussion took place regarding the discontinued measures, and concerns were raised about staff FFT measure that had been a meaningful indicator. The Interim Director of Workforce said that work was continuing to gather data with a view to retaining it and monitoring regularly. It was noted that the outcome from staff survey would be embedded locally. The Interim Director of Workforce agreed to explore the FFT measure further. The Chair asked about the self-management measure that was not part of key performance indicators; an important measure to increase the level of delivery in terms of improvement. The Executive Director of Operations said that she would be looking into the benefits in several domains, and the impact on productivity and patients. She said this was part of a productivity group's remit, introducing new ways of working and demonstrating benefits realisation. **Action:** • Workforce quarterly report to include alternative practices and measures for effective recruitment processes. • The progress on the self-management approach (in terms of productivity, outcomes, etc.) to be considered at a future meeting. • The Executive Director of Finance & Resources to describe the remit of the productivity group at the next meeting in April 2018.	AH SP BM

	Outcome: The Committee approved the list of high level indicators for 2018/19. **97c – Business Committee annual report 2017/18 and terms of reference** A draft annual report 2017/18 was received by the Committee for approval. The current terms of reference were also presented for endorsement or amendment as delegated by the Trust Board. The report provided an overview of the workings of the Committee and demonstrated that the Committee had complied with the respective terms of reference. It was noted that the Executive Director of Operations asked to become a member of the Committee. The Chair of the Committee agreed to review the membership and attendance of the Committee and proposed to discuss the matter with the Chair of the Trust. The Chair asked whether the Committee's responsibility, its remit and processes best serviced the Trust in terms of planning issues, strategic issues and project issues. A detailed discussion took place on the Committee's effectiveness. The Executive Director of Operations suggested that the service deep dive format is re-considered to focus on service performance and issues highlighted and escalated in the heat map. It was agreed that this type of conversation should be taking place at the performance panel meetings, and then brought to the attention of the executive team to demonstrate challenges and hot spots before discussions at the Business Committee meeting for assurance. The Chair agreed to the proposition, and said that the first step was to try and change the regular cycle of presentations and then to move to an escalation process around the hot spots in the business. The Executive Director of Operations said that she would like to discuss the intervention process with the Senior Management Team (SMT). The Executive Director of Operations said that in terms of the three projects, she was in an early conversation with the project managers to re-assess the procedure. The Chair said that a composite report to the Committee highlighting key points, issues and risks would be sufficient for the Committee to consider going forward. The Executive Director of Finance & Resources said that the common themes coming through for each project could generate a report for assurance about each individual project approach for implementing. **Action:** The Executive Director of Finance & Resources to follow up on different approaches of generating progress reports and reporting mechanism. **Outcome:** The Committee approved the annual report prior to submission to the Audit Committee meeting on 20 April 2018.	BM

Board Assurance Framework (BAF)
The Executive Director of Finance & Resources tabled appendix 1 and 2 of BAF strategic risks for 2018/19, providing assurance to the Trust Board. The report set out those strategic risks which were aligned with the work of the Business Committee.

The Executive Director of Finance & Resources reviewed the strategic risks on the BAF in line with operational plan for 2018/19 so that the Trusts objectives were effectively managed.

Attention was drawn to the newly assigned BAF risk 3.3 (failure to engage with staff, creating low morale, retention issues, and failure to transform services). The Executive Director of Finance & Resources said that he would be working with the Interim Company Secretary about the governance processes for BAF risk 4.1 and 4.5 (working in partnership to deliver integrated care).

Outcome:
The Committee received and agreed the revised strategic risks for 2018/19 BAF.

97d - Operational and non-clinical risks register 8+
The Executive Director of Finance & Resources introduced the risk register. The summary report showed changes to note to the risk register since February 2018, as follows:

- No new operational or strategic risks
- No risks with an increased score
- Three risks with a decreased score
- One risk had been closed since the previous report.

There were two extreme risks in total (scoring 15 or more) as at 1 March 2018; risk 224 – reduced level of care due to the prevalence of staff sickness, and risk 872 - difficulties recruiting to and retaining staff within neighbourhood teams.

The Chair asked if there had been a plan for staffing capacity for the year ahead. The Interim Director of Workforce responded to say that an annual workforce plan was being submitted to NHSI at end of April 2018, and each of the business units had a workforce plan triangulated with finance in terms of budgets and that the services were currently working towards forecasting for the new year.

Outcome:
The Committee noted the recent revisions made to the risk register.

97e - Internal audit report (staff recruitment and retention)
The internal audit report provided a summary of the outcomes from completed internal audit report related to the review of staff recruitment and retention. The review considered the Trust's recruitment and retention strategy, policies and processes and concluded that it provided reasonable assurance.

The Interim Director of Workforce said that the internal auditors picked up on two issues; an incomplete establishment control form and to ensure that

	all recruitment documentation were retained as required. She said that a reminder had been sent to all recruitment managers reminding them of the requirements to fully complete the forms. The recruitment team now had a process in place to monitor and spot check on a monthly basis. The Committee noted the outcome of the internal audit report relating to staff recruitment and retention as part of the approved 2017/18 plan. **Outcome:** The Committee noted the content of the internal audit report.	
2017/18 **(98)**	**Business Committee work plan** The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(99)**	**Matters for the Board and other Committee** • Children's services strategy • E-rostering • Operational plan and targets for 2018/19 • Review of Business Committee's format • Effectiveness governance arrangements and annual report • CAMHS new care model.	
2017/18 **(100)**	**Any other business** **Internal audit plan 2018/19** The Executive Director of Finance & Resources tabled a paper to advise the Committee of the finalised internal audit plan for 2018/19 that identified a number of key areas which required internal audit coverage during the year. He asked the Committee to review the audits highlighted in yellow relevant to the Business Committee which addressed areas of risk and provided assurance levels to the Committee. The Executive Director of Finance & Resources said that he would like comments emailed back to him by next week so that the agreed plan could be submitted to the next Audit Committee meeting in April 2018 for approval. **Outcome:** The Committee received the internal audit annual plan for 2018/19 and noted that completed audit reports would be received by the Committee during the course of the year.	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (18c)

Quality Committee
Monday 19 March 2018
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Neil Franklin	Trust Chair
	Dr Tony Dearden	Non-Executive Director
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Diane Allison	Interim Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Stephanie Lawrence	General Manager and Clinical Lead for Children's Services (joined at 10.20)
	Rhian Wheater	Quality Lead for Adult Services (joined at 10.20)
	Mandy Young	Senior Clinical Lead, Musculoskeletal and SpineFit Service (item 78)
	Tom Langford	Senior Practitioner, Musculoskeletal Service (item 78)
	Caroline Schonrock	Business Planning Manager (item 79e)
	Janet Addison	Head of Service, Children's Speech and Language Therapy and Project Manager for Children's Strategy (item 79f)
Observing	Olive Keating	Neighbourhood Clinical Quality Lead, Holt Park Neighbourhood Team
Minutes	Nicola Wood	PA to Executive Director of Nursing
Apologies	Thea Stein	Chief Executive
	Dr Phil Ayres	Interim Executive Medical Director
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (77a)	**Welcome and Apologies** Non-executive Director (IL) welcomed members to the meeting. Apologies were noted from Thea Stein, Dr Phil Ayres and Elaine Goodwin.	
2017-18 (77b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (77c)	**Minutes of meeting held on 19 February 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following two amendments: <u>Item 2017-18 (72a) clinical audit</u> • Amend 127 audits to 117 audits • Amend the wording on line three from 'would' be completed in year to 'could' be completed in year.	

2017-18 (77d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>Wording around closure of incidents and mortality</u> The General Manager and Clinical Lead for children's services informed the Committee that some of the overdue incidents were not closed down pending a discussion at the Mortality Surveillance Group. They proposed that these cases be closed down until they were due to be heard at the meeting. The Clinical Lead for Adult Services believed that these cases were to be discussed at business unit level rather than at the Mortality Surveillance Group. It was suggested the Clinical Lead for adult services and the General Manager and Clinical Lead for children's services discuss further and clarify the wording. **Action: Clinical Lead for adult services and the General Manager and Clinical Lead for children's services to clarify the wording around the overdue incidents and mortality.**	**Clinical Lead for Adult Services and General Manager and Clinical Lead for Children's Services**
Service spotlight: Musculoskeletal Service		
2017-18 (78)	The Executive Director of Nursing introduced colleagues from the Musculoskeletal Service (MSK). The Senior Practitioner and Senior Clinical Lead provided an overview of the presentation and provided an outline of the service. How the service was performing against key performance indicators: • Staff absence had reduced from 6% in November 2017 to 4.14% in February 2018. • Clinical supervision rates were at 85.71% against a target of 90%. • All statutory and mandatory training was up to date. Compliance was monitored by team managers. • Appraisals rates were at 92.13% against a target of 95%. • Harm incidents were very low. Learning from incidents was shared at team meetings. • Friends and family test: 98.69% of MSK patients and 98.36% of SpineFit patients would recommend the service. • Numbers of complaints received by the service were low. • Compliments were largely received through the friends and family test. All compliments and comments were shared with named staff. What was going well in the service: • Monthly in service training. • Weekly case discussion time with peers and senior members of staff. • Six monthly study days. • Band 7 development roles/succession planning. • NIHR Award (clinical lectureship). • Advanced training case accredited USS. • NICE compliant with arthritis and low back pain guidelines. Quality Challenge+ 2017/18 had reported as green for all standards with the exception of one amber rated standard requiring improvement. The Committee Chair thanked the team for the presentation which provided a clear view on the quality elements of the service. He asked how the service managed the 90,000 contacts per year. The Senior Practitioner for MSK said that the service operated 33,000 new contacts per year; the additional contacts were follow-up appointments. MSK contacts happened in a variety of clinics	

	across the city, mainly in GP practices and hub sites on a hub and spoke system. Some spinal treatment clinics operated from Chapel Allerton Hospital. In response to a query from Non-executive Director (TD), the Senior Practitioner for MSK said the range of interventions were initial assessment, MSK or physiotherapy treatment, investigation, injection and referral to secondary care. He continued to say that the Spinal Treatment Service had one point of referral and used a 'choose and book' system. Triage was carried out by senior practitioners using Tier 1: straightforward physiotherapy appointment and Tier 2: more complex requiring further referral. In response to a query from the Trust Chair around wait times following preliminary assessment and the current position of the service, the Senior Practitioner for MSK said that the patient was involved in the decision making and plan of treatment. He added that there was no ongoing pressure in the service or delay to treatment once the patient had been assessed. The Trust Chair asked if the pressure on the service was such that it could not guarantee to see the patient. The Senior Practitioner for MSK responded that there had been concern raised previously; however the service had conducted an internal review with colleagues to look at the perception of staff regarding pressure and morale, and to review diaries when slots became available. The concern had not been raised since the review. The Senior Clinical Lead for MSK highlighted that patients phoned the service following the initial assessment if their position had changed and added that therapists did try to meet individual patient's needs. The Clinical Lead for adult services asked how the MSK service supported self-management and new ways of working. The Senior Clinical Lead for MSK said that as part of the initial assessment, practitioners would ask the patients what their expectations were and what they thought was the best form of treatment. She added that some members of the team had attended the 'how to have a difficult conversation' training and the team were also in the process of completing the health coaching course. Staff were encouraged to have those difficult conversations with patients wherever possible, for example, the impact of carrying additional weight. Practitioners' also sign-posted patients to other services where appropriate, for example, long term conditions, diabetic service and the Improving Access to Psychological Therapies service. The Executive Director of Operations highlighted that the service was 'ahead of its time' with regards to new ways of working. The Senior Clinical Lead for MSK highlighted that some band 6 MSK physiotherapists also worked in the SpineFit service, which was cognitive therapy based, and the learning from this service was shared at case discussions. She added that the service was 'ahead' with de-medicalising. The Head of Medicines Management asked where the service was with regards to developing and implementing outcome measures. The Senior Practitioner for MSK said the service had looked a various tools and models and were using Patient Global Impression of Change (PGIC). The Senior Clinical Lead for MSK added that the PGIC audit was ongoing and the data should be available by 31 March 2018. The Senior Practitioner for MSK highlighted that the results from outcome measures were fed back to staff. The Head of Medicines Management suggested the service link in with the Trusts Outcome Measures Project Manager. In response to a query from the Committee Chair around quantification of outcome measures, the Senior Practitioner for MSK said that currently there	

	was no system in place to break down the data to quantify if individual conditions had improved due to treatment. In response to a query from Non-executive Director (TD) around staffing and skill set, the Senior Clinical Lead for MSK said that the service had experienced difficulty in recruiting band 6 physiotherapists and added that this was a national problem. The Senior Practitioner for MSK highlighted that the lack of career progression and development opportunities had had an impact on the retention of staff. He added that the service were currently succession planning with the band 7 development roles. The Clinical Lead for adult services added that MSK physiotherapists had the skill set to work in the private sector and this was an additional retention issue. In response to a query from Non-executive Director (TD) around education, the Senior Practitioner for MSK said that it was difficult to get the advanced practitioner education that was specific to MSK. Non-executive Director (TD) asked if complaints were received around confidentiality and privacy, following his visits to some MSK clinics and observation of large treatment rooms divided by curtains. The Senior Practitioner for MSK acknowledged that there was an issue and highlighted that this did form part of the Quality Challenge+ for the service. Following a query from Non-executive Director (TD), the Senior Practitioner for MSK assured the Committee that the service was compliant with all NICE guidance. The Committee Chair thanked the Senior Practitioner and Senior Clinical Lead for their interesting presentation and discussion, and added that he was interested to hear more about how the benefit of good practice translated into improved outcomes for patients. The Senior Practitioner for MKS proposed that he would welcome the opportunity to discuss the risk and pressure in the service in more depth. The Executive Director of Nursing responded that the MSK patient story being delivered at Trust Board on 25 May 2018 would provide the opportunity to continue the discussion.	
Quality governance and safety		
2017-18 (79a)	**Performance brief and domain reports** The Committee reviewed the document and the Executive Director of Nursing highlighted the following for the Committee to note under the safe, caring and effective domains: **Safe** The Trust was currently achieving most of its targets within the safe domain for the year to date. The exception was avoidable category 4 pressure ulcers where three had been recorded for the year to date. **Caring** All indicators were expected to be rated green at year end. The percentage of inpatients recommending care (friends and family test) in February was 100% **Effective** Non-executive Director (TD) queried the forecast rating for clinical audit as there appeared to be some disparity in the report.	

	A number of audits had been abandoned from the programme due to reconfiguration of services. Other contributing factors included resources within services due to reduced capacity and services that had been decommissioned. The Executive Director of Operations highlighted that the current rate of clinical supervision was 81.7%, therefore achieving the target of 80% ahead of year end. **Outcome:** The Committee: • Agreed reasonable **assurance** was provided on the safe domain • Agreed reasonable **assurance** was provided on the caring domain • Agreed limited **assurance** was provided on the effective domain based on the clinical audit	
2017-18 (79b)	**Director of Nursing quality and safety report** **Clinical Governance exception report** The Executive Director of Nursing presented the report and highlighted that there had been a significant increase in overdue incidents since the last exception report. A number of these were attributable to discharge incidents and work was ongoing to reduce these. The Trust Chair queried if there was a connection between the increased number of incidents and staffing pressures. The Executive Director of Nursing highlighted that there had been no increase in incidents in the Trust's care; however, there had been an increase in patients being discharged from Leeds Teaching Hospitals NHS Trust where incidents had been identified. She added that the Clinical Lead for adult services regularly reviewed discharge incidents with a colleague from Leeds Teaching Hospitals NHS Trust. The Executive Director of Operations highlighted that a quarterly paper was presented to Business Committee regarding activity quality issues and assured the Committee that a specific issue had not been identified; she welcomed any ideas on how this could be triangulated more effectively. The Committee Chair reiterated the benefit of presenting 'harm' and 'no harm' incidents in ratio charts. He added that in times of increased service pressure the recording of 'no harm' incidents was often reduced. The Executive Director of Operations highlighted that this was an ongoing discussion at the Senior Management Team meeting. In response to a point raised by the Trust Chair around the risk of compromising the quality of care when under additional service pressure, the Clinical Lead for adult services assured the Committee that the quality metrics were reviewed monthly at the Neighbourhood Team Quality meeting and the level of quality had been maintained. **Director of Nursing Report** The Executive Director of Nursing provided an update on the Quality Improvement Plan (QIP) in relation to the Leeds Integrated Sexual Health Service and Community Neurological Rehabilitation Centre. <u>Leeds Integrated Sexual Health Service</u> • A meeting had been scheduled with the workforce team to rectify the issues around the levels of safeguarding training required.	

	• All staff that required safeguarding training had now been booked onto a course before 31 March 2018. • Confirmation that the waiting time display was in place was expected. • All other targets were on track to meet the required timescales. <u>Community Neurological Rehabilitation Centre</u> • Dementia training: all staff would be trained to the required level by 15 May 2018. • Good progress had been made to improve the friends and family test response rates. The year to date figure, at 28 February 2018, was 18%. • All other targets remained on track to meet the required timescales. The Committee Chair thanked the Executive Director of Nursing for the update and proposed that the completed QIP action plan be presented to Quality Committee at the May 2018 meeting. If there were any exceptions, an update would be provided at the April 2018 meeting. The Committee Chair stated that the assurance level remained limited until the completed QIP action plan was reviewed at the May 2018 meeting. The Executive Director of Nursing provided an update on clinical audit, summarised as follows: • The number of clinical audits originally identified and ratified on the clinical audit programme for 2017/18 by Quality Committee was 117. • The number now registered on the database within the department for 2017-18 was 133. The increase was due to participation in national audits not previously identified. • It was predicted that the overall number of clinical audits expected to be completed by 31 March 2018 was 78. • There was ongoing scrutiny as to the reason for audits not progressing against the proposed timeframe. • Support was given to teams and staff through many methods: 1:1 meetings, telephone discussions, business forums, audit meetings. • The Clinical Audit Team was working to engage with staff and ensure clinical teams understood the importance of audits. Non-executive Director (TD) highlighted that there seemed some slight disparity between the figures and there appeared to be a significant shortfall. The Committee Chair highlighted that a clear plan was required for 2018/19. The Trust Chair highlighted that there was a commitment to quality improvement and the failure of some services to comply with clinical audit raised some concern. The Executive Director of Operations informed the Committee that some services had been registered for clinical audit without the knowledge of senior management and suggested that lessons could be learnt from this in 2018/19. The Committee Chair proposed that the clinical audit plan for 2018/19 be presented to Quality Committee at the May 2018 meeting. **Action: Clinical audit plan for 2018/19 to be presented to Quality Committee at the May 2018 meeting.** The Committee Chair stated that assurance remained limited for clinical audit.	**Executive Director of Nursing**

	Clinical Leads' quality reports A summary of the reports appended to the Director of Nursing Report was provided by the Executive Director of Nursing. *Adult services:* • Ongoing winter pressures were continuing to impact on capacity in the neighbourhood teams and senior leadership team. • The MUST nutritional screen tool had been introduced. • Progress had been made on the therapy waiting list. The Executive Director of Operations highlighted the excellent efforts of staff and teams in response to the bad weather in continuing to deliver the service. In response to a query from the Trust Chair around safety huddles, the Clinical Lead for adult services informed the Committee that safety huddles focused on patient risk and happened weekly. One neighbourhood team was piloting daily safety huddles. The leadership coach was working to roll out safety huddles across all teams. Band 6 nursing and therapy staff and Community Matrons were being encouraged to lead the huddles. There was a brief discussion around recognising winter pressures and early planning. There was a suggestion that appraisals and statutory and mandatory training could be planned for other times in the year to allow services to focus on additional pressures from the acute Trust in the winter months. **Action: Clinical Lead for adult services to confirm that appraisals and statutory mandatory training has been planned outwith of winter months 2018/19. Update required at the September 2018 meeting.** *Children's services:* • Pathway work continued. • The latest Community Health Matters focussed on children's services. • Waiting list initiative for CAMHS was progressing well. Learning was being shared with other services. • Focus remained on supervision and audit activity. *Specialist services* • Additional support was being provided due to the current gap in senior leadership. • Progress was being made with 'low' and 'no harm' incidents. • Promoting the friends and family test continued. • Low level of complaints. • Clinical supervision remained a focus. The Executive Director of Nursing informed the Committee that there had been a joint Care Quality Commission and Her Majesty's Inspectorate of Prisons inspection at Wetherby Young Offenders Institute in March 2018. The initial feedback had been extremely positive. The written report was awaited. The Executive Director of Nursing had written to the team to commend them. **Action: Care Quality Commission and Her Majesty's Inspectorate of Prisons inspection report to be presented at June 2018 Quality Committee meeting.** **Outcome:** The Committee: • Agreed **limited** assurance on clinical audit	**Clinical Lead for adult services** **Executive Director of Nursing**

2017-18 (79c)	**Schedule of KPIs** The Executive Director of Nursing presented the report which detailed how the high level indicators used to assess the Trust's performance in the performance brief would change for 2018/19. Non-executive director (TD) informed the Committee that the responsive, well led and finance domains of the report had been reviewed by Business Committee in March 2018. The Quality Committee reviewed the safe, caring and effective domains of the report. There was a discussion around the discontinued measures, in summary: • 5% reduction in falls: related to in patient units therefore no longer applicable. • Compliance with NICE guidance: the policy had been revised to two years. • Outcome measures: measure for 2018/19 removed, to be reintroduced in 2019/20: The Trust's Outcome Measures Project Manager was scheduled to attend Quality Committee in April 2018 to provide and update on how outcome measures were progressing in the Trust; it was proposed the improvement target could form part of the report, to ensure the Committee did not lose focus. • Number of unexpected deaths of patients on EPaCCS: An update from the Mortality Surveillance Group was to be presented to Quality Committee in April 2018. **Outcome:** The Committee: • Approved the list of high level indicators for 2018/19	
2017-18 (79d)	**Quality account** The Executive Director of Nursing introduced the first draft of the quality account 2017/18 and highlighted that the report followed the methodology used in the 2016/17 report. The quarter four data had not been incorporated into the report. The Committee Chair requested that Committee members send any comments and contributions on the first draft quality account to the Executive Director of Nursing by 23 March 2018. **Action: Committee members to send any comments and contributions on the first draft quality account to the Executive Director of Nursing by 23 March 2018.** It was agreed that there would be a substantive discussion on the quality account at the April 2018 meeting, prior to final approval at the May 2018 meeting ahead of the Trust Board meeting. **Outcome:** The Committee • Received the draft report	**All**
2017-18 (79e)	**2018/19 operational plan** The Executive Director of Nursing introduced the Business Planning Manager to present the report, which outlined the Trust's draft 2018/19 operational plan for review by the Committee, prior to submission to Board for approval. Following a brief discussion around some key issues raised in Business Committee, the Committee Chair proposed the Quality Committee review the 2018/19 quality priorities.	

	The Executive Director of Operations asked the Committee to review the revised Board Assurance Framework summary 2018/19. Following a brief discussion it was agreed that although strategic risk 4.5 did have a quality element, accountability would sit primarily with the Business Committee. **Outcome:** The Committee • Reviewed the draft 2018/19 operational plan • Recommended approval of the plan to Board	
2017-18 (79f)	**Children's services strategy 2018-2021** The Executive Director of Operations introduced the final draft of the children's services strategy 2018-2021 and asked the Committee if there were any further comments prior to submission to Board for approval. Non-executive Director (TD) stated that he was supportive of the strategy in terms of its scope and ambition. The Trust Chair highlighted that the strategy fed into the citywide strategy and the relationship was recognised clearly. Following discussion, the Committee Chair proposed that some amendments be made to include a reference to the 'best start' programme in the context section, and a key indicator of avoidable deaths in appendix 1 be added. **Action: Executive Director of Operations to work with the Children's Strategy Project Lead to incorporate children's mortality and avoidable deaths in children and young people into the strategy prior to submission to Board for approval.** **Outcome:** The Committee: • Approved the strategy for submission to Board	**Executive Director of Operations**
2017-18 (79g)	**Risk Register** The Interim Company Secretary introduced the report which outlined risk movement amongst risks scored at eight or above, since the last report in February 2018. The Committee noted there were no new operational or strategic risks, no new risks with an increased score, three risks with a decreased score and one risk closed since the last report. There were two extreme risks in total, scoring 15 or more. <u>Risk 224: reduced level of care due to prevalence of staff sickness in particular services and or across the Trust</u> The Trust Chair highlighted that emphasis on care must remain through times of increased pressure and there should be a clear plan to address this. <u>Risk 918: reduced staff capacity at Hannah House</u> Following a query from Non-executive Director (TD) the Executive Director of Nursing confirmed that the band 7 post had been successfully recruited to. **Outcome:** The Committee: • Noted the recent revisions made to the risk register	

Review of Committee		
2017-18 (80a)	**Committee's annual report and review of Terms of Reference** The Interim Company Secretary presented the Quality Committee's annual report 2017/18 and revised Terms of Reference. Some amendments were suggested for the annual report: the Committee Chair confirmed his appointment as chair to the Committee as January 2018, QIP plan focus to include the sexual health service and CNRC and the head of medicines management to be included in the attendees list. There was a discussion around the revised Terms of Reference, in summary: • It was agreed the wording around the purpose of the meeting needed to be amended to state that the purpose of the Committee was to seek assurance and accountability. • It was agreed some clear narrative around partnerships, new models of care and care navigators was to be incorporated. • It was suggested multi agency services should be reflected. Paragraph to be drafted to take into account and oversee assurance around shared governance. **Action: Interim Company Secretary to amend the wording to the terms of reference, to state that the purpose of the Committee was to seek assurance and accountability. Executive Director of Nursing to draft a paragraph to take into account and oversee assurance around shared governance, partnerships, new models of care and care navigators. The revised terms of reference to be presented to Quality Committee at the April 2018 meeting for agreement.** **Outcome:** The Committee: • Approved the annual report prior to submission to the Audit Committee	**Interim Company secretary** **Executive Director of Nursing**
2017-18 (80b)	**Committee's review of agenda composition** The Committee Chair presented the proposal regarding a new format for the Quality Committee meetings going forward. **Principles for Quality Committee** • Continue to work to existing Terms of Reference • Focus on strategic assurance in relation to all aspects of quality and patient experience • Develop agendas to be 'key issues/topic' based • Strengthen the contribution of patient voice/experience • All attendees encouraged to actively contribute **Proposed future shape of meetings** • Six full (conventional agenda) meetings per year, linked to Trust Board meetings • Four focused based meetings o Maintain 45 minutes for performance brief/key issues o In depth focus/consideration of one clinical business unit and one key quality topic • Maintain team presentation with clear focus on key quality indicators and quality improvement – refresh template and provide clarity of expectations	

	• Potential to link non-executive director visits:
	  o To clinical business unit in depth exploration
	  o To key focus areas
	  o To Quality Challenge+ visits
	
	Action: Executive Director of Nursing to refresh the team presentation template and provide clarity of expectations.
	
	Potential quality focus areas
	Safe
	• Medication and treatment errors
	• Safeguarding
	• Falls
	• Incident reporting
	Caring
	• Patient experience/voice
	Effective
	• Mortality
	• Clinical supervision
	• Research
	• Education and training
	• Clinical audit/NICE guidance
	• Quality improvement initiatives
	
	The Trust Chair suggested that the template and briefing for service spotlight presentations be addressed to incorporate a sense of openness and honesty and to understand the position of the service in more detail.
	
	It was agreed the quality improvement methodology should be used to continually refine the presentations.
	
	The Committee agreed that some of the non-executive director service visits could be linked with the Quality Challenge+ visits in order to obtain a concentrated set of observations. The Trust Chair highlighted that it was essential that the purpose of the visit be made clear.
	
	Action: Format of Non-executive Director visits and links with Quality Challenge+ to be discussed at the May 2018 Board Workshop.
	
	In response to a query from the Head of Medicines Management, the Committee Chair confirmed that key issues from sub-groups should be highlighted to Quality Committee and this should mirror the process through the organisation.
	
	The Trust Chair agreed to the proposal of six 'business' meetings linked to Board and four 'focus based' meetings and agreed that this would allow the Committee to focus more sharply and effectively on key items. The Committee Chair suggested that support from the Organisational Development Team would be helpful. The Trust Chair suggested that it would be useful to link with the quality improvement initiative within the Trust.
	
	Proposals for the focus based meetings were:
	• New ways of working and partnership working
	• New models of care and improving quality
	• Pathway of incidents and lessons learnt
		Executive Director of Nursing
		
		Interim Company Secretary

	The Committee agreed to the new format of the Quality Committee meetings and agreed to review again in March 2019 as part of the annual self-assessment. The General Manager and Clinical Lead for children's services highlighted that mortality and learning would be the focus of the first 'workshop' based meeting in June 2018. This would follow the update on mortality processes due to be presented to the Committee in April 2018. **Outcome:** The Committee: • Agreed to the new format of Quality Committee meetings • Agreed to review in March 2019	
Clinical Effectiveness		
2017-18 (81)	**Patient group directions** The Executive Director of Nursing confirmed that the patient group directions (PGDs) had been through the correct processes and recommended both for ratification. In response to a query from Non-executive Director (TD) around the lack of medical directorate approval, the Head of Medicines Management confirmed that this related to non-medical prescribing and the administration of medication. **Outcome:** The Committee ratified the two approved PGDs: • 063-08 Patient Group Direction for the administration of Chlordiazepoxide 10mg Capsules or Tablets • 108-05 Patient Group Direction for the Administration of Diazepam 2mg Tablets	
Patient experience		
2017-18 (82)	**Business units' key priorities for patient experience and engagement** The Executive Director of Nursing presented the paper which provided the Committee with information relating to the three priorities for patient experience and engagement in the three business units during 2018/19. The Committee Chair asked how the Quality Committee could involve patient engagement. There was a suggestion that there be some involvement from Health Watch. **Outcome:** The Committee: • Received and noted the report	
Reports and minutes for approval and noting		
2017-18 (83a)	**Board members' visits** The Interim Company Secretary presented the report which detailed the three service visits undertaken since Quality Committee in January 2018. One report had been submitted by Non-executive Director (Ian Lewis) which detailed a joint visit with Non-executive Director (Richard Gladman) to the Integrated Children's Additional Needs Service hub at Wortley Beck. **Outcome:** The Committee: • Received the report on non-executive directors' service visits April 2017-March 2018.	

2017-18 (83b)	**Mortality Surveillance Group: draft minutes: 8 February 2018** **Outcome:** The Committee: • Received the draft minutes	
2017-18 (83c)	**Safeguarding Committee: draft minutes: 22 February 2018** **Outcome:** The Committee: • Received the draft minutes	
2017-18 (83d)	**Clinical Effectiveness Group: draft minutes: 22 February 2018** **Outcome:** The Committee: • Received the draft minutes	
2017-18 (84)	**Quality Committee future work plan** The future work plan was received for information. It was agreed that all scheduled dates would remain the same. The April and May 2018 meetings would follow the current work plan and the first focused based meeting would be held in June 2018. **Action: Interim Company Secretary to make amendments to the work plan in line with the new format of the Quality Committee meetings.**	**Interim Company Secretary**
2017-18 (85)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair would provide an update to the Board at the meeting on 29 March 2018. Items to be reported include: • Children's strategy • New format of Quality Committee meetings • Clinical audit **Assurance levels:** • Performance Brief o Safe: **reasonable** o Caring: **reasonable** o Effective: **limited** based on clinical audit	
2017-18 (86)	**Any other business** a) Internal audit plan 2018/19 The Committee Chair asked for any comments to be sent to the Interim Company Secretary by 23 March 2018. **Action: Committee members to any comments on the internal audit plan 2018/19 to the Interim Company Secretary by 23 March 2018.**	**All**
	Dates and times of next meetings (09:30 – 12:30) Monday 23 April 2018 Monday 21 May 2018 Monday 25 June 2018 Monday 23 July 2018	

Leeds Safeguarding Adults Board

Minutes of a Meeting held on 14th November 2017

Board Membership		
Name	**Representing**	**Attended**
Richard Jones CBE	Independent Chair – Leeds Safeguarding Adults Board	✓
Maureen Kelly (Member and, Deputy Board Chair and Chair – Executive Group: SARs)	Leeds CCGs, Member of Executive Group, Chair of LSAB Executive Group: SARs	x
Cath Roff	Leeds City Council, Adults and Health	x
Shona McFarlane	LCC Adults and Health, Member of Executive Group, LSAB Quality Assurance and Performance Sub Group	✓
Nigel Parr	LCC, Adults and Health	✓
Max Naismith	LCC, Adults and Health, Chair of MCA LIN Sub Group	x
Philip Bransom (Member and Chair, LSAB Citizen Engagement Sub-group)	Advonet for Third Sector Leeds, Chair of Citizen Engagement Sub Group	✓
Gill Marchant	Leeds CCGs, Chair of Learning and Development Sub Group	x
Superintendent Samantha Millar	West Yorkshire Police, Member of Executive Group	x
Tim Whaley	Vice Chair, MCA LIN Sub-Group	✓
Jo Harding	NHS Leeds Clinical Commissioning Partnership	✓
Suzanne Hinchliffe CBE	Leeds Teaching Hospitals NHS Trust (LTHT)	x
Helen Christodoulides	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Richard Hattersley	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Karen Sykes	Leeds Teaching Hospitals NHS Trust (LTHT)	x
Paul Lumsdon	Leeds and York Partnership NHS Foundation Trust (LYPFT)	x
Lindsay Britton-Robertson	Leeds and York Partnership NHS Foundation Trust (LYPFT)	✓
Marcia Perry	Leeds Community Healthcare NHS Trust (LCH)	✓
Sally Morgan	Healthwatch Leeds	✓
Max Lanfranchi	National Probation Service	x
Rachel Garry	National Probation Service (North East)	x
Sandra Chatters	Community Rehabilitation Company	x
Mandy Sawyer	Leeds City Council: Housing Leeds	✓
Emma Stewart	Alliance of Service Experts	x
Emma Howson	Leeds City Council: Public Health	✓
Zoe Hiner	HMP Wealstun	x
Laura-Jane Kershaw	HMP Wealstun	✓
Kelly Pearce	HMP Leeds	x
Kathryn Richardson	West Yorkshire Fire and Rescue Service	✓
Sal Tariq	LCC, Children and Families	x
David Rickus	Leeds Safeguarding Adults Board Strategy Unit, Observer	✓

Board Membership		
Name	**Representing**	**Attended**
Emma Mortimer	Leeds Safeguarding Adults Board Strategy Unit	✓
Kieron Smith	Leeds Safeguarding Adults Board Strategy Unit	✓
Loraine Danby	Leeds Safeguarding Adults Board Strategy Unit [Minutes]	✓

Item No.	Item
1	**Chair's Welcome**
	Richard Jones, LSAB Independent Chair welcomed members to the Leeds Safeguarding Adults Board meeting. Members of the Board introduced themselves and apologies were noted. Richard introduced the agenda and the issues for consideration at today's meeting.
1.ii)	**Minutes of the Leeds Safeguarding Adults Board meeting held on 26th September 2017 and Matters arising**
	The minutes of 26th September 2017 were agreed as correct. Richard presented actions from previous meetings requesting updates. **LSAB Meeting: 26th September 2017** **~ Action**: Item 2) West Yorkshire Trading Standards Safer Project to provide an annual report to the LSAB. **Update:** To report in 2018 via annual report. West Yorkshire Trading Standards Safer Project have a further two years funding. **~ Action**: Item 6) Guidance to be issued and forms updated to allow removal of substantiation of abuse from Leeds safeguarding adults operational practice. **Update**: Complete. **~ Action**: Item 8) Yorkshire and Humber Board Self-Assessment to be undertaken by members **Update**: On the agenda at Item 5.
2	**The Three Leeds Safeguarding Boards' Event – learning and next steps**
	Emma Mortimer spoke to a report regarding feedback from the Three Boards event. Richard asked for thoughts, the key points were as follows: • There is an opportunity to do a joint campaign on prevention and awareness of harm • It was asked that there be a focus on co-production with citizens • The work around prevention / early intervention should include provision of joint communication materials. It was agreed that the three Chairs will meet to discuss this work. The Three Boards' Managers were thanked for organising the Event and to be advised that the LSAB endorses the proposed work plans.

Item No.	Item
3	**Learning from citizens' lived experience – scoping proposal**
	Philip Bramson introduced the scoping proposal regarding learning for citizens' experiences with an ambition included to ensure that we hear and learn from the views of those citizens that have been directly involved and supported within the multi-agency policy and procedures. A discussion took place with members providing their views and expertise from their own agency experience. Philip referred to the importance of transparency and commissioning processes, and his potentially conflicted role as Chair of the Citizens Engagement Sub Group and also as Chief Exec of Advonet, a service that would potentially bid for this work. Richard acknowledged Philip's concerns and welcomed his ethical approach to the matter. A number of Board members offered to further support this project and to form a task group to progress this agenda.
4	**16 Days of Action / White Ribbon Campaign 2017**
	Kieron Smith introduced the LSAB members to the White Ribbon Campaign explaining this is a global movement that encourages men and boys to work together to end male violence against women and girls. The White Ribbon Campaign is being led by Safer Leeds, with support and some funding from the Leeds Safeguarding Children Board and LSAB. The Board was asked for approval of £500 from the LSAB Budget to help support the programme. This was agreed. Board Members were asked to consider if there are actions within their own organisations they can take to help support this campaign: The following details about the campaign were given: o 16 Days of Action is a global campaign founded by the first Women's Global Leadership Institute in 1991, which strives to eliminate violence and abuse against women and girls from around the world. o The campaign runs every year from 25th November, the International Day for the Elimination of Violence against Women, to 10th December, Human Rights Day. The campaign has been running in Leeds since 1999. Richard Jones acknowledged the £500 commitment.
5	**Safeguarding Adults Partner Self-assessment**

Item No.	Item
	Richard Jones thanked LSAB members for returning the regional Yorkshire & the Humber Safeguarding Adults Board Self-Assessment for 2017 which asked members to self-assess their organisation against a range of standards. o 10 Board member organisations were able to provide a response at the time of the report being written. o There was no expectation that those representing citizen groups i.e. Alliance of Service User Experts or those representing sectors i.e. Third Sector, to return a submission. o It was also acknowledged that some members with very particular roles, such as Healthwatch Leeds find the format difficult for their organisations The current format is specifically for Board Member organisations, however there has been discussion previously about adopting an alternative format in future years, akin to the Section 11 process used by the Leeds Safeguarding Children Board. Kieron Smith introduced the paper Safeguarding Adults Partner Self-assessment and explained member organisations responses have been collated, and the Report highlights a high level of compliance with the standards and areas of good practice have been highlighted, as have areas of organisational challenge. o The self-assessment provides the Board with an assurance that a high proportion of standards are being met. o The report provides good assurance about the systems and processes in place amongst member organisations, and identifies some areas for potential development. o The self-assessment identified a number of areas of potential development for particular organisations to consider how best to improve practice in these areas. Kieron Smith asked the Board members agree the following: (i) The report could be shared with the Quality Assurance and Performance Sub-group to further explore the areas of development highlighted. This was agreed. (ii) The Quality Assurance and Performance sub-group should review the self-assessment format for use in future years, taking into consideration the Section 11 self-assessment process used by the Leeds Safeguarding Children's Board. This was agreed. Richard thanked the Board members for their contribution to this item and asked them to take forward their areas of potential development.
6	**Working together to make Leeds a safe city for everyone: what do we know?**
	Shona McFarlane introduced the paper that focussed on the use of intelligence to improve our approach to safeguarding adults in Leeds and provided a narrative and analysis of data of performance in relation to the application of the multi-agency procedures over a year, from Quarter 2 2016/17 to Quarter 2 2017-18. The data is constantly changing, this is just a snapshot.

Item No.	Item

	The following key themes were highlighted and discussed:
	
	• Concerns are going up, Section 42 going down and 'not safeguarding' going up
	• We have to do something about 'not safeguarding' alerts
	  o 90% of the 'not safeguarding' alerts were actioned
	  o Is safeguarding a route; are people struggling, are they making alerts so as to get something done quickly?
	  o Do front line staff understand?
	  o Bigger organisations have advice available to them; this is not something care providers have
	• How do we capture BME data
	  o Age profile, area
	• Sexual exploitation – negligible
	  o Does not include trafficked
	  o Modern slavery – safety and would not necessarily come to safeguarding
	
	Members were asked what data is already collected by partner agencies to understand how adults in need of care and support are safeguarded from harm. The following key themes were highlighted and discussed:
	
	• In particular, Board members were asked to reflect on information held within their own agencies.
	  o This may not be information that is labelled as 'safeguarding', but could be wider evidence which could enable Board members to understand the breadth of information that already exists and to agree how to use the evidence to inform its strategic planning going forward.
	  o Board Members were asked to provide this information to the LSAB Strategy Unit.
	
	Shona informed the members that a country-wide analysis of data is published by the Department of Health annually and will be brought to the Board when available.

7	**LSAB Executive & Sub Group Updates**
	The LSAB sub-groups provided a report with an update of the current activity of the Board's Executive groups and its sub-groups for the LSAB members to note. LSAB Executive - Richard Jones provided an overview of discussions from the Executive Group on 24th October 2017. LSAB Executive Group: SARs- Emma Mortimer reported the group had met on 24th October and had reviewed all the current cases. Citizen Engagement – Richard Bramson provided an overview. The sub-group has decided to move to quarterly meetings and so has not met since the last Board Meeting. The sub-group are looking to develop a Communications and Engagement plan that it will consider at its next meeting in December. Quality Assurance and Performance – Shona McFarlane provided an update from its meeting held 12 October 2017.

Item No.	Item
	Learning and Improvement – Gill Marchant gave a brief update explaining the plans for the future of this group. No questions were raised. MCA Local Implementation Network – Maxine Naismith's report provided a summary overview of current work-streams. Tim Whaley spoke of improvements around advanced care and briefly mentioned the tools they are using around quality assurance.
8	**Board Member Updates**
8 (i)	Leeds Community Healthcare, Overview of safeguarding elements of CQC inspection. Marcia Perry spoke about the related learning from its CQC Inspection report published 29th August 2017. Richard Jones thanked Marcia for the overview and congratulated Leeds Community Healthcare on its achievement.
8 (ii)	NHS Leeds North, NHS Leeds South and East and NHS Leeds West Clinical Commissioning Groups will become one statutory body, they will be referred to as NHS Clinical Commissioning Group. The website is www.leedsccg.nhs.uk
9	**Reflection**
	Richard asked member's views on the on the effectiveness of the meeting. The following comments were made: • The partnership intelligence information discussion working together to make Leeds a safe city for everyone was good, members welcomed the informative discussion. • The proposal regarding learning from citizens' lived experience was appreciated. • Work is ongoing around information sharing and this is an important area of development, particularly for frontline staff.

Leeds Safeguarding Adults Board

Actions from 14th November 2017

Item No.	Action	Person / organisation responsible	Target date
Item 2	The Three Boards' Managers to be thanked for organising the Three Boards Event and to be advised that the LSAB endorses the proposed work plans, asking that there be a focus on co-production with citizens and that the work around prevention / early intervention includes provision of joint communication materials.	Three Boards Managers	By:
Item 3	Citizen Engagement Sub-group to progress the 'Learning from Citizens' lived Experience' work by convening a meeting with a wider group to support the development of the project.	Citizen Engagement Sub-group	By: 31st December 2017
Item 4	Member agencies to consider how they might support these campaigns and contact Safer Leeds as detailed in the paper.	LSAB Members	By: 25th November 2017
Item 5	Quality Assurance and Performance Sub-group to review the 2017 self-assessment returns and consider how to support members who have recorded areas as 'amber' or 'red'. Quality Assurance and Performance Sub-group Quality Assurance and Performance Sub-group to advise the LSAB on the development of a Leeds self-assessment tool. 31st May 2018	Quality Assurance & Performance Sub-group Quality Assurance and Performance Sub-group	By: 7th December 2017 By: 31st May 2018
Item 6	Board members are asked to consider information that their agency collates or is aware of that could help the Board understand how adults with care and support needs are safeguarded from harm. Board members are asked to provide this information to the LSAB Strategy Unit - lsab@leeds.gov.uk	All Board Members	By: 11th December 2017
Item 7	The MCA LIN Sub-group will provide the Board with recommended Mental Capacity Act tools and an update on its Advanced Care Planning work.	MCA LIN Sub-group	By: 31st March 2018

Leeds Safeguarding Adults Board

Continuing Actions from Previous Board Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
21st February 2017	Item 1.ii	It was noted that LCH is still awaiting the CQC report. LCH to report safeguarding – related learning from its CQC Inspection at the Board meeting following publication of the inspection report	Marcia Perry	TBC	Item 8 on today's agenda
15th June 2017 and 14th November 2017	Item 4	Presentation re DoLS Audit to Board. DoLS audit and the initial report is expected in December 2017, the final report will be shared with the LSAB.	Max Naismith	March 2018	Update presentation to be brought to the March 2018 meeting.
26th September 2017	Item 2	West Yorkshire Trading Standards Safer Project to provide an annual report to the LSAB.	West Yorkshire Trading Standards	To a future Board meeting in 2018	Agreed - October 2018
14th November 2017	Item 6	Shona informed the members that a country-wide analysis of data is published by the Department of Health annually and will be brought to the Board when available.	Shona McFarlane	To a future Board meeting in 2018	Published: safeguarding-adults-collection-sac-annual-report-england-2016-17 To LSAB in July 2018