NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (held in public)
Friday 4 August 2017, 9.00am – 12noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2017-18 (18)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2017-18 (19)	Declarations of interest	Neil Franklin	N
9.10	2017-18 (20)	Questions from members of the public	Neil Franklin	N
9.15	2017-18 (21)	Patient's story: special educational needs and disabilities	Marcia Perry	N
9.30	2017-18 (22)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 31 May 2017 b. Actions' log c. Committees' assurance reports: i. Charitable Funds Committee: 23 June 2017 ii. Nominations and Remuneration Committee: 23 June 2017 iii. Audit Committee: 21 July 2017 iv. Quality Committee: 24 July 2017 v. Business Committee: 26 July 2017	 Neil Franklin Neil Franklin Brodie Clark Neil Franklin Jane Madeley Tony Dearden Brodie Clark	 Y Y N Y Y Y Y
		Quality and delivery		
9.50	2017-18 (23)	Chief Executive's report	Thea Stein	Y
10.00	2017-18 (24)	Performance brief and domain reports	Bryan Machin	Y
10.10	2017-18 (25)	Serious incidents report	Marcia Perry	Y
10.20	2017-18 (26)	Safe staffing report	Marcia Perry	Y
10.30	2017-18 (27)	Freedom to speak up annual report	Thea Stein	Y
10.40	2017-18 (28)	Guardian for safe working hours annual report	Mandy Thomas	Y
		Strategy		
10.50	2017-18 (29)	Digital strategy	Bryan Machin	Y
11.00	2017-18 (30)	Research and development strategy: implementation update	Mandy Thomas	Y
		Governance		
11.10	2017-18 (31)	Leeds Health and Social Care Academy	Sue Ellis	Y
11.20	2017-18 (32)	Medical director's report: medical revalidation	Mandy Thomas	Y
11.30	2017-18 (33)	Nurse revalidation	Marcia Perry	Y
11.40	2017-18 (34)	Significant risks and risk assurance report	Thea Stein	Y
11.50	2017-18 (35)	Corporate governance update	Thea Stein	Y
11.55	2017-18 (36)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2017-18 (37)	Approved minutes for noting: a. Audit Committee: 28 April and 26 May 2017 b. Quality Committee: 24 April, 22 May and 26 June 2017 c. Business Committee: 26 April, 24 May and 28 June 2017 d. Leeds Safeguarding Adult Board:21 February 2017 and 19 April 2017 e. Leeds Health and Wellbeing Board minutes: 20 April 2017	Neil Franklin	 Y Y Y Y Y
12.00	2017-18 (38)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 6 October 2017, 9.00am -12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PFV2

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

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

AGENDA ITEM 2017-18 (22a)

Wednesday 31 May 2017, 9.00am – 12.00noon

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Amanda Thomas	Executive Medical Director
	Ann Hobson	Assistant Director of Workforce (deputising for the Director of Workforce)
Apologies:	Elaine Taylor-Whilde	Non-Executive Director
	Sue Ellis	Director of Workforce
In attendance:	Vanessa Manning	Company Secretary
	Steve Keyes	Head of Organisational Development(for item 12)
	Kirsty Jones	Clinical Pathway Lead (for item 3)
	Gillian Hiles	Senior Community Nurse (for item3)
Minute taker:	Liz Thornton	Board Administrator
Observers:	Steve Keyes	Head of Organisational Development(for all items apart from item 12)
	Rebecca Le-Hair	Clinical Governance Manager
	Helen Dixon	HR Advisor
	Julie Thornton	Organisational Development Lead
	John Walsh	Organisational Development Lead
	Helen Benkinsop	Clinical Effectiveness Manager
	Collette Smith	Organisational Development and Resourcing Manager
Members of the public:		

Item	Discussion points	Action
2017-18 (1)	**Welcome and introductions** The Trust Chair welcomed Trust Board members, the Assistant Director of Workforce who was deputising for the Director of Workforce and extended a welcome to members of staff from the Trust who were attending as observers. **Apologies** Apologies were noted from Non-Executive Director (ET-W) and the Director of Workforce.	

	Chair's opening remarks The Chair said he wished to make some 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, these being: • ***Meeting the requirements of the Trust's regulators, particularly the Care Quality Commission (CQC):*** ensuring and evidencing that the Trust's services are safe, caring, effective, responsive and well-led for patients, for staff and for the organisation as a whole. The formal feedback and report from the CQC's inspection in January 2017 was expected during the second quarter of 2017. • ***Financial performance***: meeting the challenges in the short term. The Trust satisfactorily met its financial duties in 2016/17 but in the longer term the Chair said 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 2016/17 and to continue to address the quality, financial and workforce challenges in the coming year particularly the Trust's most significant risks; recruitment, retention and sickness absence. • ***Working within the wider Leeds health and social care economy***: working with partners to achieve change strategically and operationally in the context of the West Yorkshire Sustainability and Transformation Plan and the Leeds Plan would be a top priority.	
2017-18 (2)	**Declarations of interest** The Non-Executive Director (JM) noted a reference in the Chief Executive's report to the Trust's work with the Lifelong Learning Centre at the University of Leeds and she declared this as a potential conflict of interest.	
2017-18 (3)	**A patient's story** The Executive Director of Nursing introduced the patient's story item and welcomed the Clinical Pathway Lead and the Senior Community Nurse from the South 2 Neighbourhood Team and invited them to speak about their work in a neighbourhood team. The Clinical Pathway Lead explained that the work of the neighbourhood teams was about providing person centred healthcare in the community. Care always centred on the individual, helping patients to maximise their potential and, where they had complex needs, working with partner organisations to provide support. The Senior Community Nurse said that on average she visited 12-18 people a day either in their own home or in a residential care setting. As an example of her work she described a visit she had made to a residential care home. During that visit, it had come to her attention that the care home staff were experiencing difficulty mobilising a resident and were trying to move him inappropriately. Although the resident was not under the direct care of the Trust, she felt that she should intervene to ensure that everything was done safely. By undertaking a full holistic assessment including a falls assessment she was able to put a safe care plan in place and ensure that when the patient required mobilising this was done correctly, supported by the use of appropriate equipment and aids. After spending time speaking to the patient and his family, a referral was made to social services as it was felt that nursing care rather than residential care was more appropriate for the patient. A successful transfer to a more appropriate care setting was successfully achieved. The Clinical Pathway Lead said this was just one example of how staff from the Trust supported partner organisations such as residential care homes to ensure that their residents received safe and appropriate care.	

	The Chief Executive said that this was a powerful example of a member of staff going the 'extra mile' to provide high quality care and she was immensely proud of the dedication and commitment of staff working in the neighbourhood teams. The Chair thanked the Clinical Pathway Lead and the Senior Community Nurse for sharing their very compelling story. He said this demonstrated not only the care and commitment of staff but was also a good example of how the Trust was able to support colleagues in other sectors to ensure patients received good quality care.	
2017-18 (4)	**Questions from members of the public** There were no members of the public in attendance.	
2017-18 (5) **(5a)** **(5b)** **(5c)**	**Minutes of the previous meeting held on Friday 31 March 2017 and matters arising** **Minutes of the previous meeting held on Friday 31 March 2017** The minutes were reviewed for accuracy and agreed to be a correct record subject to an amendment to item 100 where a reference to the Trust Chair should be changed to the Trust Vice Chair. **Items from the actions' log** ***Item 2016-17 (48) Safeguarding annual report 2015/16:*** This action referred to the interaction between the school nursing service and health visiting service in relation to safeguarding. The Executive Director of Nursing reported that a new service model would be developed over the next 12 months. On that basis, it was agreed that this action should be marked as closed on the actions' log. The completed actions from previous meetings were noted. **Assurance reports from sub-committees** **Item 5c(i) – Quality Committee held 22 May 2017** A verbal update from the meeting was provided by the Committee Chair and Non-Executive Director (TD) who highlighted the key issues discussed, namely: • ***Director of Nursing's quality and safety report*** **–** The Committee received a more streamlined report, the format of which had been revised in order to ensure the Committee received a broad overview of current issues and concerns, drawing attention to a number of key quality improvement and professional matters. This was supplemented by an enhanced section on quality in the Performance Brief. The Committee was to receive a more comprehensive Director of Nursing's quality and safety report on a quarterly basis. • ***Falls prevention*** **–** A new approach to falls prevention and falls review in line with the learning from the work relating to pressure ulcer reduction is to be introduced. All falls resulting in moderate or serious injury will be reviewed within 48 hours. • ***Serious Incidents*** **–**Six serious incidents were reported in April 2017 and these comprised four category 3 pressure ulcers and two fractures. • ***Neighbourhood teams*** **–** There is continuing pressure on neighbourhood teams. The actions agreed as part of the Silver Command process were being progressed but many solutions were medium and long term. The capacity in relation to staff sickness absence and vacancies was improving; with greater availability of agency staff but remained on the risk register at an extreme level. • ***Freedom to speak up guardian and guardian for safe working hours –*** The first overview of the work undertaken by the two roles had been considered. Reports would be presented to the Board on 4 August 2017.	

- ***Quality Account –*** The final quality account for 2016/17 was recommended by the Committee for Board approval.
- ***End of life care –*** Progress was noted in the Trust's ability to achieve a patient's preferred place of death. The figure recorded for April 2017 was 85%.

Item 5c(ii) – Business Committee held 24 May 2017

A verbal report was provided by the Committee Chair and Non-executive Director (BC) who highlighted the key issues, namely:

- ***Performance brief and domain report 2016/17 –*** The Trust had met all its financial requirements for 2016/17. There was good compliance with all quality targets the main exception being the falls reduction target and some aspects of NICE guidance compliance. Turnover, sickness absence and appraisal rates were red indicators at the end of 2016/17.
- ***Performance brief and domain report April 2017 –*** Financial performance during April 2017 showed an overspend against pay budgets and cost savings plans were 25% below expected levels. Mitigations had been put in place to address both these issues. Good performance against waiting time targets was welcomed, however activity was below profile.
- ***Recruitment and retention –*** Recruitment and retention in neighbourhood teams remained a priority. There was continued concern about the number of leavers exceeding joiners and the impact on sustainability in the long term. The immediate focus would be on qualified staff. The Committee is to receive a quarterly workforce report.
- ***Procurement annual report –*** The annual report on procurement activity showed satisfactory performance against NHS procurement standards.
- ***Organisational development strategy –*** The Committee had considered the revised strategy, action plan and staff pledges. The quarterly workforce report would include updates against the objectives in the action plan.
- ***Review of the Business Committee's agenda* framework –**
  The Committee had considered its workplan. Discussion focused on the challenge to ensure that cross cutting issues were well managed in order to ensure delivery of the Trust's strategy.

Item 5c(iii) – Audit Committee held 27 May 2016

A verbal update from the meeting was provided by the Committee Chair and Non-executive Director (JM) who highlighted the key issues discussed, namely:

- ***Annual report and account 2016/17 –*** The Committee had considered the draft annual report and annual accounts for 2016/17. All end of year processes had been achieved smoothly, on time and to a good standard. The Chief Executive had made a presentation on achievements and challenges in 2016/17 at an informal meeting of the Committee on 12 May 2017. Both annual report and annual accounts items had been recommended for adoption by the Board.
- ***Internal audit –*** The conclusion of the 2016/17 audit plan had included receipt of the statutory and mandatory training audit which provided a limited assurance opinion. SMT were to consider the recommendations and progress required action. A further short report was to be made to the Committee in July 2017. The annual report included the Head of Internal Audit opinion indicating a reasonable conclusion as to the adequacy and effectiveness of the Trust's risk management, control and governance processes. The annual audit plan for 2017/18 was approved all audits are aligned with the bard assurance framework and risk register and assigned to an executive lead and a committee.
- **Cyber security –** The Trust's immediate response to the recent incident, the current position and 'lessons learnt' were discussed. The outcomes and actions from a recent penetration test exercise which had tested the Trust's

	resilience in a number of areas was also discussed. The Committee would seek further periodic assurance on receipt, implementation and compliance with bulletins, guidance issued by NHS Digital or NHS Improvement. The Committee also sought further assurance on the business continuity plans in relation to SystmOne. **Outcome:** The Board noted the verbal update reports from the committee chairs and the matters highlighted.	
2015-16 (6)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • Staff success stories • Foundation degree for nursing and therapy support workers • Cyber security incident • Compliance with the well-led framework Referring to risk management under the section on compliance with the well-led Framework a Non-Executive Director (JM) questioned the rationale for de-escalating risk management from the well-led development priorities and asked whether it would be more appropriate to review this after the CQC inspection report had been published. The Chief Executive agreed that this was a sensible course of action. A Non- Executive Director (RG) was pleased to note that the Trust had no reported incidents of the ransom-ware virus and the clinical and business systems had operated as normal throughout the cyber security incident. The Board noted the introduction of a revised Well-Led Framework by CQC and NHS Improvement. The Chief Executive advised that the transition from the 'old' to 'new' well-led framework and well-led self-assessment would be considered at a Board workshop. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2017-18 (7a) **2017-18 (7b,c &d)**	**Annual report and accounts 2016/17** ***Annual report*** The Executive Director of Finance and Resources introduced this item and began by referring to an informal meeting of the Audit Committee on Friday 12 May 2017 at which the Chief Executive had made a presentation setting out the achievements and challenges in 2016/17. A Non-Executive Director (JM), in her capacity as Chair of the Audit Committee, said that the Committee had very much welcomed the Chief Executive's presentation and the opportunity to comment and contribute to the draft annual report. She added that the Trust's external auditors had confirmed that the annual report's content was in line with the requirements stipulated by the Department of Health. The Audit Committee had recommended the draft annual report for adoption by the Board. ***Annual accounts, letter of representation and external auditors' opinion*** The Executive Director of Finance and Resources stated that the Audit Committee had given full and proper scrutiny to the Trust's accounts for 2016/17. At the Audit Committee meeting on Friday 26 May 2017, the Committee had also reviewed the letter of representation and the audit memorandum on the Trust's financial statements issued by the external auditors, KPMG.	

	The Executive Director of Finance and Resources confirmed that, as noted in the letter of representation, directors had provided confirmation that, to the best of their knowledge, all information relevant to the financial statements had been disclosed. The external auditors had confirmed their confidence that this had been the case. Referring to the external auditors' opinion on the accounts, the Executive Director of Finance and Resources said he could report that the auditors would issue an unqualified opinion on the Trust's accounts; there had been some minor presentational changes and three recommendations as a result of KPMG's audit. None of which were fundamental or material. A Non-Executive Director (JM), as Chair of the Audit Committee, reported that she was very satisfied with the opportunity the Committee had had to review the accounts and she extended her thanks to the finance team for their efforts in maintaining a robust process both throughout the year and for the year end processes. This conclusion had been supported by the external auditors' opinion on the accuracy of the financial statements. A Non-Executive Director (RG) asked whether the Senior Management Team had considered thanking staff for their efforts in helping the Trust to achieve its financial targets. The Chief Executive agreed to consider the most effective way of communicating this message to staff across the Trust. **Outcome:** The Board accepted the recommendations of the Audit Committee and: • adopted the draft annual report, including the annual governance statement • adopted the annual accounts, having noted the external auditors' opinion • approved the letter of representation.	
2017-18 (8)	**Quality account 2016/17** The Executive Director of Nursing introduced the Trust's quality account for 2016/17. She advised the Board that the account, in its draft format, had been scrutinised by the Quality Committee. Four out of fifteen outcome measures remained a concern (zero category 4 pressure ulcers, duty of candour, appraisals and staff engagement). A Non-Executive Director (TD), in his capacity as Chair of the Quality Committee, reported that the Quality Committee had reviewed progress against quality indicators set for 2016/17 and had set a number of priorities for the coming year. Achievement of priorities would be monitored by the Quality Committee throughout the year. He added that he felt that stakeholders had provided a good and well-balanced response. He noted his thanks to the team responsible for compilation of the document. The Chair stated that he felt that the document was comprehensive and struck a correct balance between realistic expectations and aspirations. **Outcome:** The Board : • received the report • noted the final position of the quality improvement priorities for 2016/17 • approved the final version of the quality account for 2016/17.	
2017-18 (9)	**Operational plan 2016-17:end of year report** The Executive Director of Finance and Resources presented the report which provided an overview of delivery at the year-end of the five corporate objectives, key actions and success measures.	

	A Non-Executive Director (JM) referred to the section which assessed the reasons for not achieving targets during 2016/17 and sought assurance that the Trust would not be in the same position at the end of 2017/18. A Non-Executive Director (BC), in his capacity as Chair of the Business Committee advised that, as a result of lessons learnt this year, the Business Committee would be monitoring progress against the plan on a quarterly basis in 2017/18. This would allow more flexibility to review and amend targets in-year to reflect exceptional circumstances. A Non-Executive Director (JM) noted the reference to strengthening bid management in relation to service tenders and emphasised the need for the Trust to be more flexible and responsive to achieve success in tendering exercises. **Outcome:** The Board received and noted the year-end progress report in delivering the 2016/17 priorities and success measures.	
2017-18 (10a) **2017-18 (10b)**	**Performance brief and domain reports** ***Year-end performance report 2016/17*** The Executive Director of Finance and Resources presented the report which provided a high level summary of performance during March 2017 and provided a year-end position for 2016/17. **Outcome:** The Board noted the Trust's performance for the year 2016/17 ***Performance brief and domain reports April 2017*** The Executive Director of Finance and Resources presented the report, which comprised: • high level performance summary • more detailed domain reports: safe, caring, effective, responsive, well-led and finance The Executive Director of Finance and Resources said that the report provided 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 is currently achieving all of its targets within the safe domain with the exception of two: • Duty of candour was rated as amber due to one delayed apology which, once issued, was expected to turn this rating green. • Two avoidable injurious falls in April 2017; this was above the monthly target limit of one therefore the measure had been rated as red. ***Caring*** The Trust was meeting all its targets in the caring domain and the Trust expected this to be the position at the end of the year. A Non-Executive Director (TD) commented on the degree of confidence in meeting the 2017/18 safe and caring targets at the end of the year, particularly when viewed against the 2016/17 outturn. ***Responsive*** The Trust continued to perform well in respect of responsive indicators. However, the Trust's variance from activity profile was rated at red as activity was 10.09% below profile. Activity levels would be monitored and were expected to meet the target at the end of the year.	

	The Executive Director of Operations reported that the Trust had breached the diagnostic waiting times target during April 2017 when ten audiology patients had waited longer than six weeks. She said that staff had been re-allocated with the aim of offering a revised approach to audiology assessments and the expectation was that waiting times would be back on track in June 2017. ***Financial position*** The Executive Director of Finance and Resources reported that, in the first month of the year, the Trust had met its targets for the use of resources risk rating and level of net surplus/deficit. Referring to total pay costs, he reported that underspending on substantive staff in post continued in April 2017 however the combined level of pay expenditure did not deliver the vacancy factor with a year to date variance of £240,000. A Non-Executive Director (RG) asked whether any mitigations were in place to address the overspend on pay budgets. The Executive Director of Finance and Resources advised that senior review panels were in place for all vacancies; these considered the quality impact of holding vacancies open, looked for alternatives to recruitment and the financial impact if the post was deemed to be essential. The position would be clearer when the figures for May 2017 were available. **Outcome:** The Board noted the Trust's performance for April 2017.	
2017-18 (11)	**Patient experience report** The Executive Director of Nursing presented the report which provided the Trust Board with a six month update on the themes from patient experience and incidents within the Trust between 1 October 2016 and 31 March 2017 and overall during 2016/17. It identified themes arising from complaints, concerns, incidents and feedback; and offered assurance that actions were in place to address areas for improvement. The Chair noted the high number of complaints and concerns about podiatry services and suggested that more background and context on this should be included in the Director of Nursing report to the Quality Committee. **Action:** Background and context on the high number of complaints and concerns in podiatry to feature in the Director of Nursing report to Quality Committee in July 2017. The Chair welcomed the assurance provided by the report but stressed the need to demonstrate evidence of the improvements made, it was agreed that consideration would be given to including patient experience indicators in heat maps to improve correlation of performance measures. **Action:** Consideration to be given to including patient experience indicators in heat maps to improve correlation of performance measures. **Outcome:** The Board noted the themes identified and received assurance that actions and learning were in progress to address the themes identified.	**Executive Director of Nursing** **Executive Director of Finance and Resources**
2017-18 (12)	**Organisational development strategy: revised strategy and action plan** The Chief Executive introduced the report which presented a refreshed organisational development (OD) strategy for the next two years. She invited the Head of Organisational Development to present a brief overview of the main issues for consideration.	

	The Head of Organisational Development reported that the refreshed OD strategy described the actions which the Trust will take to promote and develop the organisation and the people who work in it over the next two years; so that the Trust will deliver its vision of 'best possible care to every community we serve.' The strategy was accompanied by a revised action plan based on four key objectives: • Planning for the future including recruitment, retention, aligned workforce plans and talent development • Improving staff engagement and morale as part of workplace wellbeing • Creating and developing leadership capability • Building a foundation of organisational structure/infrastructure that shows responsibilities and accountabilities, and is fit for purpose for services. A Non-Executive Director (BC) noted that a significant amount of work had been done to define what the strategy had delivered so far, however, he felt it would benefit from a clearer vision of the future workforce reflecting full recruitment, staff flexibility, training and development and staff wellbeing; he felt that this would make the strategy more inspirational. He said there also needed to be a greater emphasis on: specific objectives including costs and timescales, measurable outcomes and risks to achievement. A Non-Executive Director (RG) referred to the initiatives in the action plan and observed that the challenge would be to package and prioritise these into discreet pieces of work with an emphasis on those with the biggest impact. He also said there should be a clear alignment of the OD strategy with other key strategies across the organisation. The Chief Executive thanked Board members for their constructive comments and said she would consider the proposed actions, put together a proposal on next steps, identify who should lead on each action and include a realistic timescale. **Action:** The Chief Executive to set out the proposed actions from the discussion, identify lead responsibilities and develop a realistic timetable. **Outcome:** The Board approved the refreshed OD strategy and action plan as the focus of the work from 2017/18 onwards.	**Chief Executive**
2017-18 (13)	**Corporate risk register** The Company Secretary presented the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures and the board assurance framework (BAF) summary which gave an indication of the current assurance level for each strategic risk.The Board noted there were three risks with a current score of 15 or above relating to: • Six week waiting list breach in children's audiology due to reduced clinical staff capacity. • Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust. • Difficulties recruiting to and retaining staff within neighbourhood teams. **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	
2017-18 (14)	**Corporate governance report** The Company Secretary presented the report which covered a number of corporate governance requirements for review and to gain assurance that requirements were being met including:	

	Annual review of Board and committees' effectiveness – The report provided information gathered from a Board and committees' effectiveness diagnostic exercise and the results from a Board effectiveness workshop held in March 2017. ***Committees' annual reports 2016/17 –*** The terms of reference for the Trust's Audit Committee required that the committee had oversight of Board sub-committees. The report demonstrated that the Audit Committee had operated in line with its terms of reference and had undertaken a review of its effectiveness. The Trust's external auditors (KPMG) had confirmed the annual report contains all the relevant information. ***Committees' terms of reference –*** In March and April 2017, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. Changes had been made in order to amend and update their content. ***Compliance with the NHS provider licence:*** **self certification –** The Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence. Revised directions from the Secretary of State (effective from 2016/17) required NHS Improvement to ensure that NHS trusts comply with licence conditions as appropriate. The report showed an assessment of the Trust's compliance with the provider licence. **Outcome:** The Board: • Noted the outcome of the annual review of Board and committees' effectiveness. • Received the Audit Committee's annual report for 2016/17. • Approved the amendments to the terms of reference of Board sub-committees • Received and noted the self-certification against required NHS provider licence conditions.	
2017-18 (15)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information. She said 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 (16)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Audit Committee: 17 February 2017 b. Quality Committee: 20 March 2017 c. Business Committee: 22 March 2017 d. Leeds Safeguarding Children Board minutes:18 January 2017 e. Leeds Safeguarding Adult Board minutes: 8 December 2016 d. Leeds Health and Wellbeing Board minutes: 20 February 2017	
2017-18 (17)	**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 4 August 2017, 9.00am – 12 noon. Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF		

Signed by the Trust Chair: Neil Franklin
Date: 4 August 2017

AGENDA ITEM 2017-18 (22b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 4 August 2017

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting on 7 October 2016				
2016-17 (48)	**Safeguarding annual report 2015/26** Report on commissioners' review of interaction between school nursing service and health visiting service in relation to safeguarding to be reported to Quality Committee.	Executive Director of Nursing	A new model to be developed over the next 12 months	Closed
Meeting on 31 March 2017				
2016-17 (93)	**Performance brief** A report to be made to Business Committee which outlines the revised measures in place to meet the staffing challenge. To include the measures in place to ensure that risks to patient care are identified immediately.	Executive Director of Operations	June 2017	Completed
2016-17 (94)	**Annual staff survey 2016** Opportunities to be identified for NEDs to sit in on staff meetings when survey results are discussed.	Director of Workforce	July 2017	Closed: no longer applicable
2016-17 (94)	**Annual staff survey 2016** Data on the outcomes and impact of the staff health and wellbeing initiatives to be shared.	Director of Workforce	May 2017	Closed: superseded by OD strategy developments
Meeting on 31 May 2017				
2017-18 (11)	**Patient experience report** Consideration to be given to including experience indicators in heat maps to improve correlation of performance measures.	Executive Director of Finance and Resources	August 2017	Completed
2017-18 (11)	**Patient experience report** Background and context on the high number of complaints in podiatry to feature in the DoN report to Quality Committee	Executive Director of Nursing	July 2017	Completed
2017-18 (12)	**Organisational development strategy** Plan for the development of actions, next steps and proposed timescales to be developed.	Chief Executive	August 2017	Completed

Key		
Total actions on action log	**7**	
Total actions on log completed since last Board meeting: 31 May 2017	**7**	
Total actions not due for completion before 4 August 2017; progressing to timescale	**0**	
Total actions not due for completion before 4 August 2017; agreed timescales and/or requirements are at risk or have been delayed	**0**	
Total actions outstanding as at 4 August 2017; not having met agreed timescales and/or requirements	**0**	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (22cii)

Report to: Trust Board 4 August 2017
Report title: Nominations and Remuneration Committee 23June 2017 Committee's Chair assurance report
Responsible director: Chair of Nominations and Remuneration Committee **Report author:** Director of Workforce
Previously considered by: Not applicable

Purpose of the report

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee held on 23 June 2017, and indicates the level of assurance based on the evidence received by the Committee.

CLaSS (bank staff) and hours and costs

The Committee had received an update on how control was exercised over workers who may have more than one job role within the Trust or as agency staff. After discussion and evidence that checks were in place, the Committee moved its level of assurance to reasonable. It was agreed to ask the Executive Director of Nursing and the Quality Committee to consider the issue of lengthy shifts within safe staffing reports.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Chief Executive's and Directors' appraisals and performance uplift

The Chief Executive's and Directors' appraisals were reported and the Committee made the decision that a 1% salary uplift (in keeping with other NHS staff in the year 2016/17) could be approved in principle - subject to guidance and approval of NHS Improvement.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Committee terms of reference revision

The Committee reviewed the terms of reference again and approved proposed changes to expand the Committee's role to consider exceptional employment cases.

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Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (22ciii)

Report to: Trust Board 4 August 2017
Report title: Audit Committee 21 July 2017: Committee's Chair assurance report
Responsible Director: Chair of Audit Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Summary
This paper identifies the key issues for the Board arising from the Audit Committee 21 July 2017 and indicates the level of assurance based on the evidence received by the Committee.

Internal audit
The Committee received a follow up report on an audit completed as part of the 2016/17 internal audit plan. The audit had covered statutory and mandatory training and had received a limited assurance opinion. The Committee was advised by the Director of Workforce that the urgent recommendations had been addressed, including: access to e-learning modules through the electronic staff record; the reporting of compliance by training topic; and the expansion of the role of subject matter experts. Future performance against compliance target would be included in the workforce reports to Business Committee.

The Committee received reports on the first two audits completed in 2017/18 neighbourhood teams (demand and capacity management) and board and committee effectiveness; both audits had received a reasonable assurance opinion.

Charitable funds: annual report and accounts 2016/17
The Committee received the annual report and accounts for the Trust's charity. It was noted that KPMG had completed its work on the external audit for 2016/17 and had provided an unqualified opinion. The Committee recommended adoption of the annual reports and accounts by the Charitable Funds Committee at its next meeting (22 September 2017).

Counter fraud
The Committee received an annual report from the Local Counter Fraud Specialist; the report included an analysis of counter fraud activity for the year.

The Committee also received NHS Protect's focused quality assessment of compliance against NHS Protect's standards for NHS provider organisations. The Trust had been identified as being non-compliant and rated as 'red' related to the 'hold to account' standards. This covered aspects including: implementation and publication of anti-fraud, bribery and corruption policy; full use of national fraud, bribery and corruption reporting tool; use of national toolkit to support investigations and reporting timescales; and application of appropriate sanctions.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Security management
The Committee received an annual report from the Local Security Management Specialist; the report included a thematic analysis of security-related incidents for the year. There had been a significant increase in the number of security incidents reported during 2016/17. The Committee was keen to learn about the resolution of incidents and that outcomes and learning from investigations was shared. The report provided significant assurance in relation to security management.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Cyber security: emergency planning exercise
The Committee received a 'lessons learnt' report related to the cyber-security incident that the NHS experienced on 12 May 2017. The Trust had not been significantly disrupted but processes to support business continuity were being reviewed with a particular emphasis on ensuring robust systems of cascade communications in the event of incidents

The Committee also received a debrief report following an cyber-security emergency planning exercise run in neighbourhood teams during June and July 2017. Teams had felt confident that they would be able to maintain essential service delivery but that consideration needed to be given to the time required to recover from the impact of an incident and the time to return to full service delivery.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Information governance
The Committee received formal notification of four information governance incidents which, because of their nature, were reportable to the Information Commissioner's Office. The incidents had occurred between June 2016 and June 2017. New guidance, following the commencement of the General Data Protection Regulations EU Directive is to be published to ensure any changes to the reporting requirements for serious incidents are accommodated.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Risk management and Board assurance
In line with the agreed workplan, the Committee received an update on risk management activities in the Trust. Updated risk registers, risk assessments and risk management training were all noted as positive developments providing significant assurance.

As part of the formal annual review of the Board assurance framework, the strategic risks aligned to the Trust's corporate objectives had been reviewed by directors. Key controls and sources of assurance had been re-appraised along with gaps in controls and sources of assurance. Committee members encouraged further work on ensuring adequate controls were in place particularly where strategic risks were significant and assurance was limited.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Fire safety
The Committee received assurance that, following the Grenfell Tower incident, action had been taken within the Trust to complete essential fire safety checks on the Trust's buildings. A process of ongoing inspection was in place.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2016-17 (22civ)

Report to: Trust Board 4 August 2017
Report title: Quality Committee 24 July 2017: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Medical Director
Previously considered by: Not applicable

Purpose of the report

This paper identifies the key issues for the Board from the Quality Committee on 24 July 2017 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Director of Nursing (DoN): quality and safety report

Falls Prevention

The Committee was presented with the work undertaken within the falls prevention steering group led by the Deputy Director of Nursing. The steering group has developed an action plan and with key elements to include:

- Review of existing tools and materials
- Education and training
- Development of new guides to support staff
- Reviewing approaches to support evidence based practice

The Committee agreed that there was reasonable assurance on the work being carried out to date but requested a revised action plan with smarter actions, identification of themes with progress against the themes and evidence of the impact of the action plan in relation to falls reduction in the trust and for the rag rating to reflect the trust's standard RAG rating.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Children's Service: Hannah House

The Committee was briefed on the programme of enhanced support to Hannah House and agreed reasonable assurance of the plans and progress. An experienced internal manager has moved to support the team for an initial three month period and recruitment is underway for a substantive manager. The unit has had a peer review visit with a follow up visit in relation to the Quality Challenge+, and a team development day on 21 July 2017. All actions are being consolidated into a single action plan with specific areas of work to include:

- The completion and sign off of competencies
- Reviewing care plans for all children using the unit
- Increasing contact and communication with parents and in relation to planning each short break
- Increasing opportunities for children and planning for the summer holidays
- Working with charitable funds to further improve the environment

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Detailed analysis of Podiatry Complaints (July 2014 - June 2017)

Following a request from the Trust Board meeting held on 31 May 2017, the Committee received a detailed analysis of podiatry complaints between July 2014 – June 2017 to determine if the number of complaints is showing an increasing trend in quarter 1 2017-2018 over previous years. The apparent high numbers were not confirmed and there had not been an increase beyond the 'normal' for the service. In comparison to the previous two years data the number of complainants received had decreased by 35% and there had been a reduction in the number of complaints related to clinical judgement / treatment from 35% in 2015-2016 to 27% in 2016-2017. The number of complaints that were either partially of fully upheld has also decreased from 56% in 2014-2015 to 40% in 2016-2017. The Committee were reasonably assured but requested further information on breakdown of upheld/not upheld complaints related to the 27% clinical judgement / treatment.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Complex Care in Neighbourhood Teams

The Committee discussed the difficulties measuring complexity and intensity in community care. Two cases were described to illustrate the challenges that teams face on a daily basis. The Committee requested further information for the October 2017 meeting to include consideration of how the Trust could define and measure complexity, patient numbers and the potential to approach commissioners for additional funding for patients specific cases.

Assurance level							
Substantial		**Reasonable**		**Limited**	X	**No**	

Pressure Ulcers

A refined process for reporting pressure ulcers as serious incidents has been agreed with the CCG to align the Trust's practices with the other healthcare providers within the city and was presented and welcomed by the Committee. Only avoidable category 3, 4 and unstageable ulcers will proceed to a full investigation using root cause analysis and will be reported to the commissioners via StEIS under the serious incident criteria. The new process will enable staff to spend more time investigating pressure ulcers that were avoidable, ensuring that the focus is on areas where there is learning to be identified and embedded in practice. This is likely to be reflected in a fall in the numbers of serious incidents reported. The Committee identified an anomaly in the reporting of two Category 4 pressure ulcers in June 2017 and requested clarification of the discrepancy between the narrative in the report and the data in the performance brief and domain reports.

C difficile Infection

The Committee noted that one case of Clostridium Difficile (patient on J31 CICU) was assigned to the Trust during June 2017. The post infection review showed no significant findings, no lapses in care and the patient was asymptomatic and had no active infection (the sample was taken as part of a routine infection screen). The case was assigned to the Trust as the patient had been on the ward for longer than 72 hours.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Complaints, Concerns, PALS and Claims

The Committee discussed the 40% reduction in complaints in June 2017 and the 39% increase in concerns. This reflects the continued positive approach by the patient experience team and services to deal with issues as a concern in order to reach a resolution as quickly as possible in keeping with the refined process.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (22cv)

Report to: Trust Board 4 August 2017
Report title: Business Committee 26 July 2017: Committee's Chair assurance report
Responsible director: Chair of Business Committee **Report author:** Executive Director of Finance and Resources
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board arising from the Business Committee 26 July 2017 and indicates the level of assurance based on the evidence received by the committee.

In depth service focus: Children's speech and language therapy service
A well-received presentation was made by the service. The Committee heard about achievements including the introduction of a new skill mix, implementation of nine care pathways and the introduction of outcome measures. Whilst challenges existed in relation to the recording and reporting of contracted activity and the delivery of cost improvement plans, the greatest challenge related to waiting times for treatment. The service would welcome greater access to intelligent reporting to inform decision-making. The Committee discussed with the service the NHS 'offer' and the opportunity for growing the 'traded offer', particularly working closely with local schools.

Children's strategy
The Committee was briefed on the initial work to develop a strategy for children's services; the aim being to ensure that this would fit with the overarching Leeds children's and young people's plan. A number of guiding principles were discussed and the Committee was keen to see this translated into more specific objectives with a more business focused remit. Following a period of consultation with young people, families and staff, a first draft of the plan would be prepared for September 2017. The Committee expressed concern about the progress of this work.

E-Rostering
The Committee received an update on the roll out of e-rostering and noted its concerns around this programme and particularly the delays in meeting the project milestones. Urgent follow up actions were discussed including ongoing discussions with the system supplier.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Organisational development (OD) strategy
Following Board consideration of a revised strategy (31 May 2017), the Committee received a paper that provided an update on the strategy and provided assurance of the alignment of the OD strategy with other key strategies. The Committee welcomed the paper but remained very keen to see more measurable actions with clear timescales for delivery.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Estates strategy

The Committee gained assurance of continued delivery against the strategy's objectives to rationalise estate ensuring alignment with service provision. The Committee noted successful relocation of services from James Reed House, Shaftesbury House and Ashley Wing; consultation was currently underway in relation to the location of the child development centre. A further nine projects were in the pipeline.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Business and commercial developments

A full report was received which identified a number of fast moving developments. The challenges to the Trust were evident, significant and immediate. The Committee noted that the Trust had been successful in bidding to NHS England to take on devolved commissioning responsibility and budget for the mental health in-patient services for West Yorkshire's children and young people. The Committee was advised of further business development and tendering opportunities for which the Trust was well-placed to compete.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Performance report

Areas of satisfactory performance and some improvements across areas of previous challenge were noted. Performance against indicators relating to the safe and caring domains was strong. The Trust continues to perform well in respect of its responsive indicators; there continues to be an improvement in the Trust's variance from activity profile which is rated as green in June 2017 (activity for the year to date is 6.4% below profile and so is rated amber). In relation to workforce indicators, staff turnover (15.2%), staff stability index (83.8%), staff appraisals rate (86.6%) and medical staff appraisals rate (92%) remain below target. In the third month of the year the Trust is meeting its financial targets for most of the indicators with the exception of capital expenditure in comparison to plan and cost improvement plan delivery and the Committee took reasonable assurance from the finance report.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Waiting times

A six monthly update was considered by the Committee which noted that performance against the national waiting time targets was consistently very good and that the Trust has adopted the national standard in relation to non-reportable waiting lists and in this respect performance was also very good. The performance on waits for autism assessments is off track and additional capacity has been sourced to support the Trust to meet the 12 week target by end of March 2018.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (23)

Meeting: Trust Board 4 August 2017	**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 sets out the context in which the Trust works and helps to frame the Board's consideration of the Board meeting's papers.

Main issues for consideration

On this occasion, the report focuses on a number of local and national developments some of which are covered in more depth in later items. The main features of the report are:

- Care Quality Commission inspections
- Child and adolescent mental health care
- Service developments and locations
- Winter planning
- Responding to emergency situations: cyber security and fire safety
- City-wide workforce developments
- Listening to staff: 'Ask Thea' analysis
- The Trust's performance
- Leeds Health and Social Care Plan
- Local Authority: Scrutiny Board

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. Purpose of this report

1.1 This report sets out the context in which the Trust works and helps frame the Board papers. The paper describes a number of local developments and, in addition, refers to a small number of external or national announcements that have the potential to impact on the Trust.

2. Care Quality Commission: inspections of services

2.1 During the week commencing 30 January 2017, the Trust was inspected by the Care Quality Commission (CQC). In addition to a range of interviews and focus groups involving directors, service leads and a wide cross section of staff, the inspectors reviewed:

- Adult inpatient units: Community Intermediate Care Unit, South Leeds Independence Centre and the Community Rehabilitation Unit
- Adult community services: neighbourhood teams and some specialist services across eight health centres
- Children's community nursing inpatient unit: Hannah House
- Child and adolescent mental health services inpatient unit: Little Woodhouse Hall
- Specialist services: sexual health services
- Trust-wide review of well-led domain

2.2 Following conclusion of the on-site phase of the inspection, the CQC sought additional information from the Trust to support its inspection activity.

2.3 The formal feedback and report on the inspection is awaited.

2.4 The CQC works with HM Inspectorate of Prisons (HMIP) to protect and promote the interests and rights of people who use health and social care services in secure settings. This includes health and social care in young offender institutions (prisons for young people aged 15-21).

2.5 There have been three inspections of young offender institutions (YOIs) holding boys aged 15 to 18 and, jointly with Ofsted and the Care Quality Commission, four inspections of secure training centres (STCs) holding children (boys and girls) aged 12 to 18. This programme of inspections included YOI Wetherby. The matter of healthcare for young people was inspected as part of the 'respect' domain. Health provision was noted to be mainly good, with two areas drawn out for attention, namely: health staff not routinely attending all use of restraint incidents and issues regarding transfer and access to external mental health services. The Trust will work with colleagues in the prison service to address these issues.

3. Child and adolescent mental health services: tertiary services

3.1 The Trust has embarked on an important initiative to develop and deliver a new model of inpatient care for children's and adolescent mental health services (under the age of 18 years) across West Yorkshire.

3.2 Working collectively with mental health provider trusts in Leeds, Bradford and South West Yorkshire, the Trust has been successful in securing pilot status under wave two of the new care models programme that was set out in the NHS Five-year Forward View. The aim of the pilot is to give providers greater influence across pathways of care from commissioning through to provision over organisational and service level boundaries.

3.3 The focus of this West Yorkshire work is to develop streamlined pathways across the region for community outreach services both to reduce the need for, and the length of, an inpatient stay and/or, as an alternative, ensuring children and young people are cared for in West Yorkshire and do not need to travel out of the area unnecessarily.

4. Mental health collaborative

4.1 In terms of developments across the wider range of mental health services, chief executives and directors of finance have met and agreed to review the core work streams that will be worked on collectively. So far this includes:

- Urgent/crisis care
- Child and adolescent mental health services (CAMHS)
- Out of area treatments
- Autism and attention deficit hyperactivity disorder (ADHD)
- Suicide prevention
- Transforming care
- Support services

4.2 The organisations have agreed on the need to establish a committee in common and this will be the focus of a joint chairs' and chief executives' meeting planned for September 2017.

5 Community dental services

5.1 The Trust has recently been considering a range of improvements to community dental services across the city with the aim of ensuring that services:

- Are held in clinics with the best facilities
- Provide the most up-to-date equipment
- House all the expertise required in one place
- Provide modern, clinically safe care
- Have responsive waiting times

5.2 In line with the Equality Act, the Trust has also been mindful that services are suitably located to meet the needs of the population and offer appropriate and fair access. Currently, the Trust operates its dental services from six sites, care teams are spread thinly and not all clinics are open daily.

5.3 In February 2017, the Trust undertook extensive patient engagement to help the Trust understand how it might improve services. Focus groups were held in each of the six locations and patients were also asked to complete questionnaires. Patients were asked what was important to them about the services they receive from the Trust and whether patients were willing to travel for modern facilities, reduced waiting times and access to a fuller range of specialist care. The Trust also met with local councillors.

5.4 One of the outcomes of this exercise is that, from October 2017, the Trust will test out state-of-the-art assessment centres at two locations. There will be a children's centre at Beeston Hill Community Health Centre and an adults' centre operating from the Reginald Centre, Chapeltown.

5.5 This will require a more effective deployment of the clinical team. To achieve this aim, the best solution is to limit the service currently available at Seacroft Clinic for a trial period of six months. It has been concluded that Seacroft Clinic is the most viable option because it is the facility which is currently used the least (two surgeries a week). The service at Seacroft Clinic will reduce to two sessions per month. This will ensure local access for patients who do not need access to more specialised equipment available at the other sites.

6 Community child development centre

6.1 In a further development, it is proposed that services at the Child Development Centre, St James' Hospital will move to the Reginald Centre, 263 Chapeltown Road.

6.2 The services involved include neurodisability clinics, paediatric clinics including dieticians and continence care, complex communication assessments and programmes (speech therapy), complex developmental assessments and audiology and atiology (discovering why a child has a hearing impairment).

6.3 The move has come about after discussions with Leeds Teaching Hospitals NHS Trust which is keen that community children's services vacate the St James' Hospital site. The views of patients and carers have been canvassed about possible venues. Taking account of patients' and carers' views and working with the estates team and clinical staff, the Reginald Centre is being proposed as the best alternative. The centre is a modern facility with good levels of access. Views are being welcomed up until 7 September 2017.

7 Health visiting: accreditation

7.1 The Trust's health visiting service provides a universal, public health focused care service for 0 to 5 year olds. The evidence-based service aims to give every child in Leeds the best start in life, reducing health inequality by delivering early intervention.

7.2 The service has received positive outcomes from CQC and Ofsted inspections and has now received UNICEF's baby-friendly initiative accreditation.

7.3 UNICEF UK launched its baby friendly initiative to drive up standards in infant and maternity healthcare. The accreditation process recognises the best services and organisations by auditing performance against a range of evidence-based standards.

7.4 The Trust's health visiting services has been deemed to be 'outstanding'. The auditors gave feedback that there are 'really impressive standards' which are 'deeply embedded in practice'. Results showed that 100% of staff gave effective information about infant feeding and 95% of mothers said that they were 'very happy' with the care from their health visitor.

8 Winter planning

8.1 It is only August…..but the Trust and the wider health and social care system has begun to think about how to prepare for the service pressures that will be encountered through the winter months.

8.2 A local delivery plan has already been drawn up and two workshops involving all partner organisations have been held over the last six weeks. The plan comprises some nationally mandated components and local priorities and covers approaches to:

- A&E streaming and interface with other providers
- Management of patient flow including hospital discharge provisions
- Community capacity including referral management and capacity in neighbourhood teams and community beds
- Mental health services
- 111: greater clinical involvement in the assessment of patients
- GP access and extended hours and other primary care provider services
- Care homes: access to clinical advice for care homes
- Public health including health promotion and the prevention of infection
- Communications, escalation procedures and achieving mutual aid

8.3 NHS England and NHS Improvement have published a review of how the NHS performed during winter 2016/17 to help trusts prepare for this year's winter. It highlights the pressure the NHS faced last winter, and sets out a number of recommendations for the coming winter. The recommendations are grouped into five main themes: system capacity; peaks in demand; variation in practice; NHS England/NHS Improvement support alignment; and broader urgent and emergency care system.

9 Emergency planning exercise

9.1 At the last Board meeting, the Board heard about the Trust's response to the cyber security incident that affected the NHS in May 2017.

9.2 As part of the Trust's continuing drive to ensure the security of all its electronic-based information systems, the Trust has conducted a cyber security exercise to test the resilience of the Trust's systems. The exercise was designed to test the resilience of the neighbourhood teams in the event of the loss of multiple systems and to provide a rehearsal opportunity in place of a real incident.

9.3 A number of actions were identified and shared with wider neighbourhood teams. Positive points or ideas for the future that might establish good practice have been identified for incorporation into business continuity plans.

9.4 The lessons learned indicate that the neighbourhood teams felt confident that they would be able to maintain service delivery to an adequate degree with a focus on delivering essential work. Consideration must also be given to the time required to recover from the impact of such an incident and the time to return to normal service delivery. As the Trust moves further towards electronic-based systems to manage day-to-day delivery of services, it must be acknowledged that the impact of a technology-based incident or disruptive event will inevitably have a more significant impact on services.

10 Fire safety

10.1 The Trust, alongside all sectors of the NHS, has undertaken a number of fire safety checks following the Grenfell Tower fire of June 2017.

10.2 Significant causes of the Grenfell Tower fire are understood to include a combination of the following: the installation of plastic-filled cladding to the tower block's high-rise facades and insufficient fire breaks between sections of the cladding such that in the event of fire, flame spread is contained close to the origin of the fire.

10.3 Whilst the Trust's estates and facilities service is confident that none of the Trust's properties present such risks, a review of all of the Trust's property, owned and leased, is being carried out to identify any such risks, which will be assessed immediately in the event of identification.

11 Workforce developments

11.1 Six NHS organisations (providers and commissioners) have set up a joint approach to tackling workforce issues across the city, with a particular emphasis on recruitment and retention challenges amongst the nursing workforce.

11.2 A shared workforce plan will aim to understand the demands placed on health services and to develop innovative approaches to improving capacity and dealing with staff shortages and in particular:

- The size, shape and composition of the nursing workforce (current and future)
- The essential changes needed in terms of how, when and where staff will work with a particular focus on new, adaptable and flexible roles
- Approaches to recruiting and retaining nurses (registered and non-registered)

11.3 The group will develop plans which will cover a three to five year period and will aim to support the aspirations contained within the Leeds Health and Care Plan and the journey towards system integration.

11.4 This collaborative approach sits comfortably alongside the separate initiative to develop a Leeds Health and Social Care Academy (see later paper on this meeting's agenda) to meet the education and training needs of staff across the city.

12 Staff 'friends and family' test results

12.1 Many thanks to the 673 staff members who took the time to complete the staff friends and family test questionnaire for the first quarter of 2017/18. The 418 comments received have been read, themed and shared with senior managers for each business unit/directorate to share the feedback in team meetings. The top five themes relate to:

- Patient care
- Committed staff
- Kind, caring and compassionate staff
- The Trust: good to work for
- Supportive manager

12.2 These themes have remained relatively constant throughout 2016/17; the only area of change being that staff no longer rate 'provide a good service' as one of the top five most positive themes.

13 Listening to staff: 'Ask Thea' analysis

13.1 Staff can informally raise concerns, make comments or ask questions through the *Ask Thea* approach. This online mechanism is accessed through the Trust's intranet (Elsie) and allows any member of staff to post a comment or ask a question direct to the Chief Executive. Responses from the Chief Executive are posted within 10 days and are visible to all staff. *Ask Thea* consistently features in the top five most visited pages on the Trust's intranet site. Between 1 January 2017 and the end of June 2017 there have been 94 questions.

13.2 The table below shows a breakdown of queries against a range of categories. The analysis is a broad summary only and in some cases there is an overlap of issues, for example an enquiry about availability of tablet devices and whether training is available. The analysis will be repeated in February 2018.

Question theme	**Questions by theme**
HR processes and implementation of policies	19
Staff morale	3
Staff support/recognition	5
Communications	3
Sickness absence	1
Infection prevention and control	3
Annual or special leave	3
Training	8
Pay and expenses	7
Job security	1
Service reviews	9
Costs	2
Resources and equipment	13
Uniform	4
Car parking	5
IT and systems	4
CQC	1
Tenders	3
Total	**94**

13.3 By way of illustration, here are some examples of questions posed in the larger categories with a summary of the response shown in italic font.

13.3.1 HR processes and implementation of policies

- A correspondent was concerned that agency staff in the Trust were being paid more than permanent employees and thought that this was unfair. *Payments are not made higher than the banded rate for the post.*
- A correspondent was concerned some new starters were being appointed above the minimum of the pay scale and felt that this was unfair to existing staff. *Managers do have discretion to pay up to three points on the starting payscale in line with guidance on salary upon appointment.*
- A busy colleague was concerned that the publication of the vacancy bulletin was not consistent and as a result opportunities were missed because the closing dates for applications were very tight. *Vacancies are uploaded to NHS Jobs (a national online system) on a daily basis. Links to this system are available on the intranet; these are listed as internal vacancies and external vacancies as some posts are restricted to staff before going out more widely, using these links gives access to all posts.*
- A correspondent was frustrated about the delay in gaining approval for filling clinical vacancies. *The filling of essential approved clinical posts is not unduly delayed and the time taken for staff to arrive in post has significantly improved.*

13.3.2 Training

- A correspondent asked whether attending the mindfulness course, promoted as part of the development programme could be accessed in work time as their line manager expected them to attend in their own time. *Programmes are available in the afternoon and in the evening to enable staff to have choice; both programmes have proven to be popular. Managers are required to use their discretion and to act fairly and consistently and ensure that agreed development can be undertaken without affecting the service*
- An enquirer asked about the availability of foundation degrees for Band 3 employees and other opportunities for career development and progression for unqualified staff. *Opportunities for band 3 staff to undertake foundation degrees continue to be offered as well apprenticeship scheme options for unqualified staff*
- A correspondent suggested that mandatory training on the electronic staff record should be organised so that each element could be booked together rather than accessing each course individually; another colleague said they had spent a disproportionate amount of time booking courses and asked whether clickable links could be included to make relevant courses more easily accessible. *Improvements in accessing e-learning through the electronic staff record are being made all the time.*

13.3.3 Uniforms and equipment

- A number of clinical and non-clinical colleagues asked about the dress and appearance policy particularly in relation to wearing shorts to work in the hot weather. *There are many factors to balance in relation to supply of staff uniform; health and safety, staff comfort, professionalism and public perception. The uniform policy has been reviewed and dresses have been added as an alternative for hot weather.*
- One enquirer requested that green recycling bins be provided in all bases. *In LIFT buildings, NHS Property Services have or will be introducing a recycling programme and in Trust sites, the waste management company remove as much recyclable waste as is possible at their waste plants.*

13.3.4 Resources

- In relation to making better use of staffing resources a clinician suggested bringing patients to a central point for certain routine treatments on a weekend to enable more integrated working between practice nursing colleagues and neighbourhood teams. *This approach has been piloted and was particularly helpful during the pressurised winter months*.
- A correspondent asked about the possibility of using pieces of artwork produced by members of staff to brighten up the walls in buildings and provide the opportunity for staff to showcase their talents. *The Trust has a 'More Than a Welcome' campaign, which aims to improve people's experience of buildings; artwork could be used to brighten up buildings.*

14. Black, Asian and minority ethnic (BAME) network

14.1 The Trust is working actively to embrace and raise the profile of equality and diversity within the organisation, not just to meet legislative, regulatory and contractual requirements, but to ensure that the Trust values and celebrates the individual differences of staff and patients. The Board has heard about activities in pursuit of the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract and the 'next steps' the Trust planned to take to support improved Workplace Race Equality Standard (WRES) compliance.

14.2 These activities included the establishment of black, Asian and minority ethnic (BAME) networks and a series of workshops to identify challenges that have an adverse impact on BAME staff together with potential and real solutions.

14.3 Two workshops took place in June 2017 to which BAME staff were invited. A specialist facilitator was engaged from the NHS Leadership Academy and the aim was to form the basis of an action plan for local action as well as to engage with the national agenda.

14.4 The next steps from this include:

- Establish a BAME staff network. The first meeting will include development of formal terms of reference and agreeing the method of appointing members to respective roles within the network - quarter 2
- Agree time-off arrangements for staff to attend the network – early in quarter 2
- During Quarter 3, agree terms of reference and appoint members. Develop an outline of the workplan for the project officer type role to undertake, using the outputs from the workshops and areas identified to support organisational equality objectives, such as WRES and EDS2

14.5 By quarter 4, the Trust will have a vibrant BAME staff network in place, with a project officer appointed to drive this key work, with support from the network.

15 Health and well-being

15.1 At the heart of the Trust's work to recruit and retain talented staff, is a range of initiatives linked to the health and well-being of the workforce. Staff who are physically healthy, mentally well and well supported at work provide the best care. And that is what the Trust wants for every single person who works for the Trust.

15.2 To that end, the summer edition of Community Health Matters (the Trust's newsletter) will provide signposting advice for the range of services available to support staff with physical and emotional wellbeing.

15.3 Among the content included will be:

- Information about the organisational development team and clinical education team; both of which provide crucial support to staff
- The introduction of the Trust's 'feel good' pledge.
- Information on staff benefits, including training, family-friendly benefits, discounts, travel and health and wellbeing benefits
- How staff can take advantage of a free health MOT with health and wellbeing advisers

16 Performance and finance overview

16.1 Despite the current sustained pressures being experienced within the NHS both nationally and locally, the Trust has continued to maintain a focus on ensuring it delivers a range of performance targets and therefore evidencing it provides safe, caring, effective, responsive and well-led services.

16.2 From a quality perspective, the following remain the main areas of focus and are covered in more detail in the performance report:

- Safe staffing 'fill rate' in inpatient units: currently 95.9% against a target of 95%
- Reducing the incidence of avoidable pressure ulcers and falls. The Trust is achieving targets for avoidable category three and four pressure ulcers; and for the reduction in falls in inpatient units
- On-going work in relation to incident reporting.
- Work to ensure that the recording of duty of candour reporting matches the practice of staff is proving successful; 100% of 21 applicable incidents received an appropriate apology
- Percentage of staff recommending care: (staff FFT results) is 81% against target of 73%

16.3 The Trust continues to perform well in respect of all of its responsive indicators with continuing good performance against all statutory and non-statutory waiting times. There has been an improvement in relation to the number of patient contacts in June 2017 (minus 2.1%); the year to date figure however is minus 6.4%.

16.4 A number of workforce related indicators remain a concern, for example staff turnover (15.2%) remains high and staff appraisal rates are below target; further detail is contained in the performance report.

16.5 The finance measures remain satisfactory as at the end of June 2017, although capital expenditure and cost improvement plan delivery are behind plan. The use of resources risk rating (1) represents the lowest risk position.

17 Leeds Health and Care Plan

17.1 The West Yorkshire and Harrogate sustainability and transformation partnership comprises local health and care organisations working together across the area. The partnership includes councils, clinical commissioning groups, hospitals, mental health, community and voluntary sector care providers and Healthwatch.

17.2 West Yorkshire and Harrogate proposals sit alongside local plans that have been developed in each of the six local districts (Bradford, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These local plans have been discussed in public by Health and Wellbeing Boards and they attempt to tackle long standing issues and improve care.

17.3 Leeds' ambition is to be the best city for health and wellbeing, making sure that its services are fit and sustainable for the future. The way partners across Leeds hope to achieve this is set out in the Leeds Health and Wellbeing Strategy 2016 - 2021.

17.4 The Leeds Health and Care Plan was discussed at the Health and Wellbeing Board on 20 June 2017. The Health and Wellbeing Board gave robust feedback and challenge on the use of language, the need to address accountability and governance, and the narrative that pulls the elements of the plan together more coherently. Mental health was used as an example of where it can be strengthened to show the whole system approach rather than picking out specific actions for example relating to bed numbers and out of area treatments. Following the meeting and throughout the summer, views from Leeds' people and NHS and health and social care employees will be gathered. This will be in order to inform and improve the plan.

17.5 The Leeds Health and Care Plan addresses the three gaps that have been identified by health, care and civic leaders. These are gaps in: health inequalities; quality of services; and, financial sustainability.

17.6 There are four collective priority areas highlighted within the plan:

- ***Prevention*** – helping people stay well, keep active and feel good about themselves.
- ***Proactive care and self-management*** – providing help and support to people who are ill or at risk of becoming ill, or those who have ongoing conditions. The help will enable them to do as much as they can to look after themselves and manage their condition to remain healthy and independent while living normal lives at home with their loved ones.
- ***Making the best use of hospital care and facilities*** – reducing the length of time people stay in hospital so they can return to their homes and loved ones as soon as safe to do so.
- ***Urgent and emergency care*** – making sure people with an urgent health or care need are supported by the right professionals at the right time.

18 Scrutiny Board (adults and health)

18.1 The scrutiny board is a function of the local authority and brings together social services for adults and universal public health services to monitor the council's progress in improving health, lifestyles and quality of care across the city driving integration and partnership with health bodies. The Board works to a schedule of reports; the Trust's services feature amongst agenda items from time to time during the course of the municipal year.

18.2 Recent meeting of the scrutiny board have considered:

- ***March 2017:*** in-depth report on the functioning of neighbourhood teams and the work to further integrate services and develop cohesive neighbourhood teams. Health and social care staff were co-located, supporting strong working relationships which results in more cohesive care management for people with both health and social care needs.
- ***March 2017:*** in-depth report on the CAMHS service which faced a number of pressures including a rise in demand for services, a national requirement to make efficiencies and a shortage of specialist staff. A particular concern has been the long waiting times to access a diagnostic assessment for autism.
- ***June 17:*** the Scrutiny Board considered proposals from Leeds Clinical Commissioning Groups (CCGs) around changes to prescribing in Leeds.

19 Recommendation

19.1 The Board is recommended to:

- Note the contents of this report

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM
2017-18
(24)

Meeting: Board 4 August 2017	**Category of paper**	
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, 19 July 2017 Business Committee, 26 July 2017	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during June 2017.

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 is available in the domain reports.

The key area of focus in this paper is for single point of urgent referral (SPUR). This report was included in the performance brief last month (May 2017) but is included again this month (June 2017) for further consideration and discussion.

Main issues for consideration

Safe
The Trust is currently achieving all of its targets within the safe domain. Safer staffing currently stands at 95.9% against a target of >=95%

All measures are green. Including duty of candour and the5% reduction in falls target.

There was one case of Clostridium Difficile assigned to the Trust during June 2017; this case was found on J31community intermediate care unit. Post infection review showed no significant findings: patient was symptom free with no active infective hence finding was consequential.

Green is forecast for all indicators.

Caring
The percentage of staff recommending care (staff friends and family test) is reported as 81% in June 2017, which is above the target of 73.0%

The Trust is currently meeting all of its other targets in the caring domain and expects this picture to be the same at year end.

Effective
The effective domain is reported quarterly only. Compliance with clinical supervision is reported at 80% which is in line with the year to date target. There has been no increase in the number of services reporting outcome measures centrally, but this is expected to increase, hence it is given an amber rating. The number of clinical audits is currently zero and is rated amber as it is expected that all appropriate audits will be completed by year end. There have been zero unexpected deaths in bed bases in quarter 1 and one sudden unexpected deaths in infants and children on the Trust's caseload.

Responsive
The Trust continues to perform well in respect of its responsive indicators of which there are seven. All are rated as green for June 2017.

There continues to be an improvement in the Trust's variance from its activity profile which is rated as green in June 2017. Activity for the year to date is 6.4% below profile and so is rated amber. Activity levels will continue to be monitored and are expected to meet the target at year end.

Well Led
The Trust is currently rated green for:

- Executive team turnover
- Short term sickness absence (an improvement to below target)
- Long term sickness absence
- Total sickness absence
- Universal statutory and mandatory training
- Sustained the time between placing advertisements and filling vacancies (all three measures)
- The number of staff leaving the organisation within 12 months
- Total agency staff expenditure cap
- Response rate for community friends and family test (improved from May 2017 to over target)
- Reduce 'other' category on electronic staff record for 'reason for leaving' to 10%

It is rated amber for:

- Staff turnover
- Stability index
- Appraisals

It is rated red for:

- Response rate for Inpatient friends and family test

Finance
In the third month of the year, the Trust is meeting its targets for most of the indicators but capital expenditure in comparison to plan and cost improvement plan delivery remain rated red. The Trust is forecast to achieve these targets by year end.

Recommendation

The Board is recommended to:

- Note present levels of performance

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, June 2017

Senior Management Team – 19th July 2017
Quality Committee – 24th July 2017
Business Committee – 26th July 2017
Trust Board – 4th August 2017

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.

More detailed narrative on each of the individual indicators are available in the Domain Reports.

Contents

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 Safe

The Trust is currently achieving all of its targets within the safe domain. Safer staffing currently stands at 95.9% against a target of >=95%

All measures are green. Including duty of candour and our 5% reduction in falls target.

There was one case of Clostridium Difficile assigned to LCH during June; this case was found on J31 CICU. Post Infection Review (PIR) showed no significant findings: patient was symptom free with no active infective hence finding was consequential.

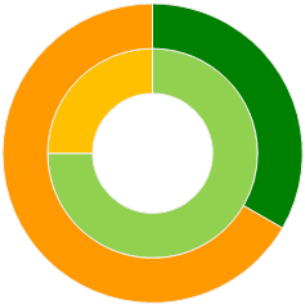
Green is forecast for all indicators.

1.1.2 Caring

The percentage of Staff Recommending Care (Staff FFT) is reported as 81% in June, which is above the target of 73.0%

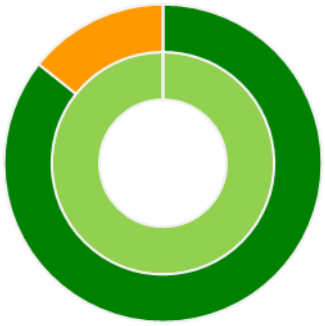
The Trust is currently meeting all of its other targets in the caring domain and we expect this picture to be the same at year end.

1.1.3 Effective



The Effective domain is reported quarterly only. Compliance with Clinical supervision is reported at 80% which is in line with the YTD target. There has been no increase in the number of services reporting outcome measures centrally, but this is expected to increase, hence it is given an amber rating. The number of clinical audits is currently 0 and is rated amber as it is expected that all appropriate audits will be completed by year end. There have been 0 unexpected Deaths in Bed Bases in Q1 and 1 Sudden Unexpected Deaths in Infants and Children on the LCH Caseload.

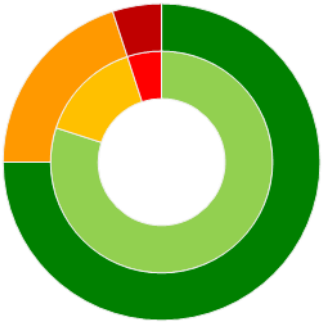
1.1.4 Responsive



The Trust continues to perform well in respect of its responsive indicators of which there are seven. All are rated as green for June.

There continues to be an improvement in the Trust's variance from our activity profile which is rated as green in June. Activity for the year to date is 6.4% below profile and so is rated amber. Activity levels will continue to be monitored and are expected to meet the target at year end.

1.1.5 Well Led



The Trust is currently rated green for:

- Executive Team Turnover
- Short Term Sickness Absence (an improvement to below target)
- Long Term sickness absence
- Total Sickness Absence
- Universal Statutory and Mandatory Training
- Sustain the Time between Placing Adverts and Filling Vacancies (all 3 measures)
- The number of staff leaving the organisation within 12 month
- Total agency cap
- Response Rate for Community FFT (improved from May to over target)
- Reduce "other" category on ESR for "reason for leaving" to 10%

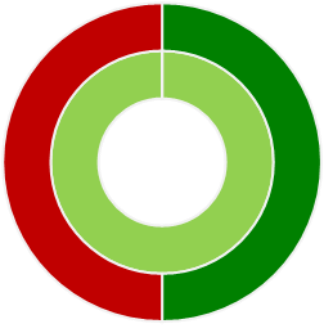
It is rated amber for:

- Staff turnover
- Stability Index
- Appraisals

It is rated red for:

- Response Rate for Inpatient FFT

1.1.6 Finance



In the third month of the year the trust is meeting its targets for most of the indicators but Capital Expenditure in comparison to plan and CIP delivery remain rated red. The Trust is forecast to achieve these targets by year end.

1.2 Statutory Breaches

Leeds Community Trust is currently performing within all nationally set targets. 99% of diagnostic tests take place within 6 weeks of referral.

At the end of June five patients were waiting more than 18 weeks for treatment in consultant-led services. Four of these patients were waiting for the Paediatric Neurological Disability (PND) service and 1 were waiting in Community Paediatrics (CHICS). All have been given appointments and all have now been seen.

The service is meeting its targets for wait times in IAPT. 96.1% of patients were seen within the 6 week waiting target for IAPT and 100% of patients were seen within 18 weeks. These are comfortably above the national targets.

2. Contract Related Highlights

2.1 Public Health Update and Re-procurement

Leeds City Council has undertaken consultations and reviews with services and partners. They are close to identifying a preferred model for the Child Health Services going forward however; they have confirmed that due to competition rules they will be unable to engage further on the final model due to concerns over unfair advantage. Plans remain on track to go to the market in 2018 for a new service/provider to begin delivery in 2019 (0-19, School Nursing, Health Visiting, Oral Health and Watch It).

2.2 Leeds City Council

We continue to work with Reed/ Leeds City Council to ensure the successful transfer of the Healthy Living Services. We have proposed to Leeds City Council to start the early transfer of users to Reed along with a transfer of an element of our current funding. This is dependent on Leeds City Council confirming they would not seek further clawbacks as performance dips during service closure. Leeds City Council is awaiting a formal response regarding our proposal. Services will be maintained as far as possible and we have already agreed the final dates for new cohorts being accepted into the service.

2.3 CIC Beds

The final bid was successfully submitted by the Partnership. Whilst the total number of beds we could offer within the price requirements was less than was hoped for we are confident that a high quality and effective bid was arrived at. Presentations to the Commissioners are due shortly and we are hopeful of a successful result in early August. In the meanwhile we are starting the planning for the potential closure of CICU and SLIC should the bid prove ultimately unsuccessful.

2.4 Health and Justice

We are still awaiting formal feedback from NHS England on the constant watch issue. This has been chased and we are pushing for a response. In the meanwhile the decision has been made to transfer delivery of the substance misuse service from a third sector provider to Leeds Community NHS Healthcare NHS Trust (LCH) with effect from October 2017. This should enable a more integrated and cost effective service for the whole Youth Prison Population.

2.5 IAPT

A regional workshop on the new IAPT Payment by Results (PbR) is due to have taken place on the 20th July. Following this we are engaging with Commissioners to review the implications for the Leeds IAPT Service. At the initial meeting in late July it is hoped we will gain some clarity on what the planned approach is for rolling this out within Leeds and whether the nationally mandated target of April 2018 is realistic and achievable. All partners are closely involved in these discussions.

2.6 NHS England Childhood BCG

Further discussions have been held with NHS England about the future provision for Childhood BCG service elements which will not be transferring to Leeds Teaching Hospitals NHS Trust (LTHT). We are awaiting confirmation of how NHS England and the local CCG will ensure this cohort of patients are

adequately treated in the coming years. We are also awaiting confirmation of Commissioners communications plans to ensure a consistent message is shared with patients and GPs.

2.7 Police Custody

The teams continue to review services and the expected commissioner requirements for the new service. We remain confident that we have a compelling offer when the tender is released.

2.8 Community Gynaecology

Leeds CCGs have completed a review of the Community Gynaecology pathway and the expected model going forward will see Leeds Teaching Hospitals NHS Trust (LTHT) take a lead provider role with Leeds Community NHS Healthcare NHS Trust (LCH) and other GP provision providing delivery in the Community. The intention is to transfer as much suitable activity into community delivery but this will require a transition period as sufficient resources are built up to support the expected volume of activity. Discussions are already underway between partners with an expectation that the new model will be in place by April 2018 at the latest. This will likely require LCH moving from a block contract position to being paid on tariff. Work is still underway to understand the full impact and to mitigate against any adverse impacts.

3. Key Areas of Focus

3.1 SPUR

3.1.1 Introduction

SPUR (Single Point of Urgent Referral) performs a gateway role for health and social care referrals, taking referrals from hospitals (LTHT and non Leeds hospitals), Yorkshire Ambulance Service, Primary Care, Hospital social work teams, hospices, community social work teams, community bed bases, nursing homes and residential homes. SPUR has a mixture of clinical and non clinical staff and provides a triage, screening and processing service in line with local processes for different referral pathways. Although SPUR was originally established for urgent referrals, the scope of the service has been widened to include some non urgent referrals.

- SPUR is situated within the Leeds City Council led corporate contact centre at Westgate in Leeds city centre and is part of the Health and Social Care Gateway
- SPUR operates 0800-1800, 7 days within the 24/7, 365 day Gateway service
- It provides professional-only referral management into Health and Social Care. There is a single number/email.
- The team coordinates referral to community services:
    - From a variety of sources as outlined above– community, acute (80% referrals), YAS, in and out of Leeds
    - Requiring a range of responses – speediness (from rapid <4 hrs to routine)
    - Requiring a range of responses – degree and type of input needed to manage person's needs (admission avoidance, End of Life, supported discharge multiple agencies etc)
    - Multiple streams of work in and out of SPUR whilst ensuring a– consistent approach
- The team has access to the Adult Social Care Clinical Information System, SystmOne, the Leeds Teaching Hospitals Trust electronic patient administration system PPM+ and Leeds Care Record and therefore the central resource reduces duplication
- The team is supported by an advanced telephony system which is safe, and guarantees a response and action
- There are strict referral management standards which ensure responsiveness

Prior to January 2017, there were a number of ways that referrals could be made to neighbourhood teams, including:

- Electronic referrals to SPUR
- Telephone referrals to SPUR
- Telephone calls to neighbourhood teams
- Ad hoc conversations with neighbourhood team staff
- Faxes to either neighbourhood team or SPUR

Most Leeds Teaching Hospitals Trust referrals were received through SPUR electronically through the hospital electronic patient record system PPM+, though some wards rang neighbourhood teams directly, particularly when the patient was already known to the neighbourhood team.

Primary care referrals tended to go directly to neighbourhood teams, though urgent referrals were often given to SPUR to triage and pass on to neighbourhood teams.

Referrals via SPUR for 'District Nursing type' services were passed straight through to Neighbourhood Teams with only brief screening. Referrals via SPUR for 'Intermediate Care type' planned services were screened and triaged up to a point when they were handed over to Neighbourhood Teams.

3.1.2 Silver Command Period

3.1.2.1 In January 2017, the Trust initiated silver command due to rising pressures in neighbourhood teams. Demand for services was outstripping the resources available in teams, and there was a concern that teams would not be able to undertake essential/ urgent patient visits.

The following arrangements were put in place:

- Daily service discussions to ensure that all teams could undertake urgent/ essential visits, often by sharing staff around the city
- Redeployment of staff from other services and additional hours available to support Neighbourhood Teams
- Buy back scheme for annual leave
- Focus on maximising additional staff resources from SPUR
- Support to teams including tea/ coffee/ lunches and de-stress sessions
- Greater focus on ensuring all CIC beds are used
- Joint work with Joint Care Management Teams to review patients with fast track status to reduce demand on neighbourhood teams
- Work with LTHT to highlight inappropriate discharges where patients could have been put at risk
- Improved leadership cover at weekends
- Focus on reviewing caseloads
- Cancellation of non-urgent meetings, some training, appraisals.
- Increased recruitment efforts
- Joint work with primary care to review some requests such as ear syringing and dressing changes and joint weekend clinics.
- Communicating to all partners that referrals for neighbourhood teams have to go through SPUR
- Holding of a waiting list in SPUR, reviewed daily by neighbourhood teams
- Triage of referrals by SPUR to ensure that the referral is appropriate.

The last three actions have caused the greatest interest in the city.

3.1.2.2 Priorities during silver command period

Following discussion with the Executive Director of Nursing the clinical priorities for Neighbourhood Teams were agreed as:

- Supporting patients on existing caseloads to remain at home
- Admission avoidance with rapid response to primary care and response to all YAS referrals maintained throughout
- Support to terminally ill patients and end of life care maintained. On-going progress in relation to preferred place of death maintained
- Transferring people out of hospital as quickly as possible- safely with good discharge working with carers and hospitals
- Use all the beds efficiently and effectively
- Daily senior oversight and review to support flow through the system – teams working across and flexibly to support flow and ensure priorities delivered.
- Flex of provision to meet demand across the city

3.1.3 Move to management of all Neighbourhood Team referrals via SPUR.

A plan to ensure consistent management of referrals was already in place prior to Winter 2016/17; however, the circumstances required that the plan was expedited

3.1.3.1 Rationale for move

- Lack of understanding of impact of direct referrals home (without the knowledge of the receiving team) at a time of increased demand led to serious concerns about safety and effectiveness
- Improvements from centralised system had already been explored and a phased implementation was brought forward
- Home situation can be unsafe and patients views of own ability can be over-estimated at home
- Rapid discharge may lead to need to sort medications, reassessment of what is needed, arrangement of more visits etc
- Necessity to flex resource across the city to meet need as efficiently as possible
- Requirement for daily oversight

3.1.3.2 Changes in referral management to Neighbourhood Teams via SPUR process Jan – June 2017

January 2017

- Planned change brought forward to enable consistent citywide approach and safe support of referrals to Neighbourhood Teams
- All referrals were routed via SPUR – screening, clinical triage and referral management

March 2017

- All new patients referred electronically via SPUR (except those discussed at case management, Gold Standards meetings or already under care of LCH)
- Screening at SPUR –to ensure information available for referral management
- Clinical triage and referral management at SPUR – for referrals requiring a rapid response including admission avoidance, referrals for support on discharge from community or hospital bed, referrals requiring coordination of different agencies
- Passed to Neighbourhood Teams for planned input – referrals requiring input 7+days post discharge e.g. catheter change, non-urgent therapy review, long term conditions management. These referrals become ‘essential’ planned visits and do not wait for discharge

April 2017

- As above +
- Clinical triage and referral management at Neighbourhood Teams for all referrals except those requiring rapid response, or coordination of agencies

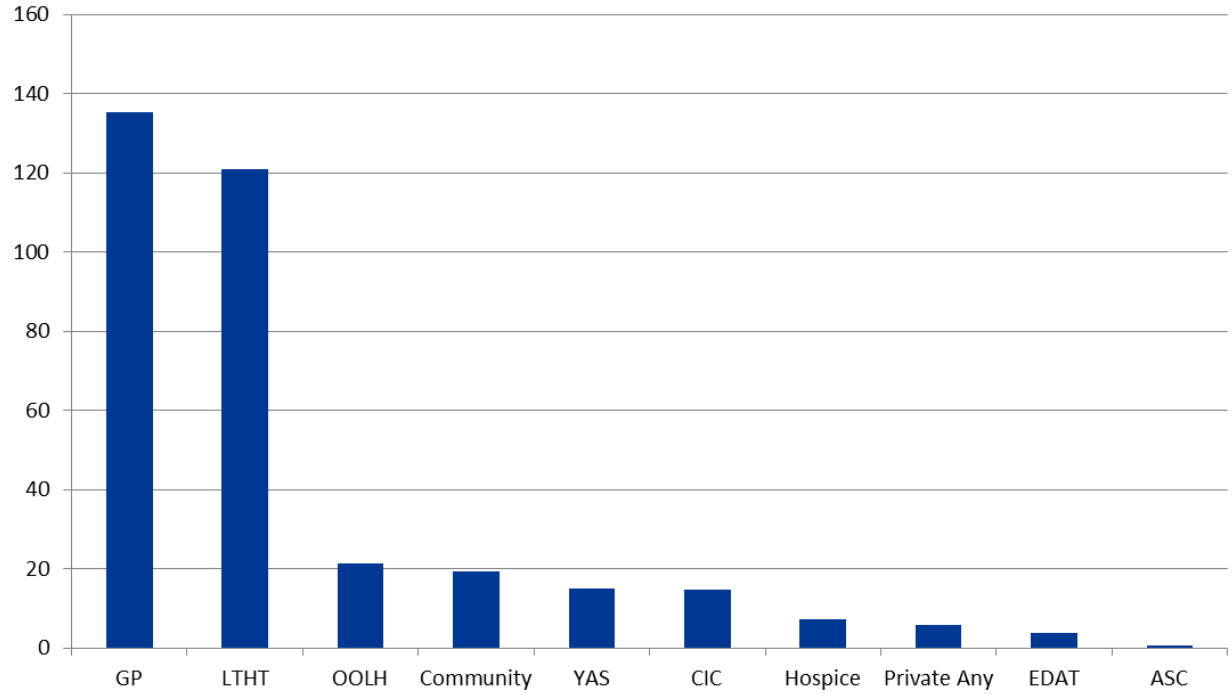
3.1.4 Analysis

Until the changes were enacted the Trust did not have a full understanding of the demand for service in the Neighbourhood Teams. The changes have enabled the teams to plan more effectively. The following table demonstrates the change in referrals for Neighbourhood Teams managed via SPUR since the new system was implemented. It is likely that the overall increase is partly due to the ability to capture information on referrals:

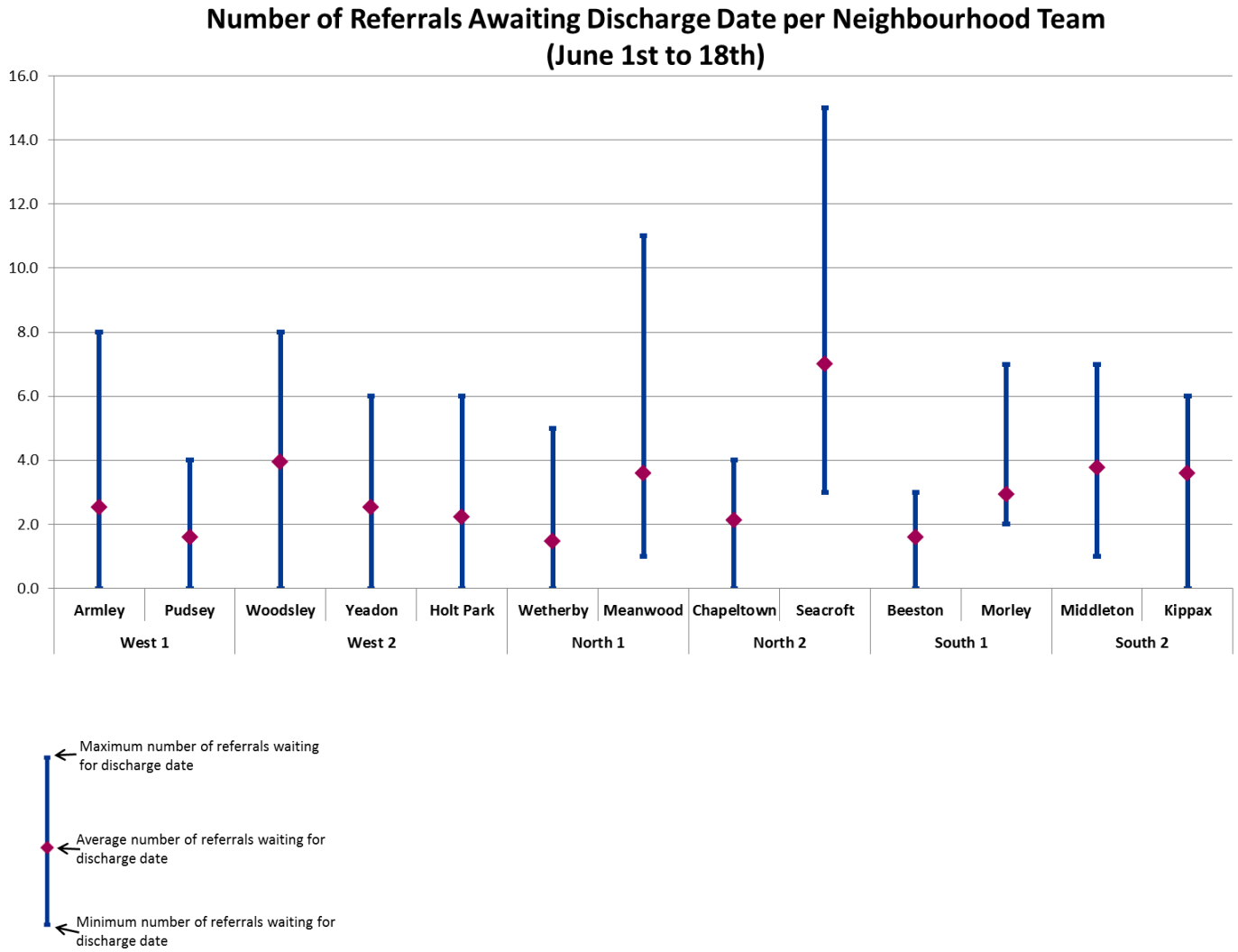
Week Commencing	Total Sent to the Team per Week
30-Jan-17	151
06-Feb-17	179
13-Feb-17	253
20-Feb-17	282
27-Feb-17	267
06-Mar-17	294
13-Mar-17	232
20-Mar-17	263
27-Mar-17	245
03-Apr-17	322
10-Apr-17	385
17-Apr-17	310
24-Apr-17	422
01-May-17	370
08-May-17	428
15-May-17	398
22-May-17	446
29-May-17	298
05-Jun-17	404
12-Jun-17	296

Referrals come from a number of sources, but are predominantly from GPs and LTHT.

Average Number of Referrals to Neighbourhood Teams via SPUR Per Week by Referral Source



The chart below shows the average and range of number of referrals waiting per day from 1st June to 18th June. The majority of Neighbourhood teams have averages between 3 and 4 referrals waiting per day. Seacroft appears to be an exception with an average of 7 referrals per day waiting for a discharge date. The graph also highlights a peak in referrals waiting for a discharge date in Meanwood. This peak took place at the beginning of June. The number of referrals waiting for discharge each day since then has been between 1 and 6.



Please note that these figures do not include all referrals to the Neighbourhood Teams, only those that are managed through SPUR. Referrals from other LCH services go directly to the Neighbourhood Teams. As a result, these numbers may underestimate the waiting list position. Further analysis is in progress to build on our understanding of full Neighbourhood Team referral demand.

The changes to the referral pathway have been kept under constant review, and a daily waiting list is shared with LTHT, so that they can better manage the discharges from hospital, and to promote transparency regarding where patients are in the system.

3.1.5 System impact

- The waiting list has provided a necessary buffer for neighbourhood teams, to ensure that patient safety has not been put at risk. It has allowed teams to respond to the most urgent demands of their patients.

- A delay in dealing with non-urgent requests for neighbourhood team support has put pressures elsewhere in the healthcare system. Hospitals have reported a rise in patient length of stays due to neighbourhood teams not being able to take patients when they are fit to be discharged.
- In a small number of cases, social care packages have to be postponed until both the neighbourhood team and the social care provider can accept the referral.
- Although the delays to discharge are usually only for a few days, these patients are occupying beds that new admissions often need. LTHT has been at a very high level of bed occupancy since for most of 2017, and has frequently had to use surge capacity and place patients in non-designated areas due to no designated beds being available.

3.1.6 Current position

- LCH de-escalated its silver command in March 2017 however it has not yet been possible for teams to return to a position where they can accept all referrals on the same day
- REAP levels remain high in some neighbourhood teams, due mainly to fluctuating demand. This demand seems to shift from week to week meaning that a number of things are still in place to ensure the whole service can prioritise resources/ staff as follows:
    - A waiting list is still in place for teams that are at capacity. The number of patients on the waiting list usually varies between 20 and 50 (split mainly between hospital and community referrals), and they are on the waiting list for around 3 days. To provide context, the neighbourhood teams are currently accepting around 70 new referrals a day via SPUR. (from a previous norm of 40 per day)
    1. Daily service allocation meetings ensure that teams support each other in dealing with the work that needs to be done
    2. A LTHT/LCH/Primary Care task group has been established to deal with some of the transfer of care issues such as reinforcing self management, new guidance around referrals to primary care, reducing the number of patients leaving hospital with a catheter in-situ and testing the clinical need of some requests such as ear syringing and dopplers. This work is now linked with the citywide Integrated Nursing Work Plan led by the Directors of Nursing in LCH and CCG – System Integration.

3.1.7 Future plans/ next steps

3.1.7.1 Waiting list

In June 2017, renewed efforts were put in place to reduce/ eliminate the waiting list so that the service could once again offer a more responsive service. To accelerate the initiative some additional measures have been put in place including:

- Reducing the maximum number of Activities of Daily Living visits to a patient per day from 4 to 2, with process for managing exceptions
- Greater scrutiny of the waiting list by senior clinical staff
- Support from other services/ teams
- Greater focus on caseload reviews to create additional capacity
- Recruitment above establishment, including agency
- Using data to determine citywide capacity requirements for new referrals to reduce risk of recurrence of waiting list

There has been some progress with eliminating the wait for people waiting for Neighbourhood Team capacity – referrals waiting for a date are down from a peak of 69 (longest wait 14 days) on 31st May to 38 (longest wait 11days) on 21st June. However further work is required to sustain this improvement

and eliminate people waiting for Neighbourhood Team input on a routine basis, whilst maintaining service safety and quality, and underlying capacity and demand challenges remain.

3.1.7.2 Process Redesign

A multi-agency group has been established to bring more consistency in to the different referral pathways in to neighbourhood teams. The group will focus on understanding demand, agreeing standard referral/ screening tools and establishing an appropriate level of triage. The long term goal is to have a “trusted assessor” process in place, where screening/ triage are only used in exceptional circumstances.

3.1.8 Action Required

The Quality/Business Committee is recommended to:

- Receive the update regarding changes in the SPUR to Neighbourhood Team referral process since January 2017
- Note ongoing work to improve flow to Neighbourhood Teams, reduce the waiting list and further improve referral processes

Leeds Community Healthcare NHS Trust

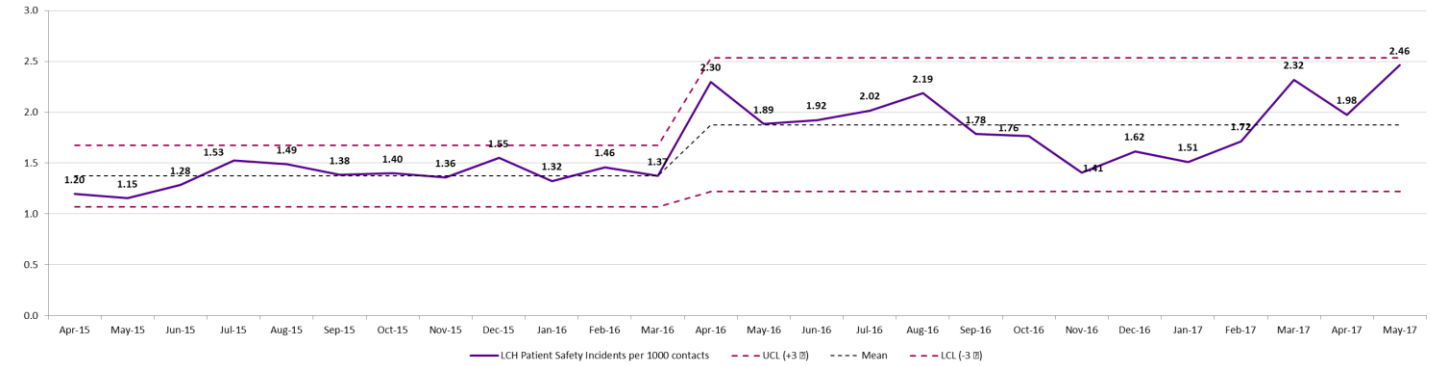
Director of Nursing Report
&
Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		YTD Target	YTD	Apr	May	Jun	Forecast
Overall Safe Staffing Fill Rate - Inpatients	2017/18	>=95%	-	97.0%	100.5%	95.9%	●
	2016/17		-	101.6%	100.0%	101.1%	
Patient Safety Incidents Reported in Month Reported as Harmful	2017/18	0.62 to 0.99	0.94	0.78	1.02	0.95	●
	2016/17		0.77	0.88	0.77	0.80	
Potential Under Reporting of Patient Safety Incidents	2017/18	1.32 to 2.59	2.30	2.00	2.46	2.23	●
	2016/17		2.47	2.92	2.46	2.55	
Serious Incident Rate	2017/18	0 to 0.13	0.01	0.04	0.05	0.06	●
	2016/17		0.05	0.06	0.05	0.09	
Percentage VTE Risk Assessment Completed	2017/18	>=95%	96.1%	96.6%	98.6%	93.1%	●
	2016/17		83.4%	67.4%	92.7%	83.0%	
5% Reduction in Falls Resulting in Avoidable Harm in our Community Inpatient Units	2017/18	3	3	2	0	1	●
	2016/17		13	-	-	-	
10% Category 3 Avoidable Pressure Ulcer Reduction Target	2017/18	5	2	1	0	1	●
	2016/17		24	5	6	1	
0 Avoidable Category 4 Pressure Ulcers	2017/18	0	0	0	0	0	●
	2016/17		0	0	0	1	
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2017/18	100%	100.0%	100.0%	100.0%	100%	●
	2016/17		57.8%	55%	48%	50%	
Clostridium Difficile - Incidence Rate	2017/18	3	0	0	0	1	
	2016/17		0	0	0	0	

Caring - staff involve and treat people with compassion, kindness, dignity and respect		YTD Target	YTD	April	May	June	Forecast
Percentage of Staff Recommending Care (Staff FFT)	2017/18	>=73%	-	81.0%			●
	2016/17		-	77.5%			
Percentage of Inpatients Recommending Care (FFT)	2017/18	>=95%	-	100.0%	100.0%	100.0%	●
	2016/17		-	100.0%	100.0%	100.0%	
Percentage of Community Patients Recommending Care (FFT)	2017/18	>=95%	-	95.9%	95.8%	95.3%	●
	2016/17		-	96.2%	97.3%	95.5%	
Written Complaints - Rate	2017/18	No Target	50	18	20	12	
	2016/17		217	19	28	29	
Mixed Sex Accommodation Breaches	2017/18	0	0	0	0	0	
	2016/17		0	0	0	0	

1. Patient Safety Incidents (LCH only)

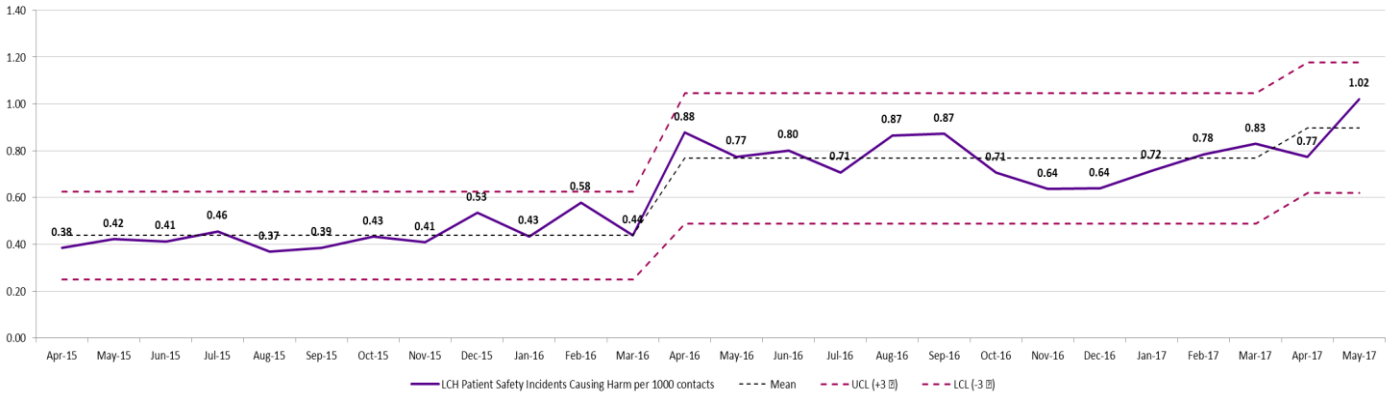
LCH PSIs per 1000 contacts (May 2017 data) currently remain within the control variation limits.



**data available to May 2017 only*

2. Incidents causing harm (LCH only)

The number of **LCH *patient safety incidents causing harm per 1000 contacts*** remains within the variation limits at this time.

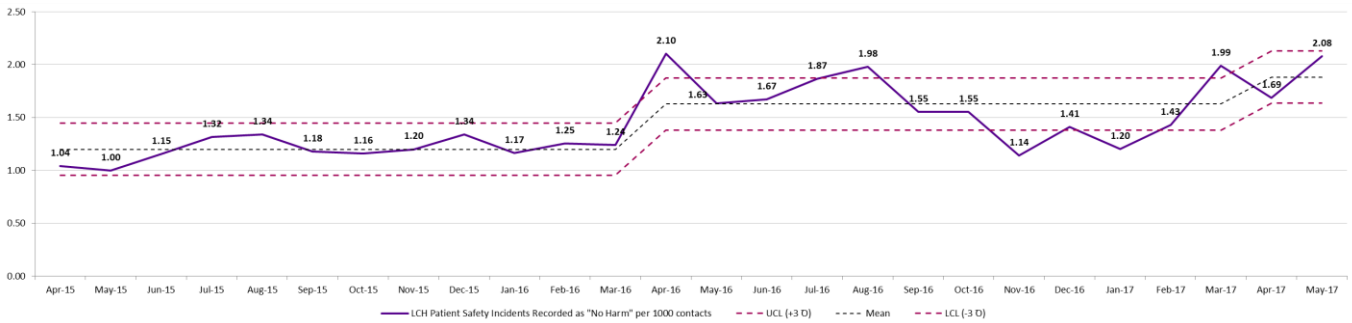


**data available to May 2017 only*

Analysis of associated data shows that there was a slight increase in activity in May. There is no significance at this time.

3. No Harm incidents

The number of LCH ***patient safety incidents causing no harm per 1000 contacts*** is currently within the upper and lower control variation limits.



**data available to May 2017 only*

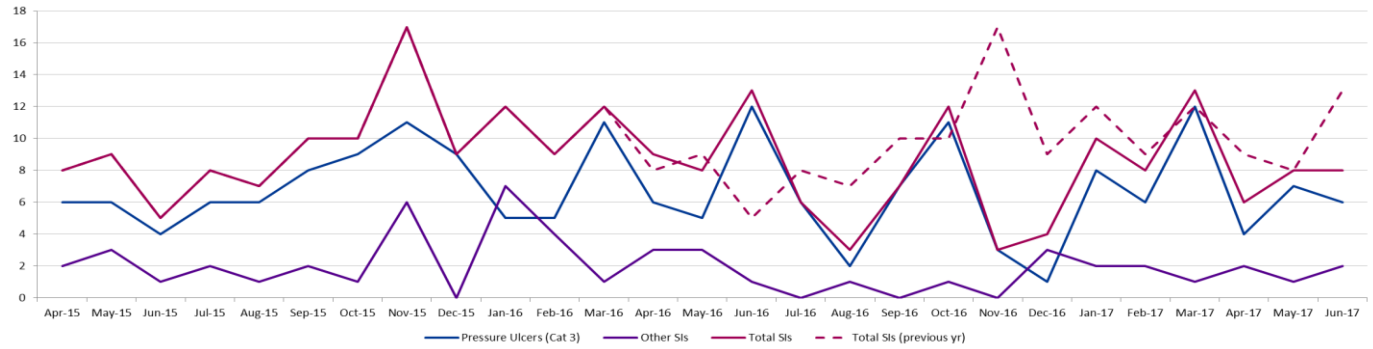
3.1 Training

A review of the plan for improving staff training on incident reporting continues with the new 'train the trainer' approach being developed. Initially planned to roll out in June, this has been rescheduled for August to allow for appropriate preparation time and necessary changes to the training programme to be fully implemented.

The Quality Leads and Clinical Governance Team are leading the implementation of the plan, which will be reviewed in March 2018 once the new approach to training has been embedded. This will be reported quarterly as part of our Quality Account priorities for 2017/18.

4. Serious Incidents

The pattern of reported SIs continues to parallel the pattern for category 3 pressure ulcers since March 2016 demonstrating the known relationship between the two. There continues to be relatively low numbers of other SI categories.

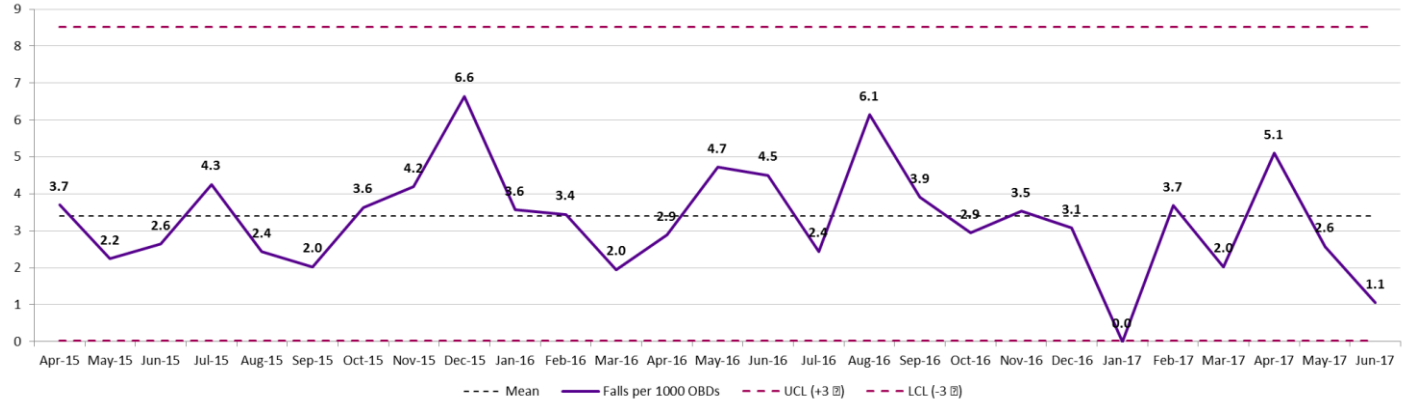


A change in this pattern is predicted over the next quarter following the implementation of a new process for reporting SI's agreed with commissioners on 3 July. Going forward, only **avoidable** category 3 and 4 pressure ulcers will meet the SI criteria (instead of all category 3 and 4 pressure ulcers).

5. Quality Account Priorities

5.1 Harm caused by falls in inpatient units

Injurious falls per 1000 occupied bed days (inpatient units) remains within the upper and lower variation limits. Monitoring continues.



5.2 Reduction (10%) in avoidable Category 3 Pressure Ulcers

Nine pressure ulcers incidents (category 3) were closed during June 2017; one of these was avoidable and eight were unavoidable.

5.3 Zero tolerance of avoidable Category 4 Pressure Ulcers

There have been no avoidable category 4 pressure ulcers since October 2016.

5.4 Quality Account Priorities 2017/18

The table below shows the new priorities for 2017/18 relating to safety. A progress report on these is presented to the SMT on a quarterly basis as part of the Quality Account reporting schedule.

Quality area for action	**Projected outcome 2017/18**	**Indicators**
1) Protecting Patients from harm that happens in our care (Sign up to Safety)	Reduce the number of patients who develop an avoidable pressure ulcer. Reduce the number of patients who have a fall resulting in avoidable harm whilst in our care.	a) 10% reduction in avoidable 3 pressure ulcers (category 2 pressure ulcers will also be monitored via the DoN report) b) No avoidable category 4 pressure ulcers. c) 5% reduction in falls resulting in avoidable harm in our community inpatient units.
2) Incident Management	Strengthen incident management and ensure investigations are completed on time	All incidents and Serious Incidents should be investigated and closed in accordance with the Incident Management Policy: including SI management. Improvement will be measured from a baseline taken at end Q4.

Any issues arising from the monitoring of the priorities, in relation to Clinical Governance, will be shared at the Patient Safety, Experience, and Governance Group going forward. The next meeting will be held on 27 July.

6. Duty of Candour

During June, at the time of incident closure, Duty of Candour was applicable* to 28 (45%) incidents that triggered the Duty of Candour. Initial data showed:

- 27 apologies were recorded as given (96.4%)
- 1 record was incomplete (3.6%)

The record that was incomplete has been reviewed by the Quality lead for Specialist Services who identified that the degree of harm chosen on Datix was inconsistent with the actual level of harm as assessed by the specialist reviewer. This has been discussed with the incident handler and the incident record to be updated to minimal harm. This would remove this incident from the Duty of Candour requirements.

The 27 incidents where a verbal apology has been given have all been quality assured by the Quality Lead for Specialist Services. Six of these incidents were deemed not to be attributable to LCH care, following a 72 hour review by the service and quality assurance carried out by the Deputy Director of Nursing. Therefore duty of candour did not apply. The Quality Lead for Specialist Services has discussed the changes with the incident handlers to ensure a consistent approach.

In conclusion, Duty of Candour was applicable in 21 incidents where 100% received an appropriate apology.

Note of good practice: on discovery of a patient safety incident, staff are having an early conversation with the patient and giving a verbal apology even when the incident may not be directly related to the care provided. This is demonstrating a move towards a culture of openness with patients.

**verified as actual moderate + harm and attributable to an LCH PSI*

7. Never Events

No Never Events were reported in June.

8. Safety Alerts (CAS)

There were no Safety Alert response breaches in June.

9. Infection Prevention Control (IPC)

9.1 MRSA bacteraemia and C difficile Infection

During June there were no reported cases of MRSA bacteraemia.

One case of Clostridium Difficile was assigned to LCH during June; this case was found on J31 CICU:

- sample taken from patient as part of infection screen and found to be C Diff positive
- Post Infection Review (PIR) showed no significant findings: patient was symptom free with no active infective hence finding was consequential.
- case assigned to LCH but no lapses in care

9.2 Sharps Safety Issues

The IPC Team continues to monitor all incidents relating to needle stick injuries within LCH and have a programme to review for all injured staff for a period of 6 months following injury. Two cases of sharps injury were reported in June (5 in April and 4 in May). Work with CCGs regarding the provision of safe insulin pen needles continues and all clinical teams have been equipped with appropriate devices to deliver care.

9.3 Outbreaks

No outbreaks were reported during June. However, the IPC Team has responded to Group A Streptococcus outbreak which occurred within the wider health care community.

Leeds Community Healthcare NHS Trust

Effective Domain Report

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence		YTD Target	YTD	April	May	June	Forecast
Compliance with Technology Appraisals Within 3 Months	2017/18	100%	-	-			●
	2016/17		-	100%			
Compliance with Other NICE Guidance Within 1 Year	2017/18	No Target					-
Full Compliance			-	3			
Working Towards Compliance			-	0			
Under Review			-	5			
	2016/17						
Full Compliance			-	4			
Working Towards Compliance			-	3			
Under Review			-	4			
Compliance with Other NICE Guidance Within 2 Years	2017/18	No Target					-
Full Compliance			-	2			
Working Towards Compliance			-	3			
Under Review			-	2			
Number of Clinical Audits Completed	2017/18	117 by year end	-	0			●
	2016/17		-	-			
Compliance with Clinical Supervision	2017/18	>=80%	-	80%			●
	2016/17		-	65.0%			
Increase the number of Services Centrally Reporting Outcome Measures	2017/18	>7	-	7			●
	2016/17		-	-			
Number of Unexpected Deaths in Bed Bases	2017/18	No Target		0			
	2016/17		-	4			
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2017/18	No Target		1			
	2016/17		-	3			

1. Compliance with NICE guidance

1.1. Technology appraisals

There were no NICE Technology Appraisals were published in Q4 2016/17 that were relevant to the Trust.

1.2. Other NICE guidance

As agreed at the June 2017 Quality Committee, compliance is now reported by the number of services involved, rather than the number of NICE guidelines issued.

NICE guidance relevant to eight services was published in Q1 2016/17. Full compliance has been achieved by three services within the last twelve months:

- NG 46 controlled drugs – full compliance reported by the Medicines Management Team working with clinical services across the Trust.
-
- CG 152 UPDATED Crohn's disease – full compliance reported by the Prison Healthcare HMYOI and Adel Beck Secure Children's Centre teams.

Work is ongoing to ensure compliance by the five other services:

- CG 42 UPDATED Dementia: supporting people with dementia and their carers in health and social care
    - Dementia Lead reviewing implications for the Trust.

- CG 98 UPDATED Jaundice in new born babies under 28 days
    - Health Visiting Service reviewing implications for their service.

- CG 152 UPDATED Crohn's disease:
    - Community Paediatrics reviewing implications for their service.

- CG 155 UPDATED: Psychosis and schizophrenia in children and young people: recognition and management
    - CAMHS and Prison Healthcare Service HMYOI are reviewing implications for their services.

NICE guidance relevant to seven services was published in Q1 2015/16. Full compliance has been achieved by two services within the last two years:

- CG 92 Venous thromboembolism in adults admitted to hospital – full compliance reported by the Community Geriatricians working across bedded areas.

- NG 12 Suspected cancer: recognition & referral – full compliance reported by the Prison Healthcare HMYOI team.

Work is ongoing to ensure compliance by the five other services:

- NG 09 Bronchiolitis in children:
    - Action plan in place within Community Paediatrics service to obtain and develop staff competency in the use of oxygen saturation monitors.

- NG 11 Challenging behaviour & learning disabilities:
    - Joint action plan agreed between Leeds City Council & LCH (covering all children's services).
    - CAMHS leading on implementation from an LCH point of view.

- NG 13 Workplace policy & management practices to improve employee health & well-being:
    - Action plan developed by Workforce Directorate.

- NG 10 Violence & aggression: short-term management in mental health, health & community settings:
    - Security Management Specialist reviewing implications for the Trust.

- CG 97 Lower urinary tract symptoms in men: assessment & management:
    - Continence, Urology & Colorectal Service reviewing implications for their service.

Oversight of compliance at a service level is reported to the Quality Committee on a quarterly basis.

Progress towards National Guidance in terms of mortality surveillance:

- A mortality review and responding to deaths policy is being drafted
- Agreement has been made about which services/under what circumstances will complete a tier 1 (light touch) and which will complete a tier 2 (full) investigation into reported patient death.
- A standard operating procedure for investigating complex deaths is under development

2. Clinical Audit Programme

The clinical audit programme 2017-18 was approved and ratified on the 24 April 2017 at Quality Committee.

The number of clinical audits included on the programme is 117.

The clinical audits identified on the ratified programme have now being implemented within the business units.

The programme will be monitored throughout 2017-18.

3. Clinical Supervision

80% of LCH staff are receiving regular clinical supervision. This is up from 77% in Q4 2016/17 and means that the Trust is meeting its end of year target early. Services continued to be supported to achieve the 80% target, with Children and Specialist business Services setting at 90% target.

Service Area	% Clinical Supervision	Service Area Target
Adult	**76.10%**	75%
Children	**85.90%**	90%
SBU: Health and Justice excluding Police Custody	**86.22%**	75%
SBU: Police Custody	**54.00%**	60%
Corporate	**66.00%**	90%
LCH Target for end of 2017-18: 80%		**80%**

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		YTD Target	YTD	April	May	June	Forecast
Patient Contacts - Variance from Profile	2017/18	0 to ± 5%	-6.4%	-12.3%	-4.9%	-2.1%	●
	2016/17		0.0%	-0.8%	3.8%	0.5%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2017/18	>=92%	-	99.9%	99.7%	99.6%	●
	2016/17		-	100.0%	100.0%	100.0%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	2017/18	0	0	0	0	0	●
	2016/17		0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2017/18	>=99%	-	96.1%	99.1%	99.5%	●
	2016/17		-	100.0%	100.0%	100.0%	
% Patients waiting under 18 weeks (non reportable)	2017/18	>=95%	-	98.7%	99.0%	99.0%	●
	2016/17		-	99.0%	98.6%	98.9%	
IAPT - Percentage of people treated within 18 weeks of referral	2017/18	>=95%	-	99.6%	100.0%	100.0%	●
	2016/17		-	100.0%	99.7%	100.0%	
IAPT - Percentage of people treated within 6 weeks of referral	2017/18	>=75%	-	96.5%	95.7%	96.1%	●
	2016/17		-	98.6%	98.1%	98.3%	

Each of the measures for discussion in the Responsive Domain Report are addressed in the Performance Brief this month. Please see the following:

- section 1.1 for information on patient contacts – variance from profile
- section 1.2 for information on waiting times

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		YTD Target	YTD	April	May	June	Forecast
Workforce Race Equality Standard	2017/18	>=14.7%	-				
	2016/17		-		-		
Staff Turnover	2017/18	<=15%	-	15.6%	15.3%	15.2%	
	2016/17		-	14.4%	14.6%	14.6%	
Executive Team Turnover	2017/18	<=15%	-	0.0%	0.0%	0.0%	
	2016/17		-	0.0%	0.0%	0.0%	
Stability Index	2017/18	>=85%	-	83.1%	83.5%	83.8%	
	2016/17		-	-	-	-	
Short term sickness absence rate (%)	2017/18	<=2.03%	-	1.6%	2.1%	1.8%	
	2016/17		-	1.6%	1.2%	1.1%	
Long term sickness absence rate (%)	2017/18	<=3.6%	-	3.8%	3.4%	3.5%	
	2016/17		-	3.9%	4.7%	4.5%	
Total sickness absence rate (%)	2017/18	<=5.58%	-	5.4%	5.5%	5.2%	
	2016/17		-	5.7%	5.9%	5.6%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2017/18	>=89.1%	-	87.3%	87.0%	86.6%	
	2016/17		-	89.3%	89.3%	88.8%	
Medical staff appraisal rate (%)	2017/18	100%	-	92.0%			
	2016/17		-	86.4%			
6 universal Statutory and Mandatory training requirements	2017/18	>=90.8%	-	90.5%	90.6%	91.0%	
	2016/17		-	89.7%	88.3%	88.6%	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2017/18	>52.0%	-	54.0%			
	2016/17		-	49.0%			
Percentage of staff who are satisfied with the support they received from their immediate line manager	2017/18	52.0%	-	62.0%			
	2016/17		-	-			
Response Rate for Staff FFT	2017/18	>22.0%	-	22.0%			
	2016/17		-	22.2%			
Sustain the time between placing adverts and filling vacancies							
Qualified Nurses		<= 112 Days	-	97			
Police Custody		<=145 Days	-	124			
Administration		<=83 Days	-	83			
Reduce the number of staff leaving the organisation within 12 months	2017/18	<=22%	-	19.4%	16.2%	16.3%	
	2016/17		-	-	-	-	
Category for Reason for Leaving in ESR Recorded as "other/unknown"	2017/18	<=10%		8.3%	16.0%	0.0%	
	2016/17		-	-	-	-	
Response Rate for Inpatient FFT	2017/18	>=23.1%	-	11.0%	15.6%	15.4%	
	2016/17		-	-	-	-	
Response Rate for Community FFT	2017/18	>=6.8%	-	4.6%	5.1%	6.9%	
	2016/17		-	-	-	-	
Total agency cap	2017/18	£1,621k	£1,037k	£563k	£474k	£584	
	2016/17		£6,366k	732k	577k	617k	
Percentage Spend on Temporary Staff	2017/18	8.0%	8.6%	8.6%	7.4%	8.3%	
	2016/17		7.5%	10.6%	8.5%	9.7%	

1. Appraisal

As at the end of June 2017 86.6% of available staff were registered as having had an appraisal within the last 12 months. This has seen a slight decrease on last month's figure of 87.0%.

A revised Organisational Development Strategy was ratified at Trust Board in May 2017.

We continue to work on a number of key priorities and this is now beginning to show results. These areas include; embedding values, feedback and involvement, personal development and appraisal, as reported via the NHS National Staff Survey and the Staff Friends and Family Survey.

2. Statutory and Mandatory Training

The level of staff compliance with universal statutory and mandatory training has increased from 90.6% last month to 91.0 %

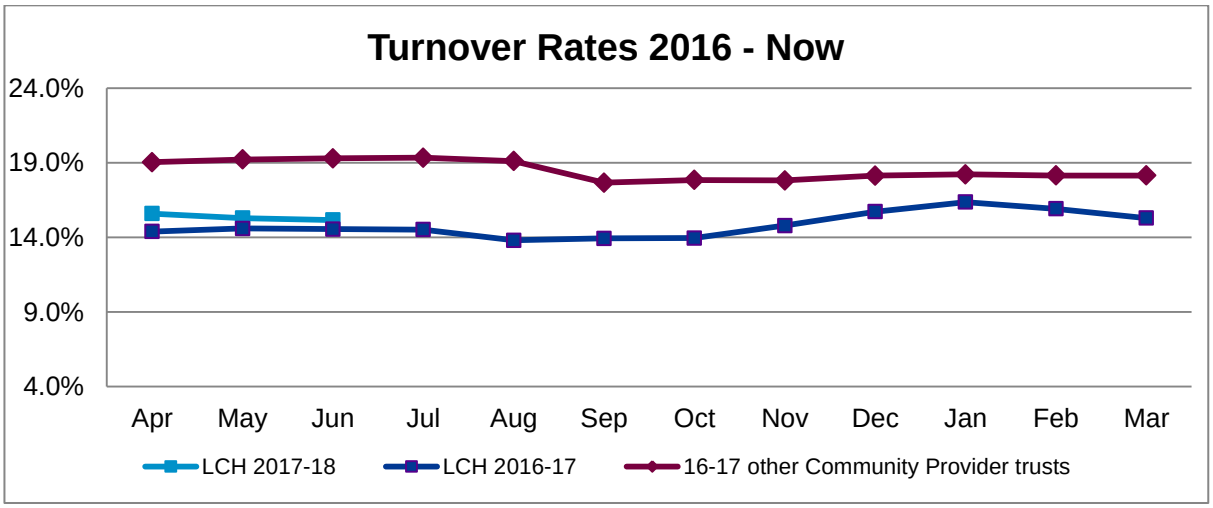
The individual topics report as follows:

- Information Governance training is at 96.7%
- Equality and Diversity training is above target with a compliance rate of 95.9%
- Health and Safety (Slips, Trips and Falls) training is 93.3%
- Fire Training, Infection Prevention and Control and Moving and Handling are all below target compliance rate at 83.3%, 86.43% and 89.2%.

Issues related to e-learning access have now been resolved for all programmes including a substitute programme for fire training. This latter topic solution has only just been communicated (21 July 2017). Staff can continue to access face to face fire training courses.

3. Turnover

The figure for the rolling year has slightly decreased from 15.3% in April to 15.2 % this is above the target of 15%



In June 2017 there were 26 leavers across the Trust.

Business Unit	June 2017 Leavers
833 Adult Business unit	7
833 Children's Business Unit	8
833 Corporate Directorate	4
833 Operations	2
833 Specialist Business Unit	5

Staff Group	June 2017 Leavers
Nursing	7
Administrative and Clerical	9
Allied Health Professionals	3
Add Prof Scientific and Technic	2
Support Services	3
Medical and Dental	2

The top 3 reasons for leaving were:

- Retirement Age (6)
- Voluntary Resignation – Promotion (4)
- Voluntary Resignation - Other/Not Known (3)

Workforce Information has put in place additional checks from February 2017 to improve the data quality to reduce the number of 'other/not known' reasons for leaving through ESR. This has decreased significantly to 0% from 16% in June.

The table below shows the number of leavers who left the trust in the first year of their employment and the number recruited in the last 12 months.

Last 12 months Leavers	Less than 1 Year	Total recruited	Percentage
Adult Business unit	33	160	21%
Children's Business Unit	11	125	9%
Corporate Directorate	6	37	16%
Operations	6	332	18%
Specialist Business Unit	20	112	18%
Grand Total	**76**	**476**	16%

4. Workforce Race Equality Standard (WRES)

Work continues to develop the BME networks and train managers in Unconscious Bias.

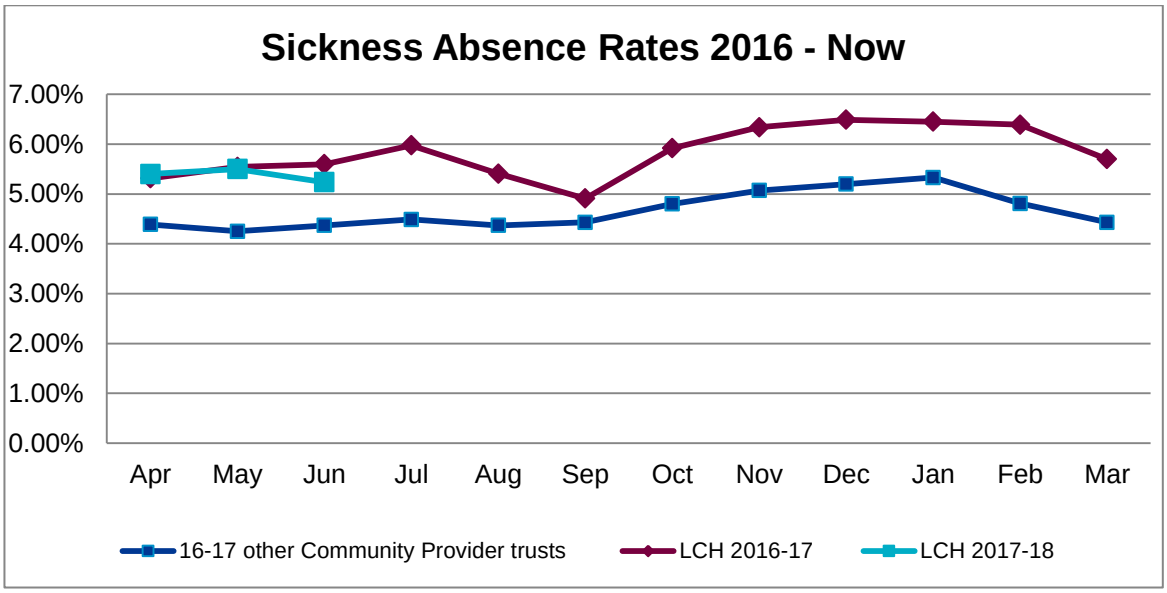
Two BME workshops will be taking place during June externally facilitated through the Leadership Academy. The outputs from this will form an action plan for a couple of BME staff to be seconded to work on this over the next 12 to 18 months.

The WRES will be updated and reported in August 2017.

5. Sickness Absence

The Sickness absence target for June is 5.58%. Sickness absence rate for June was 5.2%, which is broken down into Long-term absence 3.5% and Short-term absence at 1.8%. The good news is that

we have seen a real month on month reduction in absence rates since January 2017, where absence was running at 6.5% and now stands at 5.2%.(apart from a minor blip in May of increase of 0.1%). This is a good platform on which to launch our refreshed health and wellbeing pledge/promise over the next few months.



Business Unit	June 2017 absence rate
Adult	6.9%↑
Children	4.5%↓
Specialist	4.6%↑
Corporate and Executive Directorate	5.4%↔
Estates & Ancillary Staff (Operations)	5.4%↑

The areas of HWB focus during July include:-

- Advertising of HWB Advisor roles to deliver the HWB Programme (in conjunction with Sheffield Hallam University)
- Draft of a HWB CQUIN Plan
- Drop-in sessions for managers to meet with an HR Advisor for support and guidance in managing absences, continue
- Chief Executive to drop into team meetings/events with staff, to talk about our commitment to health and wellbeing and listen to staff ideas on areas for improvement

Leeds Community Healthcare NHS Trust

Finance Report

Finance		YTD Target	YTD	April	May	June	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2017/18	-£0.7m	-£0.9m	-£0.2m	-£0.7m	-£0.9m	●
	2016/17			£0.5m	-£0.2m	-£0.2m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2017/18	-£3.0m	-£3.0m	-£3.0m	-£3m	-£3m	●
	2016/17		-	-£2.0m	-£3.0m	-£2.9m	
Forecast underlying surplus	2017/18	-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	●
	2016/17		-	-£1.5m	-£1.5m	-£1.5m	
Capital expenditure in comparison to plan (£k) - YTD	2017/18	£0.1m	£0.2m	£0.1m	£0.2m	£0.2m	
	2016/17		-	£12k	£16k	£354k	
Capital expenditure in comparison to plan (£m) - Forecast	2017/18	£1.8m	£1.8m	£1.8m	£1.8m	£1.8m	●
	2016/17		-	£3.2m	£3.2m	£3.2m	
CIP delivery (£m) - YTD	2017/18	£0.5m	£0.6m	£0.2m	£0.4m	£0.6m	
	2016/17		-	£0.1m	£0.1m	£0.2m	
CIP delivery (£m) - Forecast	2017/18	£3.4m	£3.4m	£3.4m	£3.4m	£3.4m	●
	2016/17			£0.7m	£0.7m	£0.7m	
Use of Resources Risk Rating (from Oct 2016)	2017/18	1	1	1	1	1	●
	2016/17		-	-	-	-	

1. Summary & KPIs

At the end of Quarter 1 the Trust is running marginally ahead of the planned surplus. The early overspending on pay budgets continues but at a slower rate; this is being mitigated by underspending on non-pay and release of reserves. The Trust has not breached the agency cap to the end of June. Cost savings plans are 25% below expected levels year to date. The Trust has spent £0.2m on capital assets to the end of June. Cash is running £0.1m behind plan and the use of resources risk rating is 1.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	(£0.9m)	(£0m)	(£3.034m)	G
Remain with EFL of £2.941m			£2.941m	G
Remain within CRL of £1.816m	£0.2m	£0.05m	£1.816m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	98%	3%	95%	G
BPPC NHS Invoices Value 95%	99%	4%	95%	G
BPPC Non NHS Invoices Number 95%	93%	-2%	95%	A
BPPC Non NHS Invoices Value 95%	96%	1%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.0m recurrent in year	£0.5m	-21%	£2.9m	R
CIP Savings £0.5m non recurrent in year	£0.3m	-44%	£0.5m	G

2. Income & Expenditure

The Trust's income is continues on plan this month. Expenditure overall is £0.1m less than planned however pay costs continue to overspend and this is being offset by underspending on non-pay and reserves. The Trust has 124 wte or 4.7% less staff in post than funded in June; this is after the planned vacancy factor reduction. Temporary staffing costs are £719k for the month. Non pay expenditure is £0.1m underspent and £0.3m of reserves have remained unutilised.

Table 2 Income & Expenditure Summary	June Plan WTE	June Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m	Forecast Variance last month £m
Income									
Contract Income			(34.1)	(34.1)	0.0	(136.0)	(135.8)	0.1	0.1
Other Income			(2.0)	(2.1)	(0.0)	(7.4)	(7.3)	0.1	0.2
Total Income			***(36.1)***	***(36.1)***	***(0.0)***	***(143.3)***	***(143.1)***	***0.2***	***0.3***
Expenditure									
Pay	2,647.2	2,523.0	25.8	26.1	0.3	101.6	103.7	2.1	2.6
Non pay			8.5	8.4	(0.1)	34.6	33.8	(0.7)	(0.7)
Reserves & Non Recurrent			0.4	0.1	(0.3)	1.6	0.5	(1.1)	(1.4)
Savings Requirement							(0.5)	(0.5)	(0.8)
Total Expenditure	***2,647.2***	***2,523.0***	***34.7***	***34.6***	***(0.1)***	***137.8***	***137.6***	***(0.2)***	***(0.3)***
EBITDA	**2,647.2**	**2,523.0**	**(1.4)**	**(1.5)**	**(0.1)**	**(5.5)**	**(5.6)**	**(0.0)**	**(0.0)**
Depreciation			0.4	0.4	(0.0)	1.7	1.8	0.0	0.0
Public Dividend Capital			0.2	0.2	(0.0)	0.8	0.8	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	0.0
Retained Net Surplus	**2,647.2**	**2,523.0**	**(0.8)**	**(0.9)**	**(0.1)**	**(3.0)**	**(3.0)**	**0.0**	**(0.0)**
	Variance =	**(124.2)**							

2.1 Income

Both contract and non-contract income to be achieved as planned. The figures include accruals for CQUIN income paid in arrears. The income figure assumes the STF monies for 2017/18 will be achieved.

2.2 Pay

Table 3 below illustrates the total pay costs by category. The underspending on substantive staff in post continues in June however the combined level of pay expenditure does not deliver the vacancy factor for the year, the overspending has slowed this month. An additional £0.3m budget for the year for neighbourhood teams has been included in the June position as agreed by the Senior Management Team.

Table 3 Annual Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	26,804	23,685	**(3,119)**	**(1,044)**	
Seconded staff costs	268	300	**32**	**5**	
Vacancy Factor	(1,660)		**1,660**	**1,119**	
Sub-total Direct Pay	**25,412**	**23,985**	**(1,427)**	**80**	
Bank Staff	22	569	**548**	**343**	
Agency Staff	358	1,544	**1,186**	**(127)**	
Total Pay Costs	**25,792**	**26,099**	**307**	**295**	**2,094**

The Specialist business unit continues to underspend on pay for May; the other Business Units have overspent again.

Specialist services:	-£56k (May -£46k, Apr -£12k) underspent, this is after delivery of the vacancy factor savings.
Children's services:	£251k (May £189k, Apr £135k) overspending being mostly the non delivery of the vacancy factor.
Adult services:	£145k (May £174k, Apr £74k) overspending due to non-delivery of vacancy factor, agency costs more than underspending on substantive posts, overspending on admin and clerical posts.
QPD Clinical:	£194k (May £93k, Apr £73k), overspending on bank and agency costs not mitigated by savings on substantive staff.

Senior review panels for all vacancies continue; these consider the quality impact of holding vacancies, look for alternatives to recruitment and the financial impact if the post is deemed essential.

Table 4 **Month on Month Pay Costs by Category**	**April £k**	**May £k**	**June £k**	**YTD Actuals £k**
Directly employed staff	7,816	8,037	7,831	23,685
Seconded staff costs	72	111	117	300
Bank staff	182	175	212	569
Agency staff	563	474	507	1,544
Total Pay Costs	**8,633**	**8,798**	**8,668**	**26,099**

Agency costs overall are £507k this month.

The main areas of agency expenditure and associated staffing positions are:

- Specialist BU £385k 15.89 wte less than planned
- Children's BU £180k 5.81 wte more than planned
- Adult's BU £545k 55.99 wte less than planned
- QPD Clinical £220k 3.26 wte less than planned
- Corporate £97k 24.19 wte less than planned
- Estates £62k 21.43 wte less than planned

Total vacancies are 124 wte this is 5 less than in May.

The Trust planned for agency expenditure of up to £7,000k for the year the agency cap for 2017/18 set by NHS Improvement is £7,386k. Agency staff are recruited to replace essential substantive staff vacancies they are funded from under-spending on substantive staff as they provide the alternative capacity to enable services to continue care provision.

2.3 Non Pay

Non pay expenditure continues to run slightly behind plan. The overspending in clinical supplies is in respect of continence products. The other non pay expenditure overspending is as a result of the procurement, estates and course fees savings targets where the savings have yet to be identified.

Table 5 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	253	278	25	16	
Clinical Supplies & Services	2,268	2,319	51	37	
General Supplies & Services	627	607	(20)	(4)	
Establishment Expenses	1,619	1,469	(149)	(132)	
Premises	3,456	3,341	(115)	(141)	
Other non pay	295	393	99	64	
Total Non Pay Costs	**8,519**	**8,408**	**(111)**	**(160)**	**(726)**

3. Reserves & Non Recurrent

The Trust has £1.6m in reserve at the end of June; all un-committed reserves have been released into the forecast outturn position. Based on the forecast at this point in the year the Trust will require an additional £0.5m 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	35.1	613.7	597.8	(15.9)	8.9	8.6	(0.2)	114,662	108,194	(6,468)	•••
Childrens Services	27.7	680.6	685.8	5.2	6.9	7.1	0.2	91,616	85,851	(5,765)	•••
Adults Services	33.3	846.9	794.9	(52.0)	8.4	8.5	0.1	210,549	197,035	(13,514)	•••
QPD Clinical	6.2	89.5	86.2	(3.3)	1.6	1.8	0.2	7,392	5,843	(1,549)	•••
Ops Management & Equipment	1.2	58.3	45.7	(12.6)	0.3	0.4	0.1				••
Service Line Totals	**103.6**	**2,289.0**	**2,210.4**	**(78.6)**	**26.1**	**26.5**	**0.3**	**424,219**	**396,923**	**(27,296)**	•••
Corporate Support & Estates	26.7	358.2	312.6	(45.6)	6.8	6.6	(0.2)				••
Total All Services	**130.3**	**2,647.2**	**2,523.0**	**(124.2)**	**32.9**	**33.1**	**0.2**	**424,219**	**396,923**	**(27,296)**	•••

This month operational services have 78.6 wte (May 82.7 wte) less in post than planned. The services continue to be a net £0.3m overspent at the end of June. All operational budgets but specialist services continue to be overspent at the end of quarter 1.

The overall activity is 6.4% (May 6.5%) behind plan, as all business units continue to be delivering less activity than planned at the end of quarter 1.

- Specialist services activities are 5.6% less than planned, (May 11.2%),
- Children's services activities are 6.3% less than planned, (May 11.6%),
- Adult NT services activities are 6.4% less than planned, (May 1.1%) and
- QPD Clinical services activities are 21.0% less than planned, (May 22.1%).

5. Cost Improvement Plans

Table 7 has the Trust's performance against the cost savings plan for 2017/18. Overall the plan is £197k or 25% behind at the end of quarter 1. It is anticipated actions will be taken to recover the shortfall and this is reflected in the forecast outturn CIP delivery and expenditure.

6. Capital Expenditure

Table 7 Savings Scheme	2017/18 YTD Plan £k	2017/18 YTD Actual £k	2017/18 YTD Variance £k	2017/18 Annual Plan £k	2017/18 Forecast Outturn £k	2017/18 Forecast Variance £k	2017/18 Forecast Variance %
Child Health Admin	5	3	(2)	20	20	0	0%
Night Nursing	13	0	(13)	50	50	0	0%
JCMT	50	0	(50)	200	200	0	0%
Admin Review	0	0	0	250	250	0	0%
CAMHS	63	24	(39)	250	250	0	0%
Corporate Support	38	38	0	150	150	0	0%
LSH	38	37	(0)	150	134	(16)	-11%
Orthotics	5	5	0	20	20	0	0%
Child Health Continence Products	6	2	(4)	25	25	0	0%
Geriatricians Overhead Charge	13	4	(8)	50	50	0	0%
Training	50	0	(50)	200	200	0	0%
Procurement	45	15	(30)	180	180	0	0%
Travel	38	38	0	150	150	0	0%
Drugs	13	12	(1)	50	43	(7)	-15%
Non pay inflation	90	90	0	360	360	0	0%
Mobile/data line charges	25	25	0	100	100	0	0%
Rents	35	35	0	140	140	0	0%
Estates other	25	25	0	100	100	0	0%
Contribution to overheads/fixed costs	81	81	0	325	325	0	0%
IT kit	63	63	0	250	250	0	0%
Release of reserves	100	100	0	400	400	0	0%
Total Efficiency Savings Delivery	**793**	**596**	**(197)**	**3,420**	**3,397**	**(23)**	**-1%**

NHS Improvement has yet to confirm the Trust's capital resource limit for 2017/18. The Trust has planned for capital expenditure of £1.816m; this should not be committed until the CRL has been approved.

Expenditure has been incurred in respect of the EPR project £72k and estates maintenance of £87k for Morley HC essential toilet and water system works and works at St George's Centre.

Table 8 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.0	0.1	0.1	0.5	0.5	0.0
Equipment/IT	0.0	0.0	0.0	0.8	0.8	0.0
Electronic Patient Records	0.1	0.1	(0.0)	0.5	0.5	0.0
Totals	**0.1**	**0.2**	**0.1**	**1.8**	**1.8**	**0.0**

7. Statement of Financial Position

Table 9 has the statement of financial position as at the end of June; this is in line with the planned position overall.

Trade receivables total £7.6m at the end of June. The largest debtor is Leeds City Council which owes £1.8m. Accrued income totals £3.4m, made up of £0.4m for CQUIN income and £0.2m for NHS England contract income. There was also £0.4m for contract income with the Police and £0.8m with Leeds City Council. Sustainability and Transformation Funding (STF) accruals total £0.9m made up of Q4 and the bonus funding notified in April together with the 17/18 accrual; the STF for 2016/17 should be paid in July.

Trade payables total £11.7m at the end of June. Accrued expenditure totals £6.3m, made up of £3.2m for property charges and various other smaller accruals.

As a result of the above the cash position is £0.1m lower than planned, with cash and cash equivalents totalling £19.6m.

Table 9 Statement of Financial Position	Plan 30/06/17 £m	Actual 30/06/17 £m	Variance 30/06/17 £m	*Opening 01/04/17 £m*	Planned Outturn 31/03/18 £m	Forecast Outturn 31/03/18 £m	Forecast Variance 31/03/18 £m
Property, Plant and Equipment	27.0	26.9	(0.1)	*27.1*	27.5	27.1	(0.4)
Intangible Assets	0.0	0.1	0.0	*0.1*	0.0	0.1	0.0
Total Non Current Assets	**27.1**	**27.0**	**(0.1)**	*27.2*	**27.5**	**27.1**	**(0.4)**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	6.7	7.6	0.9	*6.7*	6.6	6.2	(0.4)
Cash and Cash Equivalents	19.7	19.6	(0.1)	*19.1*	20.7	22.0	1.4
Sub-Total Current Assets	**26.4**	**27.2**	**0.8**	*25.8*	**27.3**	**28.2**	**0.9**
Non-Current Assets held for sale	0.2	0.2	0.0	*0.2*	0.0	0.0	0.0
Total Current Assets	**26.6**	**27.4**	**0.8**	*26.0*	**27.3**	**28.2**	**0.9**
TOTAL ASSETS	**53.6**	**54.3**	**0.7**	*53.2*	**54.8**	**55.3**	**0.6**
Current Liabilities							
Trade and Other Payables	(11.5)	(11.7)	(0.2)	*(11.1)*	(11.1)	(11.2)	(0.1)
Provisions	(0.8)	(1.2)	(0.4)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.3)**	**(12.9)**	**(0.6)**	*(12.5)*	**(11.5)**	**(11.6)**	**(0.1)**
Net Current Assets/(Liabilities)	**14.3**	**14.3**	**0.2**	*13.5*	**15.8**	**16.6**	**0.8**
TOTAL ASSETS LESS CURRENT LIABILITIES	**41.4**	**41.4**	**0.1**	*40.7*	**43.2**	**43.7**	**0.5**
Non Current Provisions	0.0	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**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**41.4**	**41.4**	**0.1**	40.7	**43.2**	**43.7**	**0.5**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	0.3	0.3	0.0
Retained Earnings Reserve	13.8	13.5	(0.2)	*12.8*	15.6	16.1	0.5
General Fund	18.2	18.2	0.0	*18.2*	18.2	18.2	0.0
Revaluation Reserve	9.2	9.5	0.3	*9.5*	9.2	9.2	(0.0)
TOTAL EQUITY	**41.4**	**41.4**	**0.1**	40.7	**43.2**	**43.7**	**0.5**

8. Working Capital

Chart 1 reflects the Board approved financial plan submitted to NHS Improvement March 2017. The planned, actual and forecast cash positions for the year are illustrated.

The Trust's cash position is strong at £19.6m which is £0.1m less than planned.

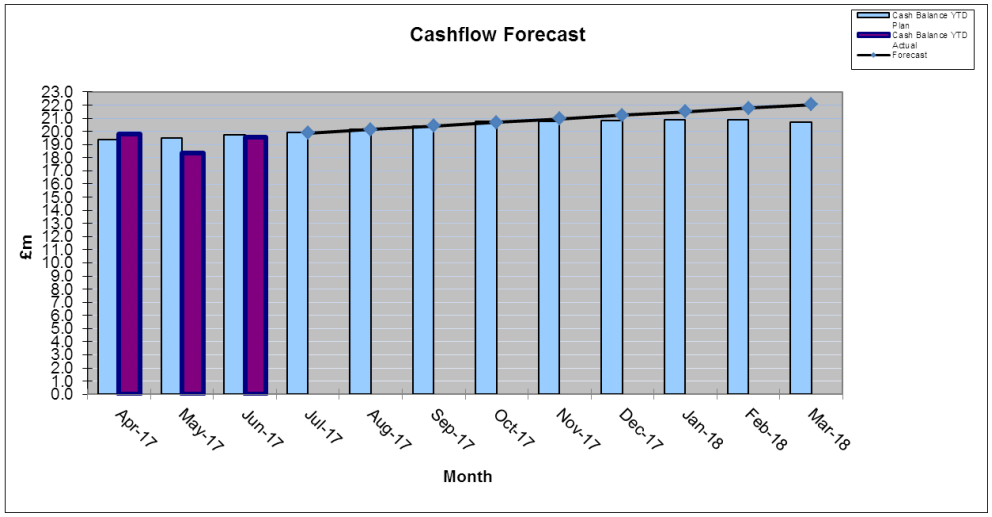


Chart 1

Table 10 demonstrates the Trust's performance in respect of the Better Payment Practice Code. Non NHS invoices have dropped below the 95% target due to the Trust holding all agency invoices in April until the employment status checks had been undertaken.

Table 10 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	98%	95%	G
By Value	99%	95%	G
Non NHS Invoices			
By Number	93%	95%	A
By Value	96%	95%	G

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 June the Trust's overall result continues to be 1, which is the lowest risk.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	37	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	7.3	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	-16%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

10. Conclusion on Financial Performance

The Trust's financial performance at the end of quarter 1 is running marginally ahead of the planned control total surplus. CIP delivery continues to be a concern and pay overspending has been mitigated by underspending on non-pay and release of reserves. Staffing levels are below funded wtes for all business units except Children's; temporary staffing is in place to mitigate service risks. Activity levels are less than planned for the month but have shown a marked improvement on last month.

Based on the current forecast outturn additional savings circa £0.5m are required to deliver the £3.034m control total set by NHSI. Further financial risks may have a negative impact on the Trust's performance as the year continues and the Trust has limited resources available to mitigate these should they arise.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (25)

Meeting Trust Board 4 August 2017	**Category of paper**	
Report title Serious Incidents Summary Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident and Assurance Manager	**For assurance**	√
Previously considered by	**For information**	

Purpose of the report

This report provides the Board with an update of the current activity in relation to serious incidents (SIs). The report summarises the outcomes, themes, actions and learning from investigations closed within the organisation during May and June 2017. An update on the current progress against action plans is also included.

Main issues for consideration

A total of 16 serious incidents were reported in May 2017 (8) and June 2017 (8) taking the total for the year 2017/18 to 22. This is a 21% reduction overall compared to the same period in the previous year.

Fifteen (93.7%) of the serious incidents in this reporting period related to pressure ulcers; with one other related to a fall resulting in fracture.

Outcomes of serious incident investigations completed in May 2017 and June 2017 are included in the report along with any themes identified through investigations. The themes remain consistent with previous reports and generally fall into four overarching categories: documentation, communication, processes and equipment.

The number of pressure ulcer serious incidents being 'de-logged' from the strategic executive information system (StEIS) has reduced. This will continue to be monitored to identify any themes relating to how serious incidents are initially categorised and recorded.

A key development in the reporting of serious incidents is a new process to align the Trust with other providers across the city that has been finalised with the CCG. This will mean only avoidable pressure ulcers are recorded as serious incidents from July 2017. Details of this new process are within the report at section 6.0.

Section 9.0 of the report details a summary of inquests. It is reassuring to note that none of the inquests concluded year to date have resulted in recommendations for the Trust.

Recommendations

The Board is recommended to:

- receive this report and note the current position regarding action plans and learning
- receive assurance regarding the management of serious incidents and handling of inquests

Serious Incident Summary Report

1.0 Purpose of this report

1.1 The purpose of this report is to provide the Trust Board with an overview of Serious Incidents (SI's) managed within LCH in the period 01 May 2017 – 30 June 2017.

1.2 The report provides a summary of the outcomes, themes, learning and actions from completed 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 of those.

2.0 Background

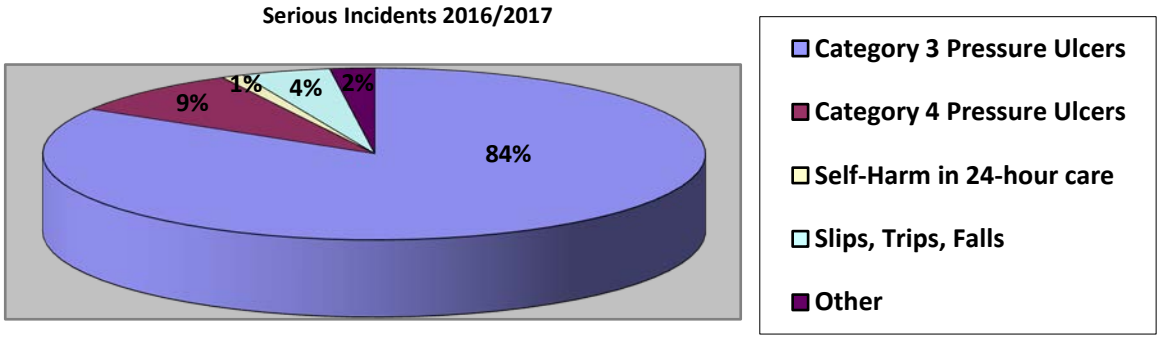
2.1 The Trust reports all incidents meeting the Serious Incident criteria, according to the NHS England Serious Incident Framework (DoH March 2015), via the Leeds West CCG Strategic Executive Information System (StEIS).

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 Clinical Governance Exception report part of the Trust's Executive Director of Nursing's Report and is submitted to the Quality Committee.

2.5 In 2016/2017 LCH recorded 92 SI's. The pie chart below illustrates the percentage of each category.



2.6 The category “other” represents two incidents. One related to an unexpected death of a patient under LCH (community) services and one was related to an intervention error (incorrect patient identification). The latter was subsequently de-logged as an SI.

2.7 The reduction of pressure ulcers is a Quality Account quality improvement priority for LCH for 2017/18; and is part of the Trust’s Sign up to Safety Pledge. The aim is to reduce avoidable category 3 pressure ulcers by 10% and have no avoidable category 4 pressure ulcers.

2.8 The SI report to Board in May reported that there had been 19 SIs in March and April 2017, of which 17 (89.4%) related to pressure ulcers; one other related to a fall resulting in fracture; and one related to a fracture sustained (cause unknown following SI investigation).

3.0 Current position

3.1 Sixteen SI’s were reported in May and June; this reflects a reduction of 23.8% in overall numbers compared to the same reporting period last year.

3.2 The numbers for May and June also reflect a decrease in pressure ulcer SI’s compared to the same reporting period last year, from 19 to 15; a 21% reduction.

2017 - 2018	Apr	May	Jun	Total
Pressure ulcer - Cat 3	4	7	6	17
Pressure ulcer - Cat 4	0	0	2	2
Self-harm during 24-hour care		0		0
Slips, trips, falls and collisions	1	1	0	2
Death in Custody		0	0	0
Other	1	0	0	1
Total	6	8	8	22
Delogged SI's				0
Previous year 2016 - 2017	8	8	13	29

3.3 One SI in May was an inpatient fall resulting in a fractured neck of femur that occurred in SLIC and is currently under investigation.

3.4 During May and June the Trust requested the CCG to ‘delog’ 1 SI from the StEIS system. This was reported as a pressure ulcer but on investigation was a trauma injury. Approval for this is currently awaited.

4.0 Completed Investigations

4.1 During May and June 2017 fifteen SI’s were completed and closed. These included 12 category 3 pressure ulcer investigations, which are reported to the CCG within a quarterly summary report.

4.2 The three SIs submitted individually to the CCG were a category 4 pressure ulcer, a fall resulting in a fracture and a fracture from unknown cause. A synopsis is provided below:

Ref	Type	Status	Root Cause(s)
5952	Category 4 pressure Ulcer	Unavoidable	Pressure ulcer may have developed whilst in hospital following bowel surgery; and deteriorated at home due to patient's general health issues and consequences of surgery. Increased risk factors were present as a result of the patients' desire to lead an active and independent lifestyle.
9148	Fall resulting in Fracture	Unavoidable	94 year old inpatient had an unwitnessed fall in their room. The patient was confused and attempted to mobilise without recommended assistance.
10313	Fracture sustained	Unavoidable	13 year old patient with complex needs accessing inpatient respite care, appeared distressed and in pain during routine care. Subsequent assessment revealed a fractured femur. Investigation identified underlying medical conditions as the likely cause and did not establish any contributory factors relating to LCH care.

4.3 The themes and learning from the closed investigations have been extracted and included in section 5.0.

4.4 All open SI's are currently within CCG investigation timescales.

5.0 Outcomes and Themes

5.1 Themes emerging from all the SI investigation reports completed in May and June identify the areas of concern to be:

5.1.1 **Documentation:**

- Accurate and specific documentation of care needs (accurate care plans) not always evident or updated in a timely way
- Specific risk assessments (relating to pressure ulcers) not always complete in timely manner/re-assessment not clearly documented
- Actions not always taken following assessment in a timely way

5.1.2 **Communication:**

- Teams and departments need clear communication channels to ensure consistency, accuracy, accountability and effective working – communication problems are often highlighted
- The importance of keeping clear records of communication with patients / family/carers is often highlighted and the need to involve carers in education and holistic assessment
- Improved communication between teams and services is an ongoing issue; particularly where other organisation/agencies are involved in the care provision

- Improved communication when there are concordance issues highlighted to ensure understanding and decisions are appropriately informed

5.1.3 **Care Delivery/Process:**

- Proactive case management not always evident – establishing process with senior clinician / escalation pathway requires embedding
- Holistic assessment not always completed or reviewed frequently
- Timeliness of reviews and skin inspections not always evident
- Responsibilities for timely and holistic assessment often highlighted as a concern
- Timeliness of referrals / visits / assessment and subsequent documentation frequently highlighted as contributing to pressure ulcer development

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 Changes to Serious Incident Reporting

6.1 A refined process for reporting pressure ulcers as Serious Incidents was agreed with the CCG in Q1 to align LCH's practices with the other healthcare providers within the city.

6.2 This will ensure a consistent approach in SI reporting city wide with only avoidable serious incidents reported via this route under the NHS England Serious Incident Framework.

6.3 The new process will enable LCH to spend more time investigating pressure ulcers that were avoidable, ensuring that the focus is on areas where there is learning to be identified and embedded in practice.

6.4 A new investigation and review process has been introduced to ascertain avoidable/unavoidable status at an early stage. This process requires written documentation of the rationale for the status given which is subject to scrutiny and review at senior level for assurance.

6.5 The new investigation review forms are also subject to regular audit to ensure consistency and assurance that the correct outcomes are identified.

6.6 The impact of this new reporting process is likely to be a fall in the number of SI's reported overall by LCH with only avoidable cases being classified as SIs from July 2017.

7.0 Action Plans and Learning

7.1 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.

7.2 The Business Units provide a monthly update of progress for open action plans. These are monitored via the Executive Director of Nursing's monthly report. The action plans are overseen by the Business Unit Quality Leads.

7.3 Status summary for SI action plans (YTD):

Total SI's	2016/17	2017/18
	92	**17**
Total number of actions generated (from closed SI's)	203	56
Actions closed within timescale	102	18
Actions closed outside of timescale	90	8
Total actions closed	**192**	**26**
Number of SI's with current open action plans	**7**	**13**
Total number of actions currently open	11	**30**
Number of actions over deadline	11	22

7.4 The identified lead for an overdue action receives an automated reminder of an approaching deadline and a subsequent reminder notifying them of an overdue action requiring completion. In addition, the details of actions overdue and the related SIs are shared with the Business Unit and appropriate teams.

7.5 Access to action plans will also support the Patient Safety, Experience and Governance Group (PSEGG) to triangulate learning from incidents, patient experience and inclusion along with patient, carer and public involvement and feedback from staff (via workshop meetings).

7.6 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.

8.0 CCG response

8.1 All SI investigations are sent to the CCG to review at a validation panel. The CCG panel will confirm closure of an incident; or request further assurance with regards to the management of and learning from it.

8.2 The CCG have not requested further assurance in relation to any SI reports in May and June.

8.3 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.

8.4 The CCG deep dive review of SI Action Plans has been delayed and will now be rescheduled for Quarter 2, 2017/18. LCH will participate in this review as planned.

9.0 Inquests

9.1 Twenty-two inquests registered with LCH as an interested party were concluded in 2016/17.

9.2 Since 01 April 2017 there have been 9 inquests registered for LCH. The table below provides a real time update on the status of these inquests:

Synopsis	Inquest Date	Outcome	Recommendations
Prisoner at HMP Leeds was found hanging in his cell in December 2013. Known to the drug misuse service but not to the mental health service in HMP.	20 Mar 2017	Narrative Conclusion	PFD report (Reg 28) issued to prison. No criticism of LCH.
Prisoner at HMP Leeds was found hanging in cell in November 2015.	02 May 2017	Narrative Conclusion	No Coroner recommendations for LCH.
Prisoner at HMP Leeds was found hanging in cell in November 2015.	03 Jul 2017	Mis-adventure – pressure to neck	No Coroner recommendations for LCH.
Patient in CIC bed developed infected pressure ulcers. Died November 2015.	19 Jul 2017	Record of inquest awaited	
Prisoner at HMP Leeds was found hanging in cell in May 2015.	04 Sep 2017		
Prisoner at HMP Leeds was found hanging in cell in February 2016.	09 Oct 2017		

9.3 There have been no Prevention of Future Death (PFD) reports served by the Coroner to LCH under the Coroners Regulation 28 (Reg 28).

10.0 Impact

10.1 ***Quality***

10.1.1 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

10.1.2 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 inbuilt to the SI management process.

10.2 ***Risk and assurance***

10.2.1 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.

11.0 Next steps – monitoring & improvements

11.1 Quality Committee will continue to receive assurance regarding SI management and learning as part of agreed monthly and quarterly reporting arrangements.

11.2 An annual themed report will be produced combining incidents (including SI's) and complaints with an interim (6 monthly) report of themes.

11.3 The Clinical Governance Team will continue to monitor the quality of SI action plans as previously advised.

11.4 LCH will participate in a deep dive analysis led by the CCG in order to assess the quality of action plans in 2017/18.

11.5 The PSEGG will bring together themes, actions and learning and evidence the sharing of learning across the organisation.

12.0 Recommendations

12.1 The Trust 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 2017-18 (26)

Meeting Trust Board 4 August 2017	**Category of paper**	
Report title Safe Staffing Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Executive Director of Nursing	**For assurance**	√
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

The paper describes the background to the expectations of boards in relation to nurse staffing, outlining where the Trust is meeting the requirements and where there is further work to be undertaken. The report is written in the context of the current system and local pressures.

MAIN ISSUES FOR CONSIDERATION

The report sets out progress in relation to maintaining safe staffing over the last six months. Updates are provided on the additional key areas of agency spend and development of the e-rostering tool.

Safe staffing has been maintained across all inpatient units for the time period. Units have also continued to provide safe and caring high quality care. It is important to note that this is now being increasingly challenged because of the CIC bed tender process and its impact on staffing.

Detail is provided in relation to neighbourhood teams and current pressures both internally and across the system as a whole. A detailed update was provided to Quality Committee in January 2017 as to how safe patient care has been maintained during this time.

The Health Visiting service has been making good progress in relation to caseload size in line with recommendations. Changes to commissioning intentions mean that the progress may be challenged going forward.

RECOMMENDATIONS

The Board is recommended to:

- Note the recruitment drive and work to support new staff
- Note the national monthly collection and publication of staffing data as recommended in “Hard Truths”
- Note that staffing levels are under constant review to maintain and ensure they are safe
- Note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting.

Safe Staffing Report

1.0 BACKGROUND

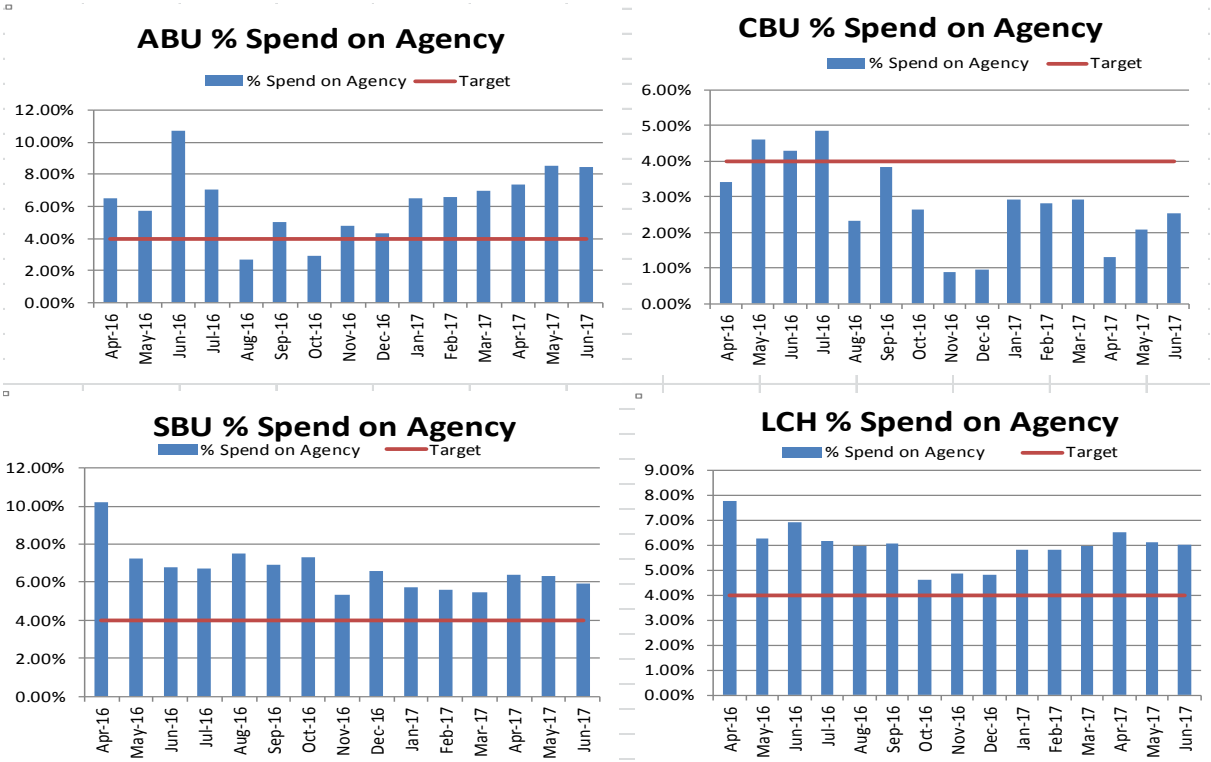
1.1 In line with the NHS England requirements and the NQB recommendations, this paper presents the six monthly nursing establishment's workforce review and sets out the approach taken by the Trust to ensure that there is sufficient nursing capacity and capability in all in-patient areas to meet the needs of our patients and maintain safe staffing across services.

1.2 Staffing levels are kept under regular review on a shift by shift basis by the nurse in charge or Operational Manager in liaison with Clinical Lead and monitored in operations across the Trust on a daily basis. The staffing levels are monitored by senior staff and detailed in the monthly performance panels and in-depth bi-annual report.

1.3 The determination of safe staffing levels is not a single process but rather an on-going review taking into account clinical experience in running the wards or team, the quality of service as determined by outcomes, including patient experience and national guidance and development of further tools. This is an important period in relation to safe staffing and the impact of changes both locally and nationally. Reports released by UCAS suggest applications for nursing and midwifery courses are down by 23% this year. NMC reporting also highlights that more midwives and nurses are leaving the profession in the UK than joining for the first time on record, with the number departing having risen by 51% in just four years. The figures show that 20% more people left the Nursing and Midwifery Council (NMC) register than joined it in 2016/17. The overall number of leavers was 34,941, compared with 23,087 in 2012/13. NMC data in June 2017 reports that applications from EU nurses to join the register are down by 96%.

2.0 AGENCY SPEND AND CAP

2.1 The government continues to issue guidance and work to drive down agency costs and agency caps and rules remain in force.



2.2 The Trust shows a downward trend until September 2016 onwards. The increase across business units of agency staff is due to winter pressures and has been a challenge to meet the 4% ceiling. Across the business units, of note is the high spend on agency in the Adult Business Unit shows a sharp increase over the winter pressures this has continued to rise. In the Children's Business Unit the levels of agency spend has started to decrease in 2017/18, this is due to the reduction of spend on medical staff where a small proportion of a medical time creates a high spend.

2.3 The Trust has undertaken work across a number of areas in 2016-17 and 2017-18 to reduce agency spend. There has been on-going dialogue with staff and information in weekly messages to ensure that staff are aware of the work to ensure that we maintain focus on quality but also work within the guidance and towards financial requirements. The trust signed a contract with the North of England on 01 May 2017 as a collaborative the competitive rates of the cluster is expected to have an impact on total agency.

3.0 SAFE STAFFING

3.1 We continue to use a set of principles as set out below to monitor safe staffing in our in-patient beds and wider teams in the absence of a national definition of community safe staffing. Safe staffing is based on the care and input provided by the multi-disciplinary team and that staff feel supported to deliver safe, high quality care. Staffing levels are kept under regular review on a shift by shift basis by the nurse in charge or Operational Manager in liaison with Clinical Lead and monitored in operations across the Trust on a daily basis. The staffing levels are monitored by senior staff and detailed in the monthly performance panels and in-depth bi-annual report.

- Patients can be treated with care and compassion.
- All patients have a thorough and holistic assessment of their needs.
- All patients have a care plan which sets out how the goals for their admission, care plan or treatment episode will be set.
- Staffing numbers allow full and timely implementation of the care plan.
- Staff numbers are sufficiently robust to allow the team or unit to function safely when faced with expected fluctuations and with the inevitable occurrence of short term sickness of staff.
- Operational Managers and Unit Managers are able to call upon additional resources if this is required by the particular needs of the inpatient group on a particular shift.
- A clear system of outcomes focussed on patient experience, patient safety and patient outcomes are in place and the information from these measures informs how the Operational and Clinical Leads run services.
- There is not an undue reliance on temporary staff to fill nursing rotas.
- The agreed processes for clinical prioritisation are followed in periods of escalation.

4.0 NATIONAL GUIDANCE

4.1 In line with the NHS England requirements and the NQB recommendations, this paper presents the six monthly nursing establishment's workforce review and sets out the approach taken by the Trust to ensure that there is sufficient nursing capacity and capability in all in-patient areas to meet the needs of our patients and maintain safe staffing across services. In addition further relevant documents and guidance was produced in 2016 and includes:

- Understanding safe caseloads in the District Nursing Service (QNI, September 2016)
- Safe, sustainable and productive staffing an improvement resource for the District Nursing Service (National Quality Board)

4.2 The National Quality Board have suggested a framework of nine characteristics of good quality care in District Nursing. This builds on the three expectations which were published in 2016 (Right Staff, Right Skills, Right Place and Time)

4.3 The Chief Nursing Officer and National Quality Board continue to build on the original guidance published in 2013/14. Further key guidance was issued in 2016 and sets out the responsibilities of a board. Although again based on acute in-patients many elements are transferable.

4.4 NHS provider boards are accountable for ensuring their organisation has the right culture, leadership and skills in place for safe, sustainable and productive staffing. They are also responsible for ensuring proactive, robust and consistent approaches to measurement and continuous improvement, including the use of a local quality framework for staffing that will support safe, effective, caring, responsive and well-led care.

Triangulated approach to staffing decisions

Expectation 1	Expectation 2	Expectation 3
Right Staff 1.1 evidence-based workforce planning 1.2 professional judgement 1.3 compare staffing with peers	**Right Skills** 2.1 mandatory training development and education 2.2 working as a multi-professional team 2.3 recruitment and retention	**Right Place and Time** 3.1 productive working and eliminating waste 3.2 efficient deployment and flexibility 3.3 efficient employment and minimising agency

Implement Care Hours per Patient Day

Develop local quality dashboard for safe sustainable staffing

Measure and Improve
- Patient outcomes, people productivity and financial sustainability -
- Report investigate and act on incidents (including red flags) -
- Patient, carer and staff feedback -

5.0 THE LOCAL PICTURE ON SAFE STAFFING

5.1 LCH has complied with NQB recommendation that monthly planned and actual staffing data is uploaded to Unify (appendix 1). The planned and actual, qualified and care staff hours are calculated to provide a "fill rate". Work has been undertaken with the performance team and workforce team as the Director of Nursing had identified that the previous tool was not working correctly. A new tool has been developed by the performance team.

5.2 Work continues across a number of important areas to support safe staffing. These include, but are not limited to:

- On-going work with the bank office team to recruit staff. The Director of Nursing with the Head of the Bank Office have met with the agencies on the new framework to influence more proactive recruitment and focus on the needs of the trust. This is showing some early positive signs in terms of numbers of CV's.
- The Trust continues to invest in nurse recruitment and detailed papers or updates have recently been provided to both business committee and quality committee. There remains on-going concern both internally and nationally in relation to being able to recruit in particular the required number of nurses. Work is also focussing on retention and opportunities for our existing workforce.
- We continue to develop new opportunities and engage in pan Leeds work such as the nursing associate pilot and nursing apprenticeships. A small number of staff are also being supported to undertake the Open University programme to nurse registration.
- Clear systems are in place to ensure that there is feedback from patients and carers who use the services and that reflection and concerns from patients and carers are acted upon.
- The Quality Challenge self-assessments have been completed and are currently being reviewed. All teams have developed action plans and detail can be viewed on the Quality Challenge+ page on Elsie.
- In Neighbourhood Teams the daily reporting tool provides a trust wide review of staffing and work allocation. This allows for movement of support and work where indicated.

6.0 WORKFORCE METRICS

6.1 The Trust reports separately on a monthly basis to Board on figures in relation to staff sickness, absence and recruitment and retention and these are included within the relevant sections of the report.

6.2 Workforce Management: LCH has been is investing in a Workforce Management project, a key part of which is the development and piloting of an e-Rostering application for the Trust. This work and project plan is currently under review and discussion with the provider.

7.0 CURRENT POSITION

7.1 The Board receives information on a monthly basis for inpatient units as part of the integrated performance report. The Trust began collecting data on each of its inpatient units in April 2014, with the first staffing report published externally in May 2014. The units included are:

- Community Intermediate Care Unit
- Hannah House
- Little Woodhouse Hall
- Community Rehabilitation Unit
- South Leeds Independence Centre

7.2 This report is written at a time of significant change for adult in-patient beds. Commissioners have issued notice and a tender process was initiated. LCH has submitted a partnership bid and the outcome should be known in August 2017. This is having a significant impact on recruitment and retention of staff at this time.

8.0 SLIC

8.1 Over this six month period the unit has continued to operate the agreed model of provision across the thirty beds. External reviews of the unit during this time have been very positive in relation to the improvements and quality of care provided on the unit.

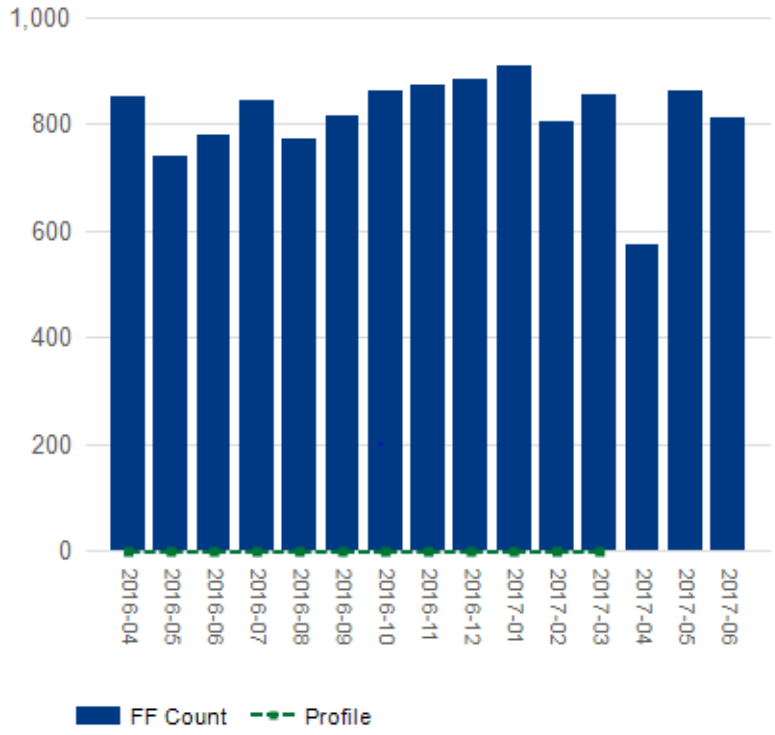
The staffing model has been maintained but is becoming increasingly challenged due to a combination of long term staff sickness and inability to recruit registered nurses due to the re tendering. Safe staffing is recorded daily on the Quality Board at the entrance to the unit.

8.2 ***Agency Staffing***

The unit remains dependent on a small group of consistent agency staff to cover some long-term staff absence and vacancies.

8.3 ***Key Quality Indicators***

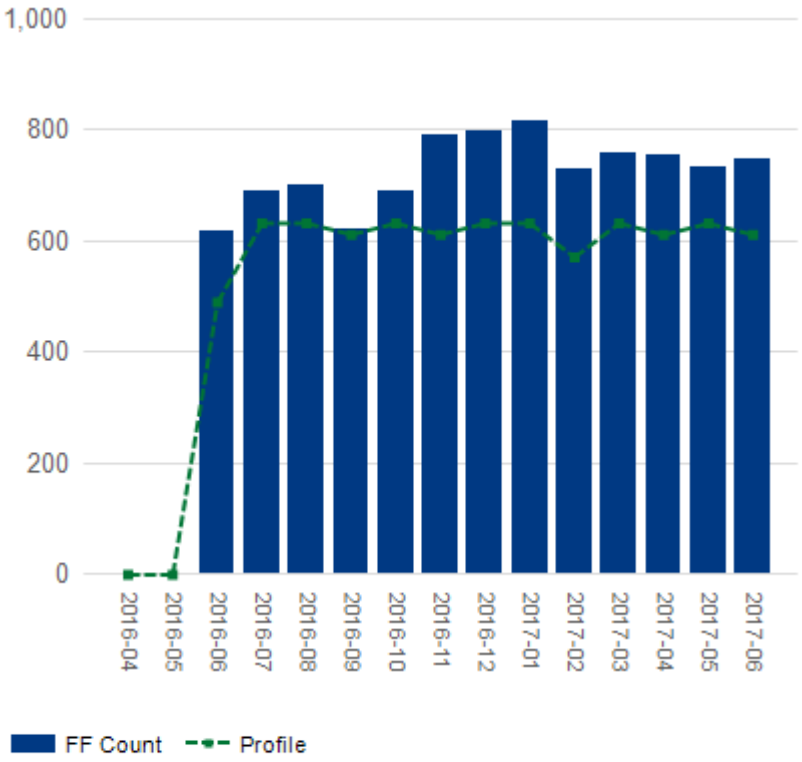
The unit has maintained the agreed model of care in relation to patient profile. Commissioners undertook a quality review visit in May 2017 and were very positive about the quality of care and the significant progress the unit had made.



8.4 The unit continues to provide safe care. The unit is using its quality board to monitor this and provides a focal point for safety huddles.

Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT %Response Rate	No data	18.97%	23.08%	12.70%	12.31%	19.05%
FFT %Recommended	No data	100%	100%	100%	100%	100%
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**10**	**7**	**14**	**15**	**20**	**11**
Serious Incidents	**0**	**0**	**0**	**1 x Fracture from fall**	**1 x Fracture from fall**	**0**

9.0 J31

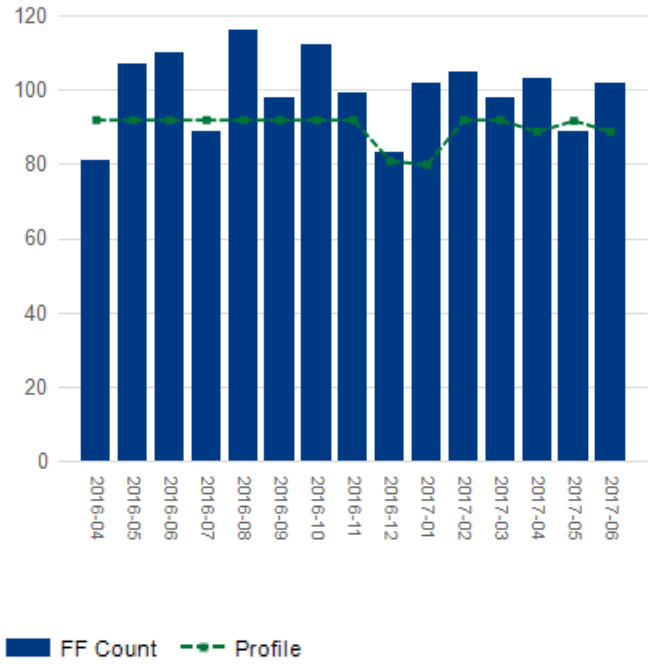


Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT	**5.97%**	**4.84%**	**No data**	**10.45%**	**17.39%**	**11.94%**
FFT %Recommended	100%	100%	No data	100%	100%	100%
Concerns	**0**	**0**	**0**	**0**	**0**	**0**
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**13**	**19**	**13**	**14**	**15**	**14**
Serious Incidents	**1 x Cat 3 PU**	**0**	**0**	**0**	**0**	**0**

10.0 COMMUNITY NEUROLOGICAL REHABILITATION UNIT

10.1 This regional unit consists of five inpatient beds and five day case places with additional community based services. Patients are typically admitted to the unit for two week episodes of care and assessment. The unit has reviewed its staffing model in line with the model of care. Safe staffing levels are maintained.

10.2 ***Activity***
The data below reflects the change to the model of care and reduction to five inpatient beds from ten and increase in day case and community services.

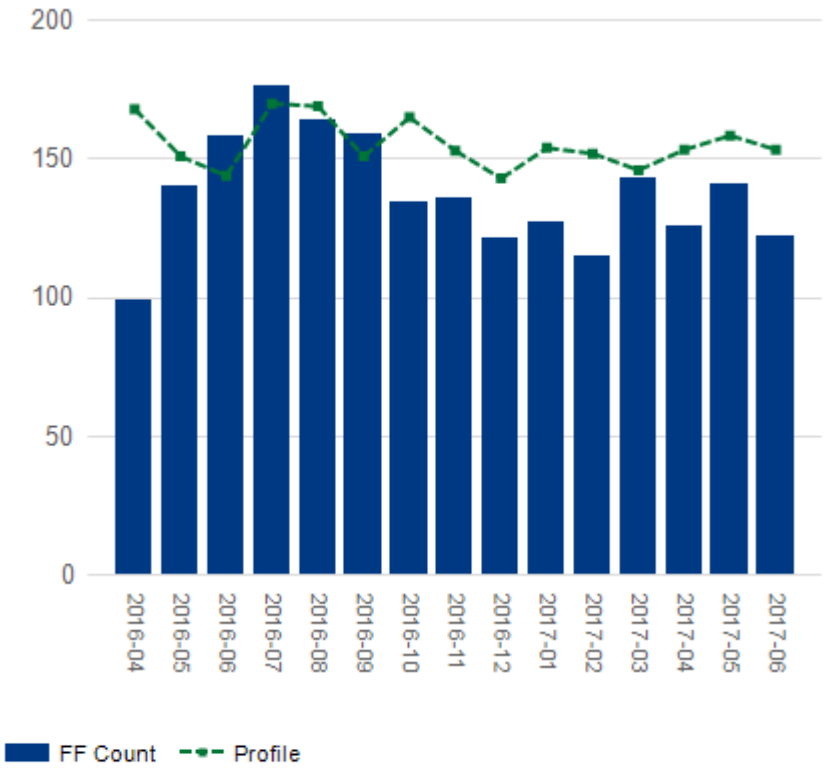


10.3 The unit provides safe care as indicated in the matrix below. The service uses a quality board. Patients care plans are reviewed at the weekly multi-disciplinary team meeting.

Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT	**13.75%**	**6.25%**	**18.75%**	**12.99%**	**16.25%**	**16.88%**
FFT %Recommended	100%	100	93.33%	90%	100%	100%
Concerns	**0**	**1**	**0**	**0**	**0**	**0**
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**3**	**4**	**10**	**7**	**6**	**7**
Serious Incidents	**0**	**0**	**0**	**1 x Cat 3 PU**	**0**	**0**

11.0 HANNAH HOUSE

11.1 The specialist unit provides short breaks for children with complex disabilities and long term health needs. An internal experienced unit manager is providing interim support to the unit whilst recruitment is on-going. A detailed action plan is in place to support identified areas of quality improvement within the unit.



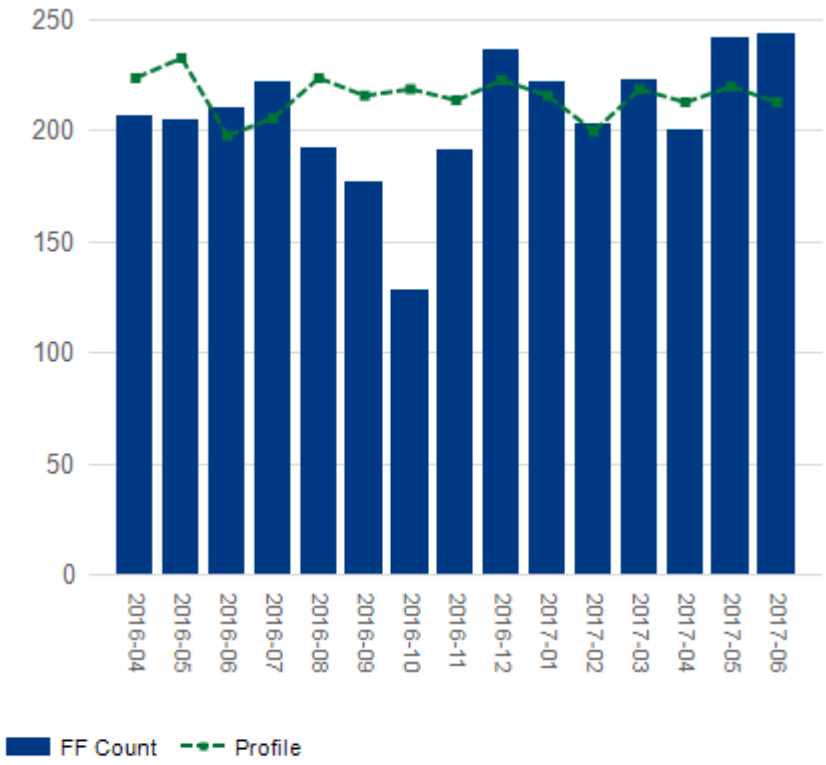
11.2 ***Key Quality Indicators***

Work is in place to develop how the quality board is used in the unit. The system for daily handover is being reviewed and quality huddles will be instigated.

Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT	No data	No data	No data	No data	**1.64%**	No data
FFT %Recommended	100%	100%	No data	100%	100%	100%
Concerns	**0**	**0**	**0**	**0**	**0**	**0**
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**2**	**1**	**0**	**4**	**4**	**2**

12.0 LITTLE WOODHOUSE HALL

12.1 Little Woodhouse Hall provides the CAMHS inpatient service. Due to the specialist nature of the unit and needs of the young people safe staffing levels are maintained at all times. Where young people have complex needs or in line with the individual risk assessment additional staff may be rostered.



12.2 ***Key Quality Indicators***

The unit delivered an extensive programme of work in relation to risk assessment and reducing ligature risks. Action was also taken following CQC findings in relation to same sex accommodation. The final report from the CQC re-inspection in January 2017 is awaited.

Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT	**No data**	**No data**	**No data**	**No data**	**No data**	**No data**
Complaints	**3**	**0**	**0**	**0**	**0**	**0**
Concerns	**1**	**0**	**0**	**0**	**1**	**0**
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**5**	**19**	**37**	**19**	**30**	**13**
Serious Incidents	**0**	**1 x medication overdose**	**0**	**0**	**0**	**0**

13.0 NEIGHBOURHOOD TEAMS

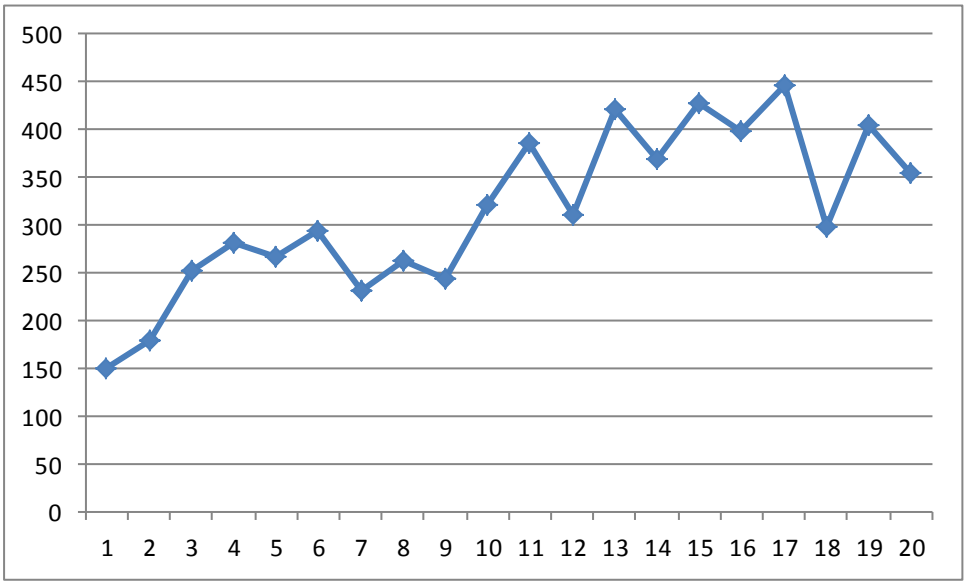
13.1 As previously stated there are no nationally agreed staffing levels for community teams or evidence based tools. The Trust continues to develop the work to set safe staffing levels in community teams. The work remains in development and there can be anomalies between what the data is reporting and the felt experience of staff on the ground. The draft standards provide some principles and examples of how to assess safe staffing for District Nursing but stop short of any specific recommendations or tools.

A major programme of work has been led by the Executive Directors of Operations and Nursing to support the leadership team and neighbourhood teams. This work is reported through quality committee and business committee.

13.2 *Neighbourhoods Demand & Capacity Tool*

Demand

13.2.1 As detailed in the Business Committee paper on SPUR, at the beginning of the year the Trust did not fully understand the demand into the Neighbourhood teams. Whilst it was possible to look backwards at referrals received in month, the system was not able to help identify daily demand. The new way of working in SPUR and the associated data collection provides dynamic information on referral demand. The following table shows demand across the period 31 January – 19 June. The average number of referrals per week was 315 within a range of 151-446**.**

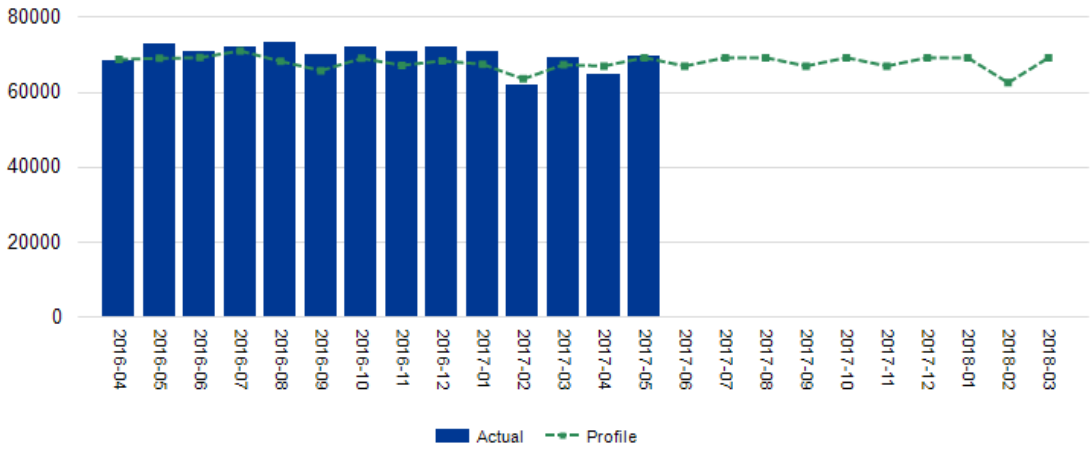


13.2.2 The period covers the implementation stage and there is more confidence that the second period of referrals accurately reflects the ongoing position i.e. in the period 10 April – 19 June the average number of referrals was 382 within a range of 298-446.

These figures do not include all referrals to the Neighbourhood Teams, only those that are managed through SPUR. Referrals from other LCH services go directly to the Neighbourhood Teams. However the workload associated with the first assessment for the average new referrals on a weekly basis equates to 15WTE.

Activity during the period has met contractual expectations but the activity has not risen in line with the increase in referrals. The following graph shows actual activity against contracted protocol.

Neighborhood Team Activity by Month



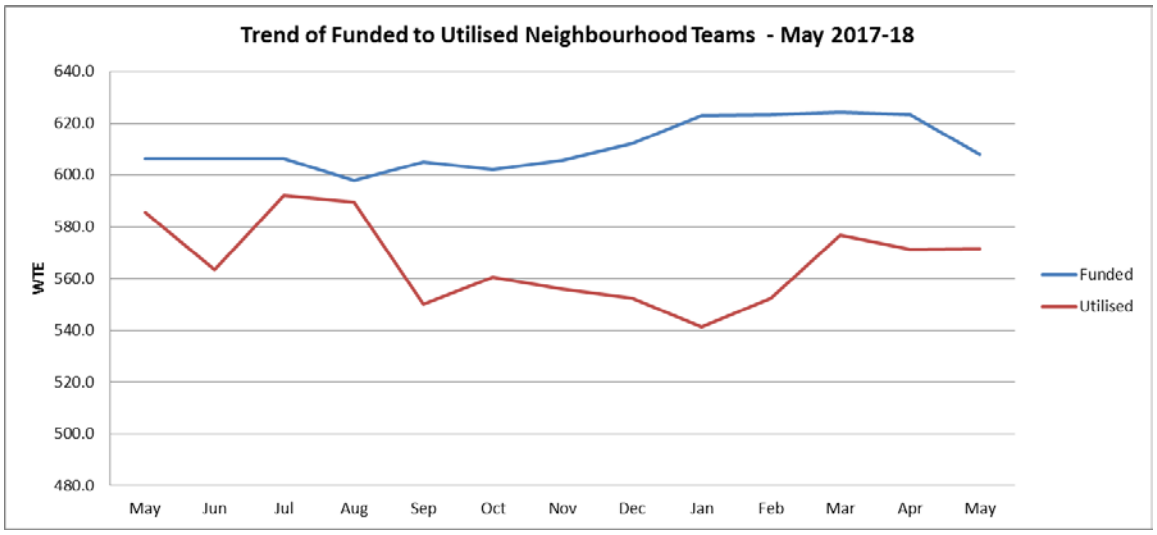
13.2.3 Measures have been put in place to manage demand during this period to ensure that activity undertaken is the most essential. These include:

- Defining essential work - the Deputy Director of Nursing has published a framework for defining essential care and how work should be prioritised on a day to day basis. The framework also identifies the point at which routine work becomes essential.
- Prioritisation of workload - the service has clear guidance on how to prioritise referrals.
- The first priority for all teams must be to maintain the current caseload safely to ensure nobody is admitted to hospital unnecessarily.
- Palliative patients with fast track status.
- Urgent referrals for people in community (including Community rapid referrals to prevent a hospital admission)
- Referrals from ED or Assessment floor to prevent hospital admissions.
- Hospital/CIC discharges.
- Routine visits – these are being deferred where appropriate and necessary (and will be managed as soon as possible)

- Redefining the offer for activities for daily living - in the last month the service has reviewed the offer regarding activities for daily living (ADLs) This work is undertaken by unregistered staff in the team and can include helping patients out of bed, supporting patients to prepare meals or with personal care etc. The aim of the intervention is to maximise independence. There has been some variation in the number of daily visits recommended and it appears that for many assessors the default recommendation had become four visits a day. Guidance has been issued to staff to carefully consider appropriate alternatives to care – such as hot meal delivery, family support and the reinstatement of a previous home care packages if applicable – enabling a reduction in the standard offer to two visits per day. Where clinically indicated teams still have the ability to recommend up to four visits per day.
- Introduction of a demand and capacity tool so there is a full understanding of the day's work in each team which allows the re-allocation of staffing across the city.

Capacity

13.2.4 The following graph shows the gap in funded and utilised staff during the period. Details regarding capacity can be found in the monthly Neighbourhood Team reports to Business Capacity.



13.2.5 The gap between funded and utilised WTE remains a concern as a proportion of the gap is attributed to sickness absence which historically has not released funding to pay for temporary staff. Sickness absence (Trust average) has now been funded within the Neighbourhood team budgets to ensure appropriate cover can be secured. 5% of the Neighbourhood establishment would equate to an additional 31WTE being utilised. The table below shows the impact the new approach to funding would have had on capacity over the winter period (providing of course that temporary staffing had been available)

	Dec-16	Jan-17	Feb-17	Mar-17	April-17	May-17
Funded WTE	**623**	**623**	**623.4**	**624.4**	**623.3**	**608.1**
Utilised WTE	**540.7**	**537.3**	**552.4**	**576.9**	**565.4**	**567.4**
WTE Gap	**82.3**	**85.7**	**71**	**47.3**	**57.9**	**40.7**
% Gap	**13**	**14**	**11**	**8**	**9**	**7**
WTE Gap + 5% temp staffing	**51.3**	**54.7**	**40**	**16.3**	**26.9**	**9.7**
Revised % Gap	**8**	**9**	**6**	**3**	**4**	**2**

Actions to mitigate a negative impact on quality

13.2.6 Over the last year the Executive Director of Nursing has worked to improve systems and processes to demonstrate that the Neighbourhood Teams are providing safe and effective care. There is little national work available or standardised tools for measuring and comparing the quality of care in adult community teams. Trust representatives continue to engage with partner organisations and national work to inform and develop this work.

13.2.7 Weekly Quality meetings for the 13 NTs were established in June 2016 and a clear work plan and set of action areas was agreed. The work was overseen by a steering group comprising the general manager, clinical lead, Director of Operations and Director of Nursing. The key priority action areas for the Clinical Pathway Leads (CPLs) and Neighbourhood Clinical Quality Leads (NCQLs) to deliver were agreed by the ABU Clinical Lead and Executive Director of Nursing.

13.2.8 An early action was the introduction of the Neighbourhood Team Quality boards. They have quickly become established as part of the routine service monitoring and quality assurance process for the clinical teams. The boards provide an overview of quality metrics including incidents (pressure ulcers, falls and medication errors with harm – the 3 highest clinical risks for the NTs), patient feedback, staffing and sickness levels, appraisal and clinical supervision rates. This initiative has been successful in tracking improvements and is supporting the awareness of variation across the NTs; we are continuing to work towards understanding this in more depth in the caseload cluster level. The quality boards support the early identification of merging trends before they become statistically significant and identified through the trust routine data surveillance.

13.2.9 A quality reporting matrix, which is reviewed on a monthly basis with the Neighbourhood Clinical Quality Leads has been established (see appendix 1). The suite of data covers the key indicators in relation to falls, pressure ulcers, medication errors and patient experience. This supports benchmarking across teams and the Director of Nursing has presented certificates to teams who have provided defined periods of harm free care. The process has also provided clarity in relation to those incidents that are attributable to LCH care and other organisations and that appropriate investigations are completed.

This work is continually reviewed and developed. Current work is focussed on systematically using the quality boards for the recording of daily safe staffing levels and ensuring this is visible to teams. This suite of data is used to inform safety huddles, focused areas for world cafes and reported through the Director of Nursing reports. Emerging trends and identified themes have been used to form the weekly message from the Director of Nursing and Clinical Lead.

13.2.10 Daily Handovers are now established in all teams, led in clusters by the senior clinicians (case managers), with registered and non-registered staff fully engaged in the process. This facilitates the timely review of safe and efficient clinical care, providing real time supervision, guidance and senior clinical oversight of the caseload on a daily basis. This provides an opportunity to review any patients of concern and agreeing any changes to care delivery and this is further supported through the safety huddles that have been developed. Patient and carer experiences and feedback are discussed in handovers, cluster, NT and Quality meetings.

13.2.11 Safety Huddles improve patient safety, engage staff in improving care and bring about positive change at caseload cluster level. The huddles take place as a minimum monthly; several NTs have at least one each week. Benefits include discussing and agreeing actions for: clinical incident themes, patients causing concern, heightening awareness for specific elements of care which are challenging, ensuring staff maintain a focus on preventative care. One team successfully focused on how they needed to work on reducing the number of missed visits by reviewing the current allocation process, ensuring staff reported patient changes, reminding staff of the processes in place, cross checking work being allocated and being clear on roles and responsibilities of the administrative and clinical staff. Communication systems have improved through the use of the quality boards and safety huddles. Key clinical and operational issues are shared with staff by the leadership team, alongside the Weekly Messages and Neighbourhood News, keeping staff abreast of latest developments of work areas that impact on the quality of care for their service.

13.2.12 Historically, the management of clinical incident investigations in Adults services had a back log of over 150 overdue incidents. Due to the healthy incident reporting culture 350-400 incidents are reported monthly with over 80% of these being no/minimal harm to patients. Incident investigation training has been rolled across the Neighbourhood Teams, supporting and developing staff to complete a comprehensive investigation, action plan and simultaneously ensure that apologies are provided to the patient, following the Duty of Candour process. There is now timely management of incident investigations from no to major harm caused to patients; where there are leadership gaps, this has a direct impact on not being able to adhere to the required timescales. Additional monitoring information is made available for the CPLs and is reviewed by the leadership team to track progress an improvement trajectory is now embedded into practice.

13.2.13 Community services have historically managed variations in demand by deferring work. This was not always completed in a systematic or consistent manner. A set of guidelines was published in January 2017 setting out what defined essential visits and grounds for deferring visits. The unallocated visits have been audited monthly on a random date from June 2016 to April 2017 (See Appendix 2). The table demonstrates that the on-going focus has consistently reduced the levels of deferred work from previous levels and that the guidelines in place are being adhered to.

13.2.14 Caseload reviews are an important element in successfully managing demand and capacity and is a current action area for the NQL's and senior clinicians. Work has been completed to develop a model to support consistent and systematic review of all caseloads. However this remains a significant challenge and there is variation across clusters. It has been difficult for senior clinical staff to protect the time to regularly undertake the reviews with teams. Senior clinical staff have supported in terms of modelling and undertaking reviews but further work is required to embed routinely across all clusters.

13.2.15 The essence of safe clinical care is grounded in an initial and comprehensive holistic assessment; this was a critical piece of work that was identified through analysing the quality of clinical records and outcomes of investigations from clinical incidents. To support the establishment of the holistic assessment standards, all clinical staff in the NTs (500+) have now attended holistic assessment training. A holistic assessment competency tool has been developed and is being rolled out for all registered staff to complete and this will further quality assure the clinical assessment process. This will now be included in the preceptorship programme. The documentation audit for the NTs now includes audit standards for: holistic assessment, pressure ulcer and falls risk assessment and end of life quality metrics, along with the basic LCH documentation core standards. We have achieved 79% across all audited standards and 85% against the LCH core standards. The teams are up to date and compliant with NICE guidance.

13.2.16 Clinical Supervision compliance has increased over the past year from 30% to over 80%, with staff regularly reflecting on the care being delivered to patients. Guidance has been developed to support staff in defining examples of clinical supervision. The process of recording supervision now more accurately reflects the good practice work being completed. Positive impacts of staff accessing supervision include teams recognising what causes them stress (e.g. young patients who are terminally ill, the work environment) and working out the best possible ways to care for their patients and their own health and well-being, agreeing changes required, with all staff owning the decisions made.

13.2.17 Establishing a baseline of competencies and skills of the NT workforce was completed in 2016. This showed significant differences and variations across teams both in terms of registered and non-registered staff. A detailed training plan was rapidly developed to ensure that staff had the core competencies and skills required for effective care delivery in the NTs. Training was supported by our specialist teams and through aligning specialist teams alongside clusters where possible. The training levels are reviewed on a monthly basis in the clusters and have been reported through quality committee. Training slowed down during escalation and work is on-going to pick up pace. Staff conversation is now positive about skills and competence but on-going work on rota management is required to ensure the correct skill mix across shifts as staff still report some challenges in this area.

13.2.18 The End of Life work has improved patient and carer experience and staff have gained benefits from the introduction of the Palliative Care Lead roles aligned to the NTs. The numbers of patients achieving their Preferred Place of Death has exceeded the 85% target. Significant progress has also been made in the number of nurses who are able to verify a death (36% increase to 65%) which supports a more positive end of life experience for families.

13.2.19 There is a trusted and valued reliance on the NT leadership team to undertake routine monitoring, reporting of quality metric information and escalate any areas of concern via the routine surveillance of performance, operational and NT Quality meetings. The level of scrutiny applied to all the work in the NTs has increased significantly, providing more professional opportunities to challenge, agree plans for addressing any barriers to completing work in expected timescales and accessing support from resources external to the NTs. There are many examples of staff and the NT Leadership team demonstrating their passion, commitment and determination to delivering quality services. Staff regularly “go the extra mile” above and beyond what is expected of them and show clearly that their work ethic matches LCH’s values and behaviours. Thank you cards are given by the NT senior leadership team to staff who are acknowledged for delivering particularly high quality and safe care, these are always well received by staff and staff have been recognised a number of times through ‘Thanks a Bunch’.

Indicator	Jan '17	Feb '17	Mar '17	Apr '17	May '17	Jun'17
FFT	**1.87%**	**1.53%**	**5.71%**	**3.15%**	**3.22%**	**3.83%**
92.59%	77.50%	91.52%	94.32%	90.32%	92.52%	**5**
Concerns	**2**	**2**	**3**	**2**	**2**	**8**
PALS	**1**	**0**	**0**	**0**	**0**	**0**
Incidents	**137**	**124**	**189**	**149**	**199**	**181**
Serious Incidents	**7 x Cat 3 PU** **2 x Cat 4 PU**	**7 x Cat 3 PU** **2 x Cat 4 PU** **1 x Fall resulting in fracture**	**11 x Cat 3 PU**	**3 x Cat 3**	**7 x Cat 3**	**5 x Cat 3 PU** **2 x Cat 4 PU**

14.0 HEALTH VISITING

14.1 Caseload size recommendations are based on Lord Laming's report following the death of Victoria Climbie and reviewed following Baby P's death. The national average for caseloads should be 400, with a reduction to 250 for the most deprived areas. Across the country there are many differences, London obviously struggles the most and have had huge caseload sizes.

This is the table we use to look at the staff figures and weighting the HV resource across the city.

The measurement for the calculation id the IDM the teams with the highest IDM (the more need the smaller the caseloads).

The IDM is relooked at every 2 years and this work is due this September so some of the figures may be out of date by then.

We have 14 practitioners on maternity leave at any given time over this next year, and a lot of requests to reduce hours. This means the picture is change constantly.

				Sept/Oct 2015			
Team	**No's of under 5's**			**Sept/Oct 2015**	**% achieved**	**vacancy**	**Caseload per WTE**
Beeston (Parkside)	3490			13.00	99	0.07	268
Bramley	2497			8.20	96	0.30	305
East Leeds	3334			11.70	91	1.19	285
Halton	1886			5.80	95	0.32	325
Harehills/Leafield	4980			11.80	90	1.31	422
Holt Park	2568			5.65	97	0.16	455
Kippax	2248			5.00	96	0.19	450
Kirkstall	1746			4.80	99	0.05	364
Chapeltown/ Meanwood	3564			11.00	95	0.60	324
Middleton	2701			8.43	92	0.71	320
Morley	3650			8.60	96	0.39	424
Park Edge	1340			5.30	100	0.01	253
Pudsey	3083			7.60	104	-0.30	406
Rothwell	1866			4.40	95	0.22	424
Seacroft	1883			5.28	96	0.24	357
Thornton	3003			9.91	99	0.12	303
Wetherby	1811			3.65	104	-0.14	496
Woodsley	1608			4.60	92	0.42	350
Yeadon	3114			6.44	103	-0.20	484
Total	**50372**			**141.16**	**96**	**5.66**	**357**

Indicator	**Jan '17**	**Feb '17**	**Mar '17**	**Apr '17**	**May '17**	**Jun'17**
FFT	**1.25%**	**1.14%**	**0.25%**	**0.07%**	**4.42%**	**15.21%**
97.14%	93.10%	85.71%	100%	99.19%	99.03%	**0**
Concerns	**0**	**0**	**0**	**0**	**2**	**0**
PALS	**0**	**0**	**0**	**0**	**0**	**0**
Incidents	**0**	**3**	**2**	**6**	**5**	**11**
Serious Incidents	**0**	**0**	**0**	**0**	**0**	**0**

15.0 CONCLUSION

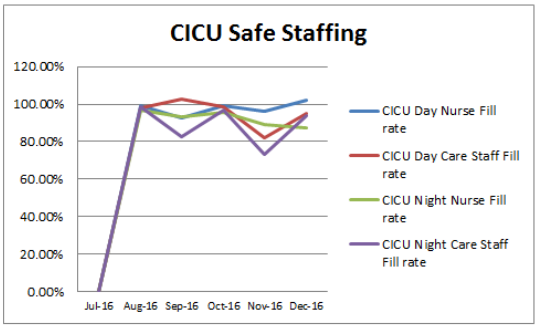
15.1 This paper presents the second six monthly reviews to Board in relation to safe staffing. The paper demonstrates that the Trust has maintained safe staffing in the six months. It also sets out and describes where the Trust has work in place to support and further develop work. The current pressures and challenges are set out and an overview of how these are being managed. The Trust will continue to monitor national guidance as released as this is likely to have significant impact.

16.0 RECOMMENDATIONS

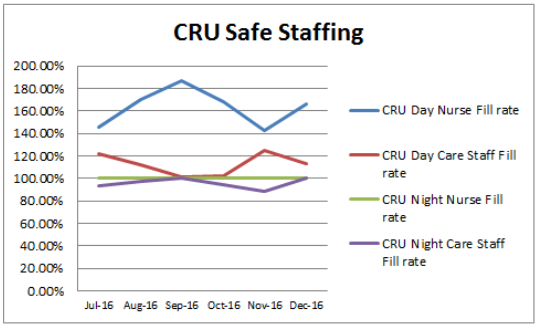
16.1 The Board is asked to support to:

- Continue to develop the staff bank to improve the responsiveness in providing appropriately trained area specific staff when needed and ongoing reduction in the need for agency usage.
- Continue the recruitment drive and work to support new staff.
- Continue to meet the national monthly collection and publication of staffing data as recommended in “Hard Truths”.
- Keep staffing levels under constant review to maintain and ensure they are safe.
- Note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting.

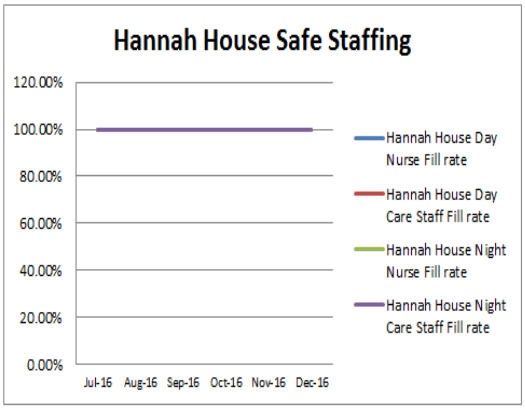
Appendix 1



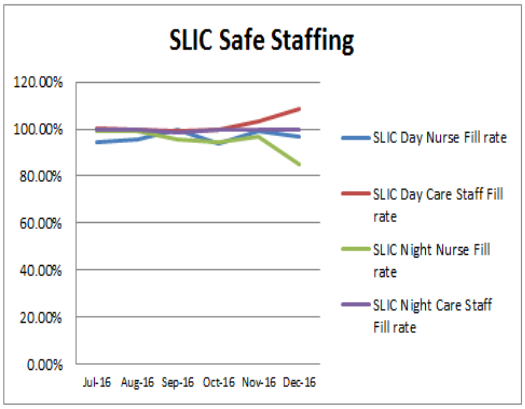
	CICU			
	Day Nurse Fill rate	Day Care Staff Fill rate	Night Nurse Fill rate	Night Care Staff Fill rate
Jul-16	-	-	-	-
Aug-16	98.9%	97.7%	96.8%	98.4%
Sep-16	92.8%	102.6%	93.3%	82.6%
Oct-16	98.9%	98.4%	95.7%	96.8%
Nov-16	96.1%	82.1%	88.9%	73.3%
Dec-16	102.2%	95.2%	87.1%	93.5%



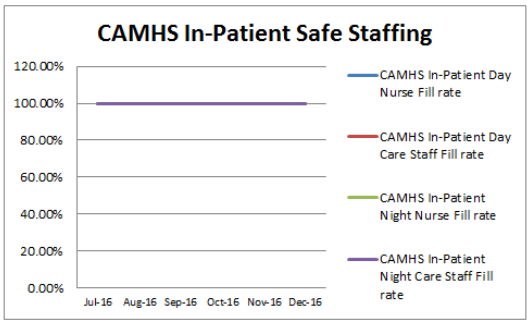
	CRU			
	Day Nurse Fill rate	Day Care Staff Fill rate	Night Nurse Fill rate	Night Care Staff Fill rate
Jul-16	145.9%	121.6%	100.0%	93.8%
Aug-16	170.0%	112.5%	100.0%	97.2%
Sep-16	187.2%	101.3%	100.0%	100.0%
Oct-16	168.4%	102.6%	100.0%	94.1%
Nov-16	142.5%	125.0%	100.0%	88.9%
Dec-16	166.7%	113.3%	100.0%	100.0%



	Hannah House			
	Day Nurse Fill rate	Day Care Staff Fill rate	Night Nurse Fill rate	Night Care Staff Fill rate
Jul-16	100.0%	100.0%	100.0%	100.0%
Aug-16	100.0%	100.0%	100.0%	100.0%
Sep-16	100.0%	100.0%	100.0%	100.0%
Oct-16	100.0%	100.0%	100.0%	100.0%
Nov-16	100.0%	100.0%	100.0%	100.0%
Dec-16	100.0%	100.0%	100.0%	100.0%



	SLIC			
	Day Nurse Fill rate	Day Care Staff Fill rate	Night Nurse Fill rate	Night Care Staff Fill rate
Jul-16	94.6%	100.3%	98.9%	100.0%
Aug-16	95.7%	99.7%	98.9%	100.0%
Sep-16	99.4%	99.3%	95.6%	98.3%
Oct-16	94.1%	100.0%	94.6%	100.0%
Nov-16	98.9%	103.0%	96.7%	100.0%
Dec-16	96.8%	108.4%	84.9%	100.0%



	CAMHS In-Patient			
	Day Nurse Fill rate	Day Care Staff Fill rate	Night Nurse Fill rate	Night Care Staff Fill rate
Jul-16	100.0%	100.0%	100.0%	100.0%
Aug-16	100.0%	100.0%	100.0%	100.0%
Sep-16	100.0%	100.0%	100.0%	100.0%
Oct-16	100.0%	100.0%	100.0%	100.0%
Nov-16	100.0%	100.0%	100.0%	100.0%
Dec-16	100.0%	100.0%	100.0%	100.0%

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (27)

Meeting: Trust Board Report 4 August 2017	**Category of paper**	
Report title: Freedom To Speak Up Guardian report	**For approval**	√
Responsible director: Chief Executive **Report author:** Freedom To Speak Up Guardian	**For assurance**	
Previously considered by N/A	**For information**	

Purpose of the paper

This paper provides an overview of the work of the Freedom To Speak Up Guardian, basic activity data and recommendations on the Freedom To Speak Up Guardian role and its development.

Main issues for consideration

This report addresses matters relating to implementing the Freedom to Speak Up role: the establishment of the role within the Trust, the mechanisms and spread of the work and its links to other programmes of work in the Trust.

Recommendation

The Board is recommended to:

- Note the report, activity to date and continue to support the embedding of the work across the Trust

Freedom To Speak Up Guardian report

1.0 Introduction

1.1 This paper provides an overview of the work of the Freedom To Speak Up Guardian, basic activity data and recommendations on the Freedom To Speak Up Guardian role and its development.

2.0 Background

2.1 The recommendation that trusts should have an agreed approach and a policy to support how organisations respond to concerns was one of the recommendations from the review by Sir Robert Francis into whistleblowing in the NHS.

2.2 CQC guidance published in March 2016, in response to the Francis recommendations, indicated that trusts should identify or appoint a Freedom to Speak Up Guardian in 2016/17. The NHS contract for 2016/17, accelerated this process and trusts were required to have made an appointment by October 2016.

2.3 Following a competitive recruitment process, the Trust appointed its Freedom To Speak Up Guardian in November 2016 and the appointee took up post on 1 December 2016.

3.0 Current position

3.1 The Freedom To Speak Up Guardian has received strong support from the Chief Executive and the wider Trust. A clear form of work has been established and is working well.

3.2 The communications team has circulated all teams with posters and information about the role. The Freedom To Speak Up Guardian has met with staffside representatives and established a good working arrangement. The Freedom To Speak Up Guardian has met with other local Guardians from local providers (LTHT, LYPFT and Locala) to discuss the work and start to create a local network. The Freedom To Speak Up Guardian has made contact with the Freedom to Speak Up National Office and it has been helpful on a number of issues.

3.3 There is ongoing work on the Trust's whistleblowing policy by the Executive Medical Director and Director of Workforce. There is a new national model policy that trusts are able to add to and develop. A final draft for consultation is in progress.

4.0 Activity data

4.1 The table below shows the volume and type of activity with which the Freedom To Speak Up Guardian has been engaged between 1 December 2016 and 1 May 2017. The table also indicates the nature of the issues raised by those staff who have contacted the Freedom To Speak Up Guardian.

Business Unit	Method of contact	Numbers of staff	Issue
Adults	Phone	1	culture
Childrens	Email	9	de-commissioning
Adults	Phone	12	culture / leadership
Specialist	face to face	1	commissioning
Specialist	face to face	1	commissioning
Adults	email	1	Culture
Adults	conversation	1	Culture

4.2 26 staff members have met directly with the Freedom To Speak Up Guardian

5.0 Themes

5.1 The section below outlines the themes that have emerged from work to date.

- ***Issues of capacity and demand.*** There is a theme of staffing and high demand and the concern for patient care this creates.
- ***Commissioning decisions and funding cuts on services and how they affect patient care.*** This happened where a LCH service had a serious reduction in budget. Staff were concerned about effects on patient care. The Freedom To Speak Up Guardian talked to the National Office as the reductions had not yet occurred and the bodies making the decision were not the Trust. The advice given by the National Office was to record as it may have a future relevance and that the commissioning body should be informed of the staff concern.
- ***De-commissioning a service and involving and including staff***. This relates to a service in Children's Services and the effects on patients and staff. The de-commissioning decision was not by LCH.
- ***Leadership and culture in teams and services.*** This was reflected in the concerns pertaining to services in the Adults and Childrens Business Units. The issue was the need of more supportive cultures and engaged leadership.
- ***Listening.*** One person who the Freedom To Speak Up Guardian worked with wished to reflect back on the importance of leaders and managers really listening to staff and their concerns.
- ***Actions*** – the role has led to support and work around culture with the business units concerned.

6.0 Conclusions

6.1 The Freedom To Speak Up Guardian has been well-received within the Trust and, whilst this is the first report, a number of conclusions can be drawn from the experience in the early months and these are as set out below:

- The Freedom To Speak Up Guardian role has had a positive start with strong support from the Trust. The next period should be one of embedding and spreading across the Trust
- The Freedom To Speak Up Guardian role raises the issue of process and working outside of formal routes. Most people seen could not or did not wish to raise issues through a formal route
- The role illustrates the centrality of workplace culture. It validates the Trust's commitment to an OD strategy and a person-centred vision
- The work reflects the importance of safe spaces, empathic listening and inclusion of the staff voice in the organisation – it offers an actualisation of the values of LCH for Freedom Guardian, staff and services.
- There is a need to develop a local working Freedom To Speak Up Guardian group with other Guardians.
- There is the question of how to balance the role with national and regional meetings – the need to keep connected to national work but focus energy and work on our staff. At the moment the energy is focussed on LCH staff.
- There may be a clear correlation between morale, sickness, staff wellbeing and the Freedom To Speak Up Guardian role that is present here. A number of staff have expressed their strong thanks for someone to listen to their concerns. One person commented that some staff may not have as many illness absences if these listening spaces and approaches were re widely available.
- The feedback to managers has been a constructive experience and the concerns have been shared.
- The role links well with wider culture work in the organisation and is engaging with different strands of that work.

7.1 Recommendation

7.1 The Board is recommended to:

- note the report, the activity to date and support the work to embed the work across the Trust

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (28)

Meeting: Trust Board 4 August 2017	**Category of paper**	
Report title: Annual Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director: Executive Medical Director **Report authors:** HR Advisor and HR Officer	**For assurance**	✓
Previously considered by Quarterly report considered by Quality Committee 22 May 2017	**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

- A system and process is in place for the Trust for junior doctors to report working hours exceptions in line with national requirements
- There have been three exception reports submitted by trainees in child and adolescent mental health services with reference to working hours. All have been closed.
- The Quality Committee 22 May 2017 received the first quarterly report and noted the need to appoint a new Guardian for Safe Working Hours and recommended an SMT review of administrative support to the Guardian.
- Recruitment is underway for the appointment of a Guardian for Safe Working Hours at 1PA per week by September 2017.

Recommendation

The Board is recommended to:

- Note the first Guardian for Safe Working Hours annual report

ANNUAL REPORT ON SAFE WORKING HOURS:
DOCTORS AND DENTISTS IN TRAINING

1. Introduction

This report is the first annual report to the Board regarding the systems in the new Junior Doctor contract for monitoring safe working practices.

As part of the junior doctors terms and conditions of service there is a requirement for the Guardian of Safe Working (GFSWH) to provide an annual report to the board. This report will provide an overview of how the new contract implementation is progressing and feedback regarding exception reporting. Data will be presented regarding rota gaps and agency spends to cover these gaps.

2. Background

The role of guardian of safe working was introduced as part of the 2016 junior doctor's contract as an assurance that the protections included in the contract regarding working hours and training would be honoured in practice. Every trust which employs more than 10 junior doctors is required to appoint a guardian of safe working hours.

The 2016 contract has introduced restrictions around maximum scheduling of rostered hours and specific rules, for example around working consecutive weekends. The new contract establishes a principle of 'pay for work done' and specifically references the right of trainees to access appropriate training which should not be sacrificed for service needs. New mechanisms have been introduced to achieve these goals. These are *work schedules* and *exception reporting* along with a *junior doctors' forum.*

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 2017.

3. High level data

Number of doctors / dentists in training (total):	31
Number of doctors / dentists in training on 2016 TCS (total):	17 (5 employed in LCH)
Annual vacancy rate among this staff group:	3% (1 post)

(Note: Core Trainees in CAMHS, 3 out of 4 posts are filled)
From August 2017 it is anticipated that all trainees will be working under the terms of the 2016 contract.

4. Annual data summary

4.1 Trainees within the Trust

Department	No.	Grade	Status
Adults	3	GP Trainees	Employed
CAMHS	5	STs	Employed (fulltime)
	3	CTs	Honorary
	5	FYs	Honorary
Community Paediatrics	3	STs	Employed
	11	STs	Honorary – (3 at full time and 8 at less than full time)
Sexual Health	1	ST	Honorary

5. Exception reporting

5.1 Working hours

There were three exception reports submitted by trainees in child and adolescent mental health services (CAMHS) with reference to working hours. All have been closed.

5.2 Training and continuing professional development opportunities

No exception reports have been raised in relation to missed training or continuing professional development opportunities.

5.3 Fines

No fines have been levied by the.

6. Rota gaps

6.1 Psychiatry Trainees “on call” rota gaps in CAMHS

The figures in the table below show sporadic rota gaps relating to trainees to cover all of psychiatry within CAMHS services across Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust.

(Note: gaps within Leeds Community Healthcare NHS Trust. have been covered from within the existing resource and supported by time off in lieu).

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	42	3	27	12	Sickness - 10 Vacant – 5 Compassionate leave – 3 Paternity leave 2 Unpaid leave – 1 Leaver – 5 *Other – 16
May	21	4	13	4	Sickness – 9 Off rota – 3 Leaver -1 *Other - 8
June	25	3	17	5	Sickness - 9 Leaver - 3 Off rota -1 Vacancy – 1 Compassionate leave –1 *Other - 10

7. Guardian for Safe Working Hours

The Trust's first guardian of safe working hours was appointed to the role in November in 2016 but resigned on 18 June 2017 when the service he was working in transitioned to another provider. Following the first quarterly report it was recognized the time allocated for the role (two hours, 0.5PA per week) was insufficient and agreement was made at Senior Management Team on 14 June 2017 to increase the hours to four per week (1PA).

The post was re-advertised and two applicants will be interviewed in August or September 2017.

The required mechanisms of *engagement, work schedules, exception reporting,* and the *junior doctors' forum* have been implemented within the Trust.

Morale amongst junior doctors throughout England remains low due to issues such as staffing and rota gaps, high costs of training and the prioritisation of service delivery over training. Trainees in this Trust have described their experiences as positive in comparison to other trusts. They particularly value the training opportunities they receive and supportive relationships with supervisors. Issues identified for trainees in community paediatrics relating largely to the on-call commitment of trainees (in LTHT) impacting on their 'day time' training (in LCH) are to be addressed by the Associate Medical Director (Education and Training).

8. Recommendation

The Board is recommended to:

- Note first Guardian for Safe Working Hours annual report

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM **2017-18 (29)**

Meeting: Trust Board 4 August 2017	**Category of paper**	
Report title: Leeds Community Healthcare NHS Trust Digital Strategy 2016-2020	**For approval**	√
Responsible director: Executive Director of Finance and Resources **Report author:** Assistant Director of Business Intelligence, Systems and IT	**For assurance**	
Previously considered by Business Committee 24 May 2017	**For information**	

Purpose of the report

The purpose of this paper is to describe a digital strategy and provide an overview of the key information management, technology and capabilities and infrastructure required by the Trust in the timeframe 2016-2020.

Main issues for consideration

This digital strategy represents an opportunity for the Trust to deliver systems and services that will enable transformation by keeping pace with the rapid developments in technologies and clinical practice whilst delivering the operational efficiencies necessary in this era of financial constraint.

The digital strategy will ensure that the Trust is able to support the NHS commitment to become paperless by 2020 through a series of recommendations to support investment decisions and approaches necessary to adopt technologies that will best support the highest quality of care for patients.

The digital strategy adequately reflects the technology and information priorities and aspirations of the Trust and links to the Trust's overall strategy.

Recommendation

The Board is recommended to:

- Approve the digital strategy

NHS
Leeds Community Healthcare
NHS Trust

Leeds Community Healthcare NHS Trust

Digital Strategy

2016-2020

Executive Summary

This Digital Strategy represents an opportunity for the Trust to deliver systems and services that will enable transformation by keeping pace with the rapid developments in technologies and clinical practice whilst delivering the operational efficiencies necessary in this era of financial constraint.

The Digital Strategy replaces the current Information Management and Technology strategy. We have called it a Digital Strategy to reflect the national Digital Maturity Assessment, the results of which were published in March 2016.

In launching the Digital Maturity Assessment, the NHS National Information Board said:

> *"Using digital technology more effectively and ensuring providers are operating paper-free at the point of care is critically important to dissolving the artificial barriers between care settings and professionals required to deliver the Five Year Forward View. It is essential to securing safe and sustainable health and care that supports healthier lives, delivering practical benefits for professionals and patients within local health and care economies. Where professionals continue to manage care in the face of unknown risks, patient experience, safety and effectiveness suffer.*
>
> *In digitally mature health and care economies, professionals are able to operate paper-free at the point of care, enabling new workflows to support collaboration and continuity of care. Through accessing the best current clinical knowledge, spotting signs of early deterioration and intervening proactively, professionals recognise and reduce unwarranted variation. Digital record systems increasingly incorporate patient recorded data and preferences. Professionals and patients make more informed decisions and better choices, improving outcomes and efficiency"*

This Strategy builds on the Digital Maturity Assessment by developing Business Intelligence as a key objective

The Board is asked to approve this strategy and the associated work programme to deliver the recommendations outlined within it. The following actions should be considered as priorities which will have a significant positive impact on the Trusts Digital Maturity Index. They are relatively simple to implement and in some cases require little or no new investment:

Action	Priority	Commencing
Deployment of the e-rostering system to ensure the right staffing resources are in place at the right time to meet the demands of patients	High	Ongoing
Scope and implement a free to access public WIFI service	High	01/04/18
Implementation of a "single sign-on" solution for staff, which removes the need for staff to use multiple logons and reduce the resulting frustration and high proportion of "lock-outs" from digital services which occurs which increases the risk of denial to clinical information	High	01/04/17

Develop the “Performance Information Portal” an in-house reporting system which will deliver desktop access to Key Performance Indicators to managers at all levels within the trust to support operational decision making.	High	30/06/16
Appointment to the role of Chief Clinical Information Officer to ensure there is appropriate clinical engagement throughout the Trust and successful adoption of digital technologies	Medium	31/12/16
Develop a firm plan for the continued deployment of the e-Referral system to services in consultation with the lead Commissioners to facilitate choice and convenience to patients.	Medium	31/12/16
Monitor emerging digital technologies using regular horizon scanning to keep the digital strategy up to date and ensure the Trust is well placed to take advantage of opportunities which are presented in a rapidly changing technological environment. Updates should be regularly reported to Board.	Low	30/09/16
Deploy remote and assistive care solutions such as through the implementation of video conferencing within the Neighbourhood Teams and through the adoption of SKYPE for business through the upgraded NHS Mail system to enable remote “face to face” consultations between clinicians and patients.	Low	Ongoing

A number of definitions relevant to the interpretation of this document are included in Appendix 1.

Contents

1. Introduction

1.1 The principal goal of the Leeds Community Healthcare (LCH) Digital Strategy is to support the organisations vision of **providing the best possible care in every Community** by the deployment, development and maximisation of benefits from electronic clinical information systems and the information derived from them.

1.2 The strategy is placed firmly within a national, local and Trust-specific context. We do not operate in isolation and our Digital Strategy is heavily influence by the national direction of travel for digital infrastructure and information systems, our service partnerships in Leeds and the priorities of the Trust and its clinicians.

1.3 The document describes the actions necessary for the successful delivery of the digital capabilities which are essential for transforming the delivery of health and social care services and creating a digitally mature organisation. The actions are grouped into the following categories:-

- Readiness
- Capabilities
- Infrastructure
- Business Intelligence

As part of the actions required the strategy acknowledges the baseline assessment established in the Digital Maturity Index for each category and how the Trust will recognise when that deliverable has been successfully achieved.

1.4 The strategy considers the risks associated with the completion of the deliverables and the resource requirements which may be required which are over and above existing approved expenditure.

1.5 The final section of the strategy contains a high level implementation plan which identifies a high level timescale when the various actions identified within the document will be actioned.

2. Vision and Values

The Leeds Community Healthcare Trust's vision and values are:

Vision

- We provide the best possible care to every community in Leeds

Values

- 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

The vision and values are underpinned by four strategic objectives:-

- To provide high quality, safe services, continuously improving the patient experience and measuring our success in outcomes

- To work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home principles
- To engage and empower our workforce, ensuring we recruit, retain and develop the best staff
- To become a viable and sustainable organisation with the ability to invest in the community and with a relentless focus on value for money

3. People and Organisational Development

The Digital Strategy must sit alongside and be delivered in accordance with values and the behaviours which underpin the "Way We Work".

The deliverables of the Digital Strategy have a significant role in supporting:

- Making the best decisions – using the information which our systems hold to help staff, patients and carers make the right choices at the right time.
- Adapting to change and delivering improvements – harnessing technology to seek safer and more effective ways of working whilst helping services to adapt to a rapidly changing healthcare landscape
- Finding solutions – the innovative use of technology and information flowing from operational systems can play a major role in helping find solutions which support the new ways in which staff work.

The ultimate success of this Strategy is how well the interface between people, technology and systems performs and this in turn relies upon a complex and related infrastructure involving communication, training, awareness and organisational development.

It will be important that the Digital and Organisational Strategies work together in a supportive process.

4. Benefits of delivering this strategey

The benefits to be achieved from the delivery of this strategy include:

- The transformation of the patient experience, enabling citizens to make the right health and care choices through the use of new technologies and services.
- Collection of information to support the delivery of safer more effective clinical care, allowing clinicians to make the best decisions for their patients
- More complete and accurate management reporting arising from a reduction in the dependency on manual data collection systems
- Facilitation of business change activities to deliver new ways of working through the use of new technologies which allow care to be provided in ways, such as through the use of teleconferencing.

The Digital Strategy will support the Trust's **vision** by:

- Providing access to the most up to date patient information to support the best possible decision making by clinicians.

The Digital Strategy will support the Trust's **strategic objectives** as follows:

- To ensure the readiness exists to plan, deliver and optimise digital systems to ensure the Trust can operate "paper free" at the point of care by 2020. Readiness requires the Trust to have the alignment of digital priorities with other priorities, the leadership, resourcing and governance in place prior to investing in digital services.
- To ensure the right digital capabilities are in place for the services we use and that they are appropriately used by staff
- To ensure the infrastructure necessary to support a digital service is in place
- To use Business Intelligence to support the commissioning and contracting processes to maximise income by ensuring we are paid for all the clinical activity which we perform.

5. Context for the Digital Strategy

5.1 National Strategic Context

There are a number of drivers at a national level that shape the priorities for LCH and the way in which it delivers information and technology services. These are identified below:

5.1.1 National Digital Drivers

NHS England's vision for the future is delivering the highest quality care to patients by harnessing the power of information technology to allow the NHS to become paperless by 2020.

The key components of this are:

i. Offering digital services for patients and citizens:
To transform the patient experience and to enable citizens to make the right health and care choices.

ii. Offering digital services for professionals:
To give care professionals all the information they need to make the best decisions for their patients.

iii. Information sharing and transparency:
To help patients, health professionals and commissioners to improve services and patient outcomes.

iv. System leadership: The National Information Board
To bring together the NHS with local government, clinical leaders, and civil society to oversee the delivery of core information priorities.

v. Digital Roadmaps – under the leadership on the CCGs, "place based" plans for the adoption of digital services to support healthcare and social care across all partners will be developed and assessed and monitored by NHS England. The expectation is that digital developments will be coordinated to provide a seamless and transparent service to patients, whilst creating efficiencies in the way in which services are provided.

5.1.2 Digital Maturity Index / Sustainability Transformation Plans

The Digital Maturity Index assessment measures the extent to which the Trusts healthcare services are supported by the effective use of digital technology. It helps identify key

strengths and gaps in the Trusts provision of digital services at the point of care and offers an initial view of the current 'baseline' position. The gaps identified in this assessment form

the key priority areas for action of the Trust's Digital Strategy. The review was completed in December 2015 and the results published in April 2016.

The high level results for the first return made by the Trust were:

Readiness	Capability	Infrastructure
OK – Good progress with a score of 47%	Some progress with a score of 30%	OK – Good progress with a score of 45%

Readiness: covers strategic alignment, leadership, resourcing, governance and information governance
Capabilities: covers records, assessments and plans, transfers of care, orders and results management, medicines management and optimisation, remote and assistive care, asset and resource optimisation and standards
Infrastructure: covers areas such as Wi-Fi, mobile devices, single-sign on and business continuity

5.2 Leeds City Context

5.2.1 The Shared Strategy Architecture and Commissioning (SSAC) vision for the city of Leeds has at its core, a single architecture for data storage, the use of common business software such as word processing or spreadsheets and a host of collaborative tools which support inter-agency and multi organisational working. The benefits of this approach include economies of scale for data storage costs, licences and a service model where technical support is harmonised, allowing for example, any engineer to support any user. This vision would deliver the robust infrastructure on which all health and local authority organisations increasingly rely upon to deliver their day to day services but at a cost which is affordable and sustainable for the city.

5.2.2 To achieve this vision compromises will be needed with respect to the software and technologies used across all organisations with investment needed to bring each organisation up to a baseline level. The foundations for achieving this strategy will be established by a separate project team hosted by the Leeds City Council IT service in 2016/17.

5.3 Trust context

5.3.1 In accordance with the deliverables detailed in the previous IT Strategy, the Trust has achieved much of what was expected including:

5.3.2 Investment in the infrastructure used to support the delivery of ICT to front line staff. Network connections to sites have been improved with the majority of sites now benefiting from 100Mb connection speeds, up significantly from the previous 10Mb speeds

5.3.3 WIFI has been installed at the majority of LCH premises alongside the delivery of significant numbers of mobile devices (laptops and tablets) and with the inclusion of WIFI

and SIM cards within these devices, allows staff to work flexibly within, across and outside of LCH buildings.

5.3.4 The EPR project has delivered both the infrastructure and electronic data collection processes which allow services to move towards paper free operations. This has seen a switch to electronic primacy for the patient record. Whilst still in deployment, the Trust expects the project to deliver to all services by the end on 2016/17.

5.3.5 The deployment of the Leeds Care Record, primarily to all of the Neighbourhood Teams but also to a number of others including, Children's Services such as Child and Adolescent Mental Health, Musculoskeletal and Podiatry as "consumers" has provided access to a range of Secondary, Mental Health and Primary care data which historically has been inaccessible to LCH staff in digital form and plays an important role in operational clinical decision making.

5.3.6 The data warehouse operated by the Trust was a successful recipient of capital funding in 2015/16 which provides a robust foundation to receive, hold, process and report corporate information which includes a capacity to hold activity, workforce and financial information.

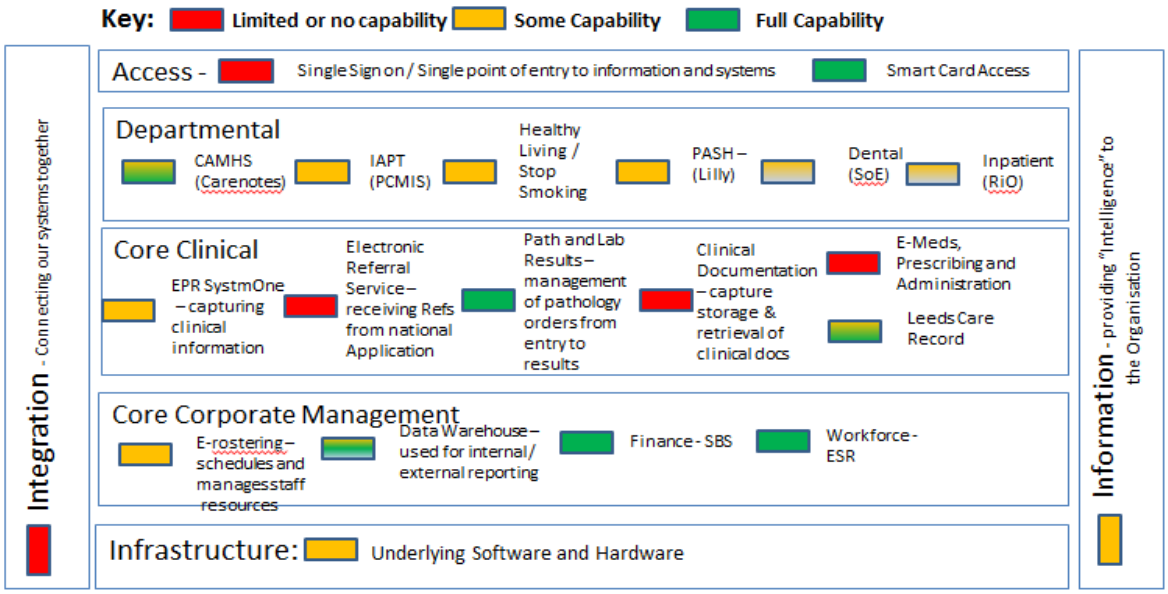
5.3.7 A significant investment is being made in the capacity and capability of the Business Intelligence Team in 2016/17 which will enable a fit for purpose analytical service to be established within the Trust to support operational and strategic decision making, an investment in a new software platform to deliver reporting to individual desktops and an investment in order to upskill and train users in the use of the new information techniques which this service will bring.

5.3.8 The transition to a new direct contractual relationship with TPP, the provider of the main clinical information system which is a consequence of the completion of the national contracts which has been provided free at the point of access since 2010. The resulting exit from this "Local Service Provider" contract provides a stable long term contractual basis on which future digital developments relating to the clinical record can be made.

5.3.9 The closure of the Yorkshire, Humber and Bassetlaw Commissioning Support Unit (CSU) has enabled the Trust to reassess and put in place a revised support arrangement for IT services and key elements of the infrastructure which we use jointly with the CCGs. The reset of this relationship allows for greater clarity and control to be established over IT support arrangements.

5.3.10 A simple assessment of the Trusts Clinical and Corporate Systems Capabilities offered by the various systems is provided in the following diagram, which highlights where future developments would be most appropriately targeted:

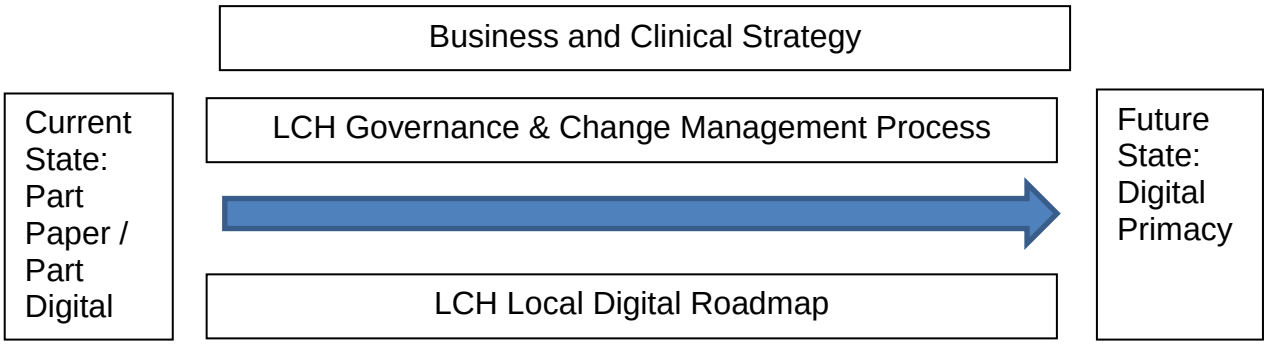
Clinical & Corporate Management Systems Technology Capabilities



In summary there are pockets of strengths and weakness within the systems which are in use by the Trust. These systems are built upon an improving infrastructure where the operating systems and anti-virus and encryption are up to date and operate on a wide and mobile area network which is sufficient for the Trust purposes.
Key weaknesses of the current configuration include a lack of a single sign-on process, which causes frustration for staff who need to use multiple log on credentials for various systems and a lack of meaningful integration of internal systems, so data about patients existing in silos and requires staff to log in to multiple systems to obtain a holistic view of a patients needs and care.

5.3.11 The trust has committed to the development of the EPR using TPP SystmOne through the EPR project and the has entered into a new 5 year contract as a consequence of the national Local Service Provider (LSP) contract terminating in July 2016. The bulk of the “digital” aspirations for clinical services are therefore embedded within this system and supporting infrastructures. However, there are currently a number of supporting clinical departmental systems which complete the digital landscape for the Trust and these play an important role in a number of LCH clinical services. An underlying principal of the digital roadmap will assess whether these can be safely merged ideally onto TPP SystmOne to reduce the risks of having “silo’d “ clinical information and to reduce the costs associated with maintaining multiple systems.

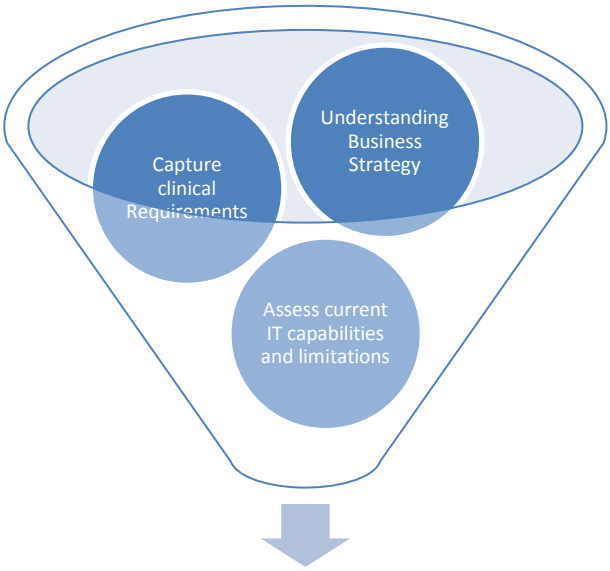
5.3.12Transition to a “digital primacy” environment will take place as a consequence of multiple projects and small incremental changes in working practices over the period to 2020, there will not be a “big bang” or the introduction of a sudden step change to business processes. However the recognised principals supporting transformational change will need to be adhered to:



The linking of Strategy, Governance and Change Management Processes will help to deliver the Digital Roadmap goals and objectives which in turn will see a future state where the digital record is the primary, legal clinical record containing the full history of assessments and care provided to an individual.

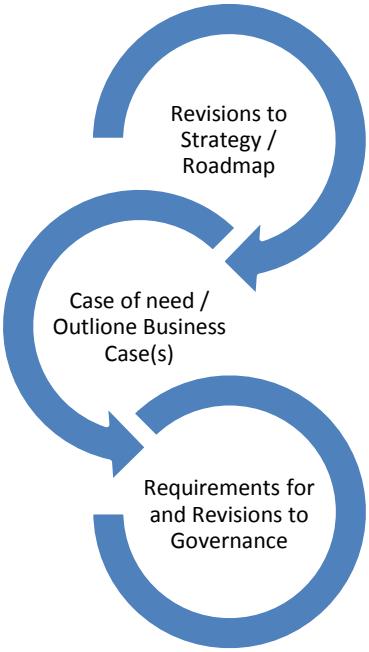
5.3.13 The proposed approach for ensuring that the future “digital” state is fit for purpose will rely on a series of core activities which seek to ensure that the future state delivers against clinical and business needs, whilst being grounded in the realities of the technical infrastructure and affordability. This will be achieved through a series of impact assessments which will drive the digital strategy forward, the governance requirements and business cases as a consequence of changes in the organisation and the environment in which it operates.

Actions



Impact Assessment

Leading to



6. Business Intelligence Objectives

6.1 The principal Business Intelligence goal of this Digital strategy is,

To support the objective of providing the best possible care in every Community by the deployment, development and maximisation of benefits from clinical and business systems and the information derived from them

It is recognised that the Business Intelligence objectives of the Trust must be consistent with and compliment the clinical and technology objectives. It is essential that the information requirements are underpinned by a technological architecture which enables systems, data and processes to run effectively providing timely, flexible and accurate reporting.

The remainder of this document will describe the actions necessary for the completion of the Digital Strategy.

DIGITAL OBJECTIVE 1 : READINESS

What will success look like?
Success, based on the national "view" would see the following components in place:

- The digital strategy is aligned so that it is integral to the success of the Trust.
- Leadership of the Digital Strategy is supported by a senior Chief Clinical Information Officer (CCIO)
- The qualitative and quantitative benefits attributed to the deployment of digital assets are fully explored in conjunction with our suppliers where necessary.
- Governance, Board led digital programmes supported by effective operational IT delivery, routinely evaluating the benefits of digital projects, adopting principles in best practice guidelines relating to digital services.
- Information Governance broadened to include the cyber security agenda with a strong emphasis on the identification, monitoring and review of new threats.
- The Board should receive an accurate picture that the Trust key information is properly managed and safe from cyber threats, this would include receiving assurance from suppliers that our digital assets are secure including penetration testing

Where are we now?
The digital maturity index score rated the Trust as "Ok", with a score of 47%

What do we need to do to succeed?
A number of actions would see the Trust improve on "Readiness"

Strategic Alignment
Implementation of the digital strategy is fully aligned to and supported by a service transformation programme. In the future provision of digital services, it is essential that the Organisational Development (OD) Team is fully embedded within the scope of the work and the change aspects (working practices, and procedures) are fully supported. In order to achieve this, the OD capacity for the Trust must be sufficient to meet the need.
There are effective processes in place to prioritize investment in digital technology and support ideas through to implementation. The capacity to deliver this requirement is largely in place through the Programme Management Function, but in order to better meet this requirement, the decision making processes used to prioritize investment to fund digital technologies should be more visible and be clearly linked to other Trust initiatives such as "integration" Health and Care services with the Local Authority.

Leadership
The Trust is expected to provide strong clinical leadership through a nominated Chief Clinical Information Officer (CCIO), Chief Nursing Information Officer or equivalent. The Trust has considered the introduction of this role but has thus far decided against doing so and the continued absence of this specific role will mark the Trust as an outlier from other NHS organisations. The role could be incorporated into an existing senior clinical position, however the Digital Maturity Index expects that the CCIO or equivalent has adequate protected time as part of their job to undertake the requirements of the role, so this approach is unlikely to be realistic. In order to successfully deliver this expectation it is strongly recommended that this specific post is created.

A simple requirement is to monitor emerging digital technologies, using horizon scanning techniques of the general IT and NHS landscape to keep the digital strategy up to date.

It is recommended that the Informatics Group feature a Horizon scanning agenda where salient items are escalated through to SMT

In order for the Board to own the digital strategy it is recommended that formal reports against the delivery of this strategy are provided which encompass key projects such as EPR as well as the broader digital initiatives, which detail the entire strategy.

Resourcing
The Trust has a good track record of investing in the infrastructure necessary for staff to achieve transformational change, however to fully achieve the potential rate of return on this investment, a more robust formalisation of benefits realisation (qualitative and quantitative) should be adopted in conjunction with IT suppliers where appropriate. It is recommended that the Trust should consider this a mandatory part of all digital projects with Project Boards receiving formal updates on benefits realised.

Governance
Board led digital programmes must be supported by effective operational IT delivery, routinely and formally evaluating the quantitative and qualitative benefits of digital projects.

Information Governance
The Information Governance function must develop and adapt to a new digital environment where cyber security becomes an indispensable feature with regular identification, monitoring and review of new risks to the Trust technical infrastructure and information residing within it.

The Board should expect to receive an accurate picture that the Trust key information is properly managed and is safe from cyber threats and it is recommended that such updates are included as part of a formal “Digital Strategy update report” for Board.
It is further recommended that the Trust receives assurance from all of our suppliers that our digital assets which they manage on our behalf are secure including the use of penetration testing.

How will we know we got there?
Success in the readiness domain will see strategic digital initiatives and projects being fully integrated into the Trusts, planning cycle, with key senior personnel, championing the needs of clinicians and being provided with the time and resource to make decisions on behalf of clinical services which will improve their use of Digital technologies. Further, the Board will be much better sighted on the benefits associated with the use of digital resources along with the risks which are associated with them.

Summary of Recommendations: Readiness

Ref	Recommendation	Proposed Action
1	Implementation of the digital strategy is fully aligned to and supported by a service transformation programme	Organisational Development function is fully integrated with the Digital Strategy Programme
2	There are effective processes in place to prioritize investment in digital	

	technology and support ideas through to implementation	
3	Provide strong clinical leadership through a nominated CCIO, Chief Nursing Information Officer or equivalent	Agree an appointment to fulfil this role
4	Monitor emerging digital technologies using regular horizon scanning	Incorporate as a standing agenda item into the IM&T Group. Escalate relevant issues to SMT
5	Ensure the Trust Board is fully sighted on the Digital Strategy agenda	Formal reports against the delivery of this strategy are provided to Board, to include updates around known or potential cyber-security threats
6	A requirement for all digital projects to report qualitative and quantitative benefits to their respective project board.	Benefits Realisation to become a mandated agenda item for all Project Boards.
7	A programme of penetration testing be developed to ensure the security of Trust information assets	To consider penetration testing be incorporated into the Internal Audit programme or sourced appropriately eg via the Cyber-Security Programme run by NHS Digital

DIGITAL OBJECTIVE 2 : CAPABILITIES

What will success look like?
Success would see all of the following capabilities in place:

- The routine use of digital assets to provide medicines management.
- Orders and Results of clinical tests provided digitally.
- Digital provision of records, assessments and care plans.
- Transfers of care between providers enabled digitally.
- Digital asset management and resource optimisation.
- Electronic decision support used in the routine provision of care.
- Options for the use of Remote and Assistive care using digital tools.
- Adoption of Standards

Where are we now?
The Digital Maturity Index score was 30% “some progress”

What do we need to do to succeed?
A number of actions would see the Trust improve on the “Capabilities” domain:

Medicines Management
LCH does not prescribe digitally at all and relies on manual and paper based processes.

The administration of medicines is not performed digitally and the Trust does not use any systems to automatically remind or prompt clinicians to check a patient has had their medicines administered.

The Trust does not use barcode technology to support the administration of medicines or to monitor adverse reactions.

Because of the nature of prescribing which takes place with many practitioners prescribing from a fairly narrow range of clinical items and the low point from which the Trust starts from, it is recommended that a scoping exercise is performed to identify in which services the adoption of digital medicines management would provide the most benefit. Only after there is clearer intelligence on the case for change, should there be consideration for strategic digital project which would aim to use modern software and technologies to reduce the risk of harm occurring as a result of prescribing or medication errors.

Orders and Results Management

The Trust is well placed to gain the benefits from ordering and receiving clinical test results from secondary care since the adoption of the LTHT e-results service which enables staff to order tests and receive the results back electronically. This has brought significant time savings to the overall process. Due the success of the existing programme of work, it is recommended that any further services which require access to results information adopt the LTHT “e-results” service as a default.

Records, Assessments and Care Plans
Due to the timing of the completion of the Digital Maturity Index Survey, none of the Neighbourhood Teams had gone live with their Electronic Patient Record (EPR), which once completed will see a far greater digitisation of records, assessments and care plans across the Trust. At this time, the EPR Project has delivered only to a limited number of Neighbourhood Teams, (Middleton and Morley, Kippax and Seacroft), by virtue of this progress, the score for this section of the digital maturity index would already be higher than it was and will rise further with the ongoing EPR deployment.

Continued support for the deployment and use of the Leeds Care Record which provides access to data held about patients consuming primary, secondary, community, mental health or social care in a simple to use application will also support staff to make more informed clinical decision making.

Electronic Transfers of Care
Digital transfer of care is a very weak area for the Trust. The Digital Maturity Index survey is not helpful as it seeks information about the percentage of patients whose referral is made digitally to outpatient and inpatient services using the national E-Referral Service which results in a very low score because the Trust does not use this service very extensively and they form a very small percentage of the overall number of referrals managed by the Trust., however the benefits of the E-Referral Service are well documented and therefore a recommendation is to ensure that the Trust continues to support the existing use of the e-Referral Service and where appropriate actively deploy to other services in order to facilitate a smoother and more reliable referral process and offering genuine choice for patients about when and where they receive their care. It is recognised that within the standard NHS contracts used by commissioners there is a clause which could see penalties introduced for a failure of organisations to offer an “e-Referral” route into their services in the future.

A common practice in primary and secondary care is the electronic transfer of record summaries, to support the onward provision of care. Whilst it is recognised the hand-off between Trust clinicians and GPs who use SystmOne can occur in a digital form, there are instances for example the transfer of children’s records when they leave Leeds which rely upon the copying of posting of paper records with all of the inherent risks that this brings. A recommendation is to explore using existing administrative staff, if it would be feasible to provide a summarising function within the Trust. Key actions would involve clinical coding training and the summarising the records themselves.

Remote and Assistive Care
In conjunction with the CCGs, the Trust is commencing a project ion 2016/17 to install videoconferencing facilities in each of the Neighbourhood Team bases to enable clinicians to take part in remote multidisciplinary meetings with GP and other primary care colleagues so they may discuss patient care with a range of colleagues. The basic equipment and training for Neighbourhood Staff is expected to commence in quarter 2, 2016/17 and continue throughout the year. Once in place this technology could act as a platform for other clinical or management services to use this technology.

The introduction of NHS Mail 2, currently scheduled for Quarter 3 2016/17 will offer further opportunities for “instant messaging” between practitioners both within and between LCH clinical services and also between LCH and other clinicians not based in the Trust.

Central to the successful introduction of remote and assistive care technologies will be the appropriate organisational development and change management activities to facilitate to a safe and orderly transfer to a new way of working, supported by technology.

Asset and Resource Optimisation
Weak areas here include: tracking patient flow digitally in real time does not take place, the location of clinical assets are not tracked digitally. Staff Rostering is not currently "digital" with a reliance on manual spreadsheets to build future rota's. The Trust has approved a business case for the introduction of a specialised e-rostering system which should ultimately bring a host of benefits including a better allocation of staff and increased visibility of potential shortfalls.

How will we know we got there?
Success here would see the embedded use of Electronic Patient Records which prompts users to take action such as medication prompts or alerts staff to contra-indications, based on the data recorded in the system. Using common (international) coding structures data can flow around the health and social care system supporting patient care across a multitude of settings. New referrals into LCH services will increasingly recevied via the e-referral service.

Summary of Recommendations: Capabilities

Ref	Recommendation	Proposed Action
8	Review the opportunities for the introduction e-prescribing	Scoping exercise is performed with Medicines Management team to identify in which services the adoption of digital medicines management would provide the most benefit. Only after there is clear intelligence on the case for change, should there be consideration for strategic project and business case
9	Increase the digitisation of Records Assessments and Care Plans	Continue with the deployment of EPR to the remainder of LCH services. Continue to support the introduction of the Leeds Care Record Commence a scoping exercise which will provide a proposal which will allow patients to access their own electronic patient record.
10	Electroninc Transfers of Care	Redevelop the business case for the adoption of E-Referrals for further LCH services
11	Remote and Assistive Care	Implementation of the CCG funded videoconferencing equipment to the 13 Neighbourhood team bases with associated training and business change support.

		Determine the opportunities of using instant messaging through the introduction of NHS Mail 2, to support support virtual consultations and provide immediate clinical advice
12	E-Rostering	Continue with the deployment of the E-Rostering System

DIGITAL OBJECTIVE 3: INFRASTRUCTURE

What will success look like?
Success in this domain would see clinicians accessing digital resources through a “single sign on” thus reducing the need for multiple passwords or PIN numbers to be remembered. It would see any appropriate devices which may be connected through a Local Area Network, WIFI, 3 or 4G being used, utilising a range of licenced software tools and having access to a support infrastructure which follows industry best practice.

All clinical systems would be underpinned by robust and annually tested business continuity plans.

From a patient perspective, when on Trust premises, they will be afforded free access to public WIFI.

Where are we now?
The Digital Maturity Index score was “OK – Good progress” with a score of 45%

In accordance with the previous IT strategy, the Trust has made significant improvements to the infrastructure which has resulted in:

Clinicians with access to secure WIFI in the majority of Trust buildings and options to work remotely via the Remote Access Solution.

Software is approved and recorded on a software asset register and is confirmed as appropriately licenced through third party verification.

The service desk prioritises incidents and business critical systems are supported by an IT infrastructure with multi-site redundancy so that normal operations are maintained in the event of an outage at a particular location.

The Trust has invested significantly in the provision of mobile devices with approximately 50% of clinical staff having access to such a device allowing increased flexibility in where they can work.

The activities in these areas should be maintained in order to continue to provide Benefit to staff and patients.
What do we need to do to succeed?

A number of infrastructure work-streams are required to enhance the organisation’s digital capability.

The implementation of a single sign on capability for all staff to enable reliable access to Trust systems and reduce the burden upon staff to remember multiple logon credentials. The introduction of this feature would bring a number of benefits including a reduction in risk of staff being locked out of systems which hold essential details of care provided and risk which can only increase with a reduction in the reliance on paper based records. The provision of this facility would also ease the burden upon the IT support staff where approximately 60%-70% of all calls made relate to access to resources in one form or another.

The provision free WIFI to the public has become mandated by NHS England although no formal deadline has been set in the community sector. It is recommended that a scoping exercise is undertaken to identify if or how the investment which has already been made to provide WIFI to staff can be leveraged for the benefit of patients.

Whilst the Trust has a process for ensuring business continuity plans are held by services, the current testing regime should be reviewed or amended to take into consideration the ever greater reliance upon digital assets.

How will we know we got there?
Success in the Infrastructure domain will be evident by a sustainable infrastructure which is competently managed, where staff can access the resources and the support they need in order to deliver patient care at a time and location which is convenient to them.

Further success criteria will be the availability of free public WIFI in all of the building which LCH delivers services from and forms part of the Trusts estate.

Summary of Recommendations: Infrastructure

Ref	Recommendation	Proposed Action
13	Provide a single sign on capability for all staff	Under the IM&T Group authorise a project to scope the delivery of a single sign on capability to all Trust systems, with the deliverable in the first instance being a business case so a formal decision can be made.
14	Undertake a scoping exercise which will lead to a business case for the provision of free WIFI	Under the IM&T Group authorise a project to scope the delivery of public access to WIFI, with the deliverable in the first instance being a business case so a formal decision can be made.
15	Ensure there is a robust testing regime for all business continuity plans at service level to ensure the progression towards a reliance on digital systems is recognised.	Engage with the Trust Emergency Planning Officer to request annual scrutiny of service Business Continuity plans to ensure the increased reliance upon digital assets is acknowledged and appropriate mitigations in place.

DIGITAL OBJECTIVE 4: BUSINESS INTELLIGENCE

What will success look like?

Success in this domain will see managers of all grades, information and business analysts, and clinicians having electronic access to dynamic business intelligence which is designed to support the best possible decision making.
Where are we now?
The Trust relies upon the provision of static Excel based spread sheet reports on a monthly cycle to support the main decision making bodies within the Trust, however a business case has been approved which provides the necessary manpower, software and on-going support to enable the vision for desktop access to intelligence to be realised.

What do we need to do to succeed?
In order to succeed, the Business Intelligence function must recruit additional capacity into the existing team to supplement the compliment of information and business analysts. Underpinning this, the team will then require the development "space" in order to design, create and establish the new reporting methods, tools and processes which will reside in the "Performance Information Portal". Multiple and conflicting demands on the Business Intelligence team is a real risk to delivery.

A programme of education will be necessary for recipients of the Business Intelligence, and support will be needed to help where required to build this new knowledge into routine decision making. Again the development "space" within the service will play an important part in the ultimate success of Business Intelligence.

Attached to the need to develop the capabilities of operational managers, another aspect which will play an important role is the education of clinicians and the role that they play in capturing not only clinical information but how this feeds into the business reporting process in the Trust. A further important aspect is the role of the clinical advisor, who will educate within services where necessary.

How will we know we got there?
Success will see the elimination of paper based or static reports. Staff will be able to access "intelligence" wherever and whenever they choose with the ability to make local selections by adding parameters to reports which make them specifically useful. Business Intelligence aims to become the centre of decision making for the Trust.

Summary of Recommendations: Business Intelligence

Ref	Recommendation	Proposed Action
16	Support the implementation of the Business Case to recruit the required staff, provide the necessary software to deliver the Performance Information Portal	In place
17	Recognise the need for development space for the team	Protect from competing demands for the BI resource
18	Recognise the education programme necessary to	Support future business cases for BI education tools

	complement BI developments	
19	Senior Management Team to lead by example and utilise the Performance Information Portal	Develop early suite of reports which meet the requirements of the Senior Management Team.

7. Risks

Each of the risks associated with this strategy has been assessed using the risk assessment matrix from the Trust Risk Management Strategy. The risks are divided into Organisational Risks, i.e. those that could jeopardise the overall strategy's delivery and Departmental Risks which individually would not cause outright failure but combined have the potential to seriously affected deliverability.

7.1 Organisational Risks

Organisational level risks relate to those which if not mitigated would individually undermine the deliverability of the Digital Strategy.

7.1.1 Insufficient Resources to Achieve Strategic Digital Objectives

Risk Assessment pre-mitigation

Likelihood	4	Impact	3	Total	12

To date this risk has been mitigated by the use of non-recurrent resources to support individual projects. The continuation for the need for resources must be picked up through the business planning process. As the financial landscape becomes more difficult, the Trust must become ever more adept at leveraging national monies to support high priority / politically important areas such as public access to WIFI or where CCGs may have non recurrent monies available to for example support further investment in mobile technologies.

Risk Assessment post-mitigation

Likelihood	3	Impact	3	Total	9

7.1.2 Conflicting Organisational Priorities

Risk Assessment pre-mitigation

Likelihood	4	Impact	3	Total	12

A number of conflicting priorities are likely to present themselves within the life of this strategy including preparing for a CQC inspection expected in 2016, the continued integration agenda with Adult Social Care and the development of the Neighbourhood teams. Being focussed on the key deliverables and shielding key personnel where possible from being diverted into other priorities will be an important mitigation tactic.

Risk Assessment post-mitigation

Likelihood	3	Impact	3	Total	9

7.1.3 Departmental Risks

There are a number of risks which exist at a departmental level, which individually would not lead to outright failure in the delivery of the Digital Strategy, but when combined could adversely impact its effectiveness.

The risk indicated below was initially rated with a combined likelihood and impact rating of at least 12 and would directly affect the organisations ability to meet its reporting obligations if no mitigating actions were taken.

Risk Description	**Likelihood x Impact =**	**Mitigation**
Failure to meet the Information schedules within the Community Contract introduces a financial risk to contract income.	3 x 4 = **12**	• Development of the LCH Data Warehouse • Active partners in national developments work for improved reporting and data
Loss of key Informatics Staff resulting in insufficient knowledge or capacity to deliver the strategy	4 x 3 = 12	• offer personal and professional development opportunities for Informatics staff

8. Resources

8.1 There are a number of areas within the strategy that will be delivered as part of the "business as usual" and these do not require specific investment to achieve delivery.

However, the estimated costs associated with the delivery of those parts of the strategy which require specific investment are presented in appendix one.

As part of the national development of Digital Capabilities, there is expected to be an announcement on the availabilities of national monies and guidance on how they may be accessed. Utilising national monies should be considered the preferred option for LCH in funding the Digital Strategy.

9. Next Steps

The adoption of this strategy needs the commitment of organisation before it is formally ratified by the Trust Board

10. Evaluation and Review

10.1 This strategy will be reviewed and evaluated by the Executive Director of Finance and Resources and Head of Informatics and Performance within 12 months from approval by the Trust Board.

11. Equality Impact

11.1 The Information Management Strategy is wide-ranging, encompassing all strands of informatics including use of information, IT infrastructure and systems (both clinical and business related) and information governance. In implementation of any new process or system it is very likely that there will be an impact on groups or individuals, this will vary from initiative to initiative. Therefore, it is recognised as critical to conduct Equality Analysis for each initiative within this strategy as part of the detailed planning processes to ensure that any potential or real negative impact is identified and appropriate action included within the initiative to address the issue.

Appendix One:Definitions

A number of key concepts relevant to the interpretation of this document are provided below:

CCG – Clinical Commissioning Group

CCIO – Chief Clinical Information Officer

CSU - Commissioning Support Unit, historic organisation from which LCH received support for the IT Infrastructure

Dataset – a collection of data.

Data Warehouse – An electronic data storage facility

Digital - innovative electronic technologies and information services to benefit patients, clinicians and the public

Digital Maturity Assessment - The Digital Maturity Assessment measures the extent to which healthcare services in England are supported by the effective use of digital technology

EPR – Electronic Patient Record

Informatics – a discipline which aligns information communication technologies alongside clinical / medical / demographic information.

ICT - Information Communication Technology (ICT) - an umbrella term that includes any communication device or application, encompassing: radio, television, cellular phones, computer and network hardware and software, satellite systems and so on, as well as the various services and applications which run upon them.

Information Management – the collection, organising, processing and reporting of information from one or more sources

Leeds Care Record – a read only view of key information gathered from Leeds secondary, primary and mental health provider clinical systems (currently) and hosted by the Leeds Teaching Hospitals

WIFI – Provides wireless connectivity to a network. WIFI can be public (insecure) or private (secure)

Appendix Two: Resource Requirements

Requirement	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	Comment
Chief Clinical Information Officer	5	20	20	20	
Penetration Testing	5	5	5	5	
Electronic Transfers of Care	10	20	20	20	
Single sign-on	0	41	6	6	
Public WIFI	0	0	7.5		
Increase the digitisation of Records Assessments and Care Plans					See EPR Business Case
E-Rostering					See E-Rostering Business Case
Performance Information Portal	78.5	56	56	56	
Grand Total					

Appendix Three – Implementation Plan

Ref	Recommendation	Proposed Action	Timescale	£000's PA	Comment
1	Implementation of the digital strategy is fully aligned to and supported by a service transformation programme	Organisational Development function is fully integrated with the Digital Strategy Programme	From 31/03/17	-	The requirements of the digital strategy are properly integrated into the OD work plan for the Trust
2	There are effective processes in place to prioritize investment in digital technology and support ideas through to implementation	PMO function ensures that the decision making processes used to prioritise investments is transparent projects are fully resourced to ensure delivery.	From 31/12/16	-	
3	Provide strong clinical leadership through a nominated CCIO, Chief Nursing Information Officer or equivalent	Consider the appointment of a part time post to fulfil this role	From 31/12/16	£20k	To explore if the role can be incorporated into GP advisor role currently in existence
4	Monitor emerging digital technologies using regular horizon scanning	Incorporate as a standing agenda item into the IM&T Group	From 30/09/16	-	Head of IT and Assistant Director of Business Intelligence to use on line resources and professional networks to enable horizon scanning
5	Ensure the Trust Board is fully sighted on the Digital Strategy agenda	Formal reports against the delivery of this strategy are provided to Board, to include updates around known or potential cyber-security threats	From	-	Provision of regular 6 monthly, formal reporting to Board, providing an update on the key elements of the digital strategy, with the provision for exception reporting where required.

6	A requirement for all digital projects to report qualitative and quantitative benefits to their respective project board.	Benefits Realisation to become a mandated agenda item for all Project Boards.	From 30/06/16	-	To ensure these are built in to the terms of reference for all
7	A programme of penetration testing be developed to ensure the security of Trust information assets	To consider penetration testing be incorporated into the annual Internal Audit programme or engage external supplier.	From 30/06/16	£5k PA	To build on the initial tests which were recommended as part of the internal Cyber Security Report – December 2015 with a specified element of the technical architecture to tested each year.
8	Review the opportunities for the introduction e-prescribing	Scoping exercise is performed with Medicines Management team to identify in which services the adoption of digital medicines management would provide the most benefit. Only after there is clear intelligence on the case for change, should there be consideration for strategic project and business case	From 01/04/17	-	Establisment of a team to scope the opportunties attributable to the use of e-prescribing. The outcome of this may result in a series of further implementation projects with associated business cases.
9	Increase the digitisation of Records Assessments and Care Plans	Continue with the deployment of EPR to the remainder of LCH services. Continue to support the introduction of the Leeds Care Record	In progress	See EPR Bus Case	

		Commence a scoping exercise which will provide a proposal which will allow patients to access their own electronic patient record.			
10	Electroninc Transfers of Care	Redevelop the business case for the adoption of E-Referrals for further LCH services	From 31/12/16	£20k PA (0.5 WTE B5)	Future deplyments of e-Referral to be incorporated into the EPR project. Requirement for e-Referral Support to be built into current BI and Systems workforce
11	E-Rostering	Continue with the deployment of the E-Rostering System	In progress	See E-Rostering Bus Case	
12	Remote and Assisitive Care	Implementation of the CCG funded videoconferencing equipment to the 13 Neighbourhood team bases with associated training and business change support. Determine the opportunities of using instant messaging through the introduction of NHS Mail 2, to support support virtual consultations and provide immediate clinical advice	In progress From 30/09/16	£0 – funded by CCG £0 – a core component of NHS Mail2	In order to be successful a programme of organisational development is necessary to support a transition to new ways of working.
13	Provide a single sign on capability for all staff	Under the IM&T Group authorise a project to scope the delivery of a single sign on capability to all Trust	From 01/04/17	£35k est.(one off cost)	

		systems, with the deliverable in the first instance being a business case so a formal decision can be made.		£6k PA thereafter	
14	Undertake a scoping exercise which will lead to a business case for the provision of free WIFI	Under the IM&T Group authorise a project to scope the delivery of public access to WIFI, with the deliverable in the first instance being a business case so a formal decision can be made.	From 01/04/18	£7.5k (one off cost)	Technical scoping survey to recommend how the existing private WIFI capability may be adapted to provide public access without compromising confidentiality. The resulting output will lead to a further business case for change.
15	Ensure there is a robust testing regime for all business continuity plans at service level to ensure the progression towards a reliance on digital systems is recognised.	Engage with the Trust Emergency Planning Officer to request annual scrutiny of service Business Continuity plans to ensure the increased reliance upon digital assets is acknowledged and appropriate mitigations in place.	From 31/12/16	-	Regular business continuity plans and the testing thereof should be in situ now although it is known further improvements can be made.
16	Support the implementation of the Business Case to recruit the required staff, provide the necessary software to deliver the Performance Information Portal	After approval of the business case in April 2016, the recruitment of staff is in process and the procurement of software and associated support	From 30/06/16	-	In process and will move increasingly into business as usual in 2016/17.

17	Recognise the need for development space for the BI team	Protect from competing demands for the BI resource from within the Trust.	From 30/06/16	-	
18	Recognise the education programme necessary to complement BI developments	Support future business cases for BI education tools	From 30/06/16	-	
19	Senior Management Team to lead by example and utilise the Performance Information Portal	Develop early suite of reports which meet the requirements of the Senior Management Team.	From	-	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (30)

Meeting: Trust Board 4 August 2017	**Category of paper**	
Report title: Research and Development Strategy implementation	**For approval**	
Responsible director: Executive Medical Director **Report author:** Research Manager	**For assurance**	√
Previously considered by: Quality Committee 26 June 2017	**For information**	

Purpose of the report:

This paper provides assurance and update on the research and development strategy 2015-2018 implementation plan.

The strategic aims of the research and development strategy are:

- Embed research and development into the culture of the organisation
- Excellence in the delivery of research
- Increase research capacity and capability
- Increase the amount of funding into the organisation to enable investment and grow additional return
- Develop and strengthen links to the National Institute of Health Research (NIHR) and Department of Health infrastructure, and other research organisations and to support synergy
- Dissemination of research

This paper provides reasonable assurance that the research team are working towards meeting the milestones as set out in the revised research and development strategy work plan.

Main issues for consideration:

- The Trust was successful in exceeding its target accrual number for 2016/17 by 258%, recruiting 716 to portfolio studies. The Trust's accrual target for 2017/18 is 720
- There has been a reduction in the core funding allocation to support research which will make the new target challenging to achieve
- Over the past six months steady progress has been made in most areas and plans are ongoing to address this challenging accrual target and outstanding issues within the strategy.

Recommendations:

The Board is requested to:

- Receive reasonable assurance on the progress of research within the Trust
- Accept the strategy implementation report Nov 2016 to June 2017

1.0 PURPOSE OF THIS REPORT

1.1 This paper reports on the progress of the Research and Development Strategy 2015-2018 implementation plan from Nov 2016 to June 2017

2.0 BACKGROUND

2.1 The strategic aims of the Research and Development strategy are to:

- Embed research and development into the culture of the organisation
- Excellence in the delivery of research
- Increase research capacity and capability
- Increase the amount of funding into the organisation to enable investment and grow additional return
- Develop and strengthen links to the National Institute of Health Research (NIHR) and Department of Health infrastructure, and other research organisations and to support synergy
- Dissemination of research

3 CURRENT POSITION

The strategy was ratified by the Trust board on 3 July 2015. After an initial year of significant change both locally and nationally, which slowed initial implementation, progress has started to gather momentum.

Progress against the specific strategic aims is as follows:

3.1 Embed research and development into the culture of the organisation

The corporate team attended the medical conference during November and have plans to continue to visit other LCH organised conferences during the year.

Corporate R&D staff have spent larger proportions of their time supporting the in service (on site) set-up of studies over recent months, which has enabled more day to day contact with service staff.

The team continue to attend and contribute to the Innovation and Research council, which is proving a valuable forum for making links and facilitating work with service improvement colleagues, library staff, innovation champions, Medipex, and academics in local Higher Education Institutions (HEIs).

Recruiting to the Yorkshire Health Study (YHS) has continued throughout the Trust, this time with a focus on patients in clinic and in patient settings. This has given the research team the opportunity to raise the profile of research activity and discuss the subject of participation in research in general with staff working in those areas.

3.2 Excellence in the delivery of research

The Trust's Clinical Research Network (CRN) portfolio accruals for the year 2016/17 year were 716 which well exceeded our stated target for the CRN for the year of 200. It compares very favourably with our previous full year totals (2015/16 were 490 and 2014/15 were 504). As previously reported, the main factor behind the increased accruals was the Trust's participation in the Yorkshire Health Study.

This year the Trust's CRN accrual target is 720. This will be challenging in view of the fact that we have reduced core funding and it is marginally higher than we achieved this year. Current accruals to CRN portfolio studies for April and May 2017 are 117. Whilst a challenging target, it is hoped that active recruitment to the Yorkshire Health Study (YHS) amongst patient groups will help achieve this target. It is worth noting that by recruiting high numbers to YHS, a cohort study, we will reduce our study complexity mix.

Quarterly submissions of the Performance in Delivery and Initiating of Clinical Research (PID and PII reports) continue on a quarterly basis.

Work to transfer information to the EDGE database system which pertains to current studies has been completed and the corporate team are now using "EDGE" for their day to day work. This has required a significant amount of additional effort and learning. Development work is still required to ensure that the EDGE system is sufficiently configured to deliver all our reporting requirements. Also work is required to ensure that EDGE is utilised more widely across research active teams.

3.3 Increase research capacity and capability

Meetings have taken place with HEI providers in both local universities and we anticipate facilitating better linkage with them with regards to Trust priorities as well as our expectations for Trust staff undertaking research projects as part of postgraduate study in the future.

Support continues for Trust staff making NIHR applications. Trust employed Physiotherapist (Dr Christine Comer) submitted an application for an NIHR Clinical Lectureship award in April, which, if successful will help to improve the care of people with Spinal Stenosis. The Trust's YOI care team is named as participant in a recent NIHR RfPB application about effective ADHD diagnosis. Our Research Facilitator has an application pending for a place on the NIHR CRN's leadership course.

3.4 Increase the amount of funding into the organisation to enable investment and grow additional return

As previously reported, our research related income last year (2016/17) primarily mainly comprised the annual core CRN allocation (£195K) and the NIHR Research Capability Funding (RCF).(£36K). This year both the core

allocation and the RCF have decreased. The 2017/18 CRN core allocation is £182K whilst the RCF is £31K.

We should have been able to increase our CRN core allocation through demonstrable increased activity measured in the form of study accruals to CRN portfolio studies. Unfortunately however, external issues have resulted in a decrease in central funding of our local CRN. This meant that increased accruals over 2016/17 did not result in an increase in core funding this year and all CRN partner organisations received a decrease in funding this year despite overall increased accruals.

A contingency bid to the CRN for funds to support additional specific portfolio studies was unsuccessful, however the CRN were willing to allocate a member of their staff to the Trust to provide additional research support. Discussions are underway to agree how this deployment might be best utilised.

RCF funding of £31K was awarded based upon our Trust's participation in NIHR funded research for a prison study over previous years. In order to increase RCF funding in the future, our Trust needs to be an active participant/fund holder in future NIHR research. We are not currently fund holding for any NIHR studies however discussion is ongoing with the University of Leeds to identify/ support pilot studies which are both of specific interest to Trust priorities and that should lead to future NIHR RfPB bids.

Medipex have continued to support the Trust in the assessment and exploitation of Intellectual Property issues. New projects with potential IP support requirements have not come to light in the past 6 months, however the Trust's Quality improvement team have been proactive in establishing a programme of innovation workshops to run through the year. The establishment of the Innovation and Research hub on Elsie should also contribute to guidance for Trust staff requiring support to develop new ideas.

Meetings with the Trust finance team take place on a very regular basis and meetings with staff in research active clinical teams are planned to review activity.

3.5 Develop and strengthen links to the NIHR and Department of Health infrastructure, and other research organisations to support synergy.

The Research Manager has continued to attend external meetings to foster collaborative relationships. In addition to regular meetings with LCH colleagues, external NHS and CRN staff, she has had meetings with University employed staff involved in differing research collaborations.

Of particular interest was the inaugural meeting of Research Leads from England's Community Health Trusts. Plans are ongoing to explore how the Research departments of Community Trusts can better support each other,

share information, ways of working, and collaborate on developing and supporting future studies. Information shared informally at the meeting revealed that LCH was the second most research active Community Trust in terms of participation in number of portfolio studies. LCH's accruals for 2016/17 as well as our target for 2017/18 were also much higher than other community trusts.

The Corporate Research team now provide the Clinical Effectiveness group with bi-monthly reports about current Trust Research activity. This information, split down into business units, is accessible via the "What's happening now" link of the Research and Development page on Elsie.

3.6 Dissemination of research

The Elsie based Innovation and Research Hub is now live, following development under the auspices of the Innovation and Research council. This hub has a number of links including:

- Research and Development page which now includes a dissemination board listing links to recent output from completed studies (eg posters, dissertations and study reports) and end of study reports.
- Library services, which provides links to publications from LCH staff members.

4 IMPACT

4.1 Quality

4.1.1 Actively participating in research, especially nationally recognised studies that have CRN "portfolio" status facilitates the Trust to offer higher quality care as well as try out new, potentially better treatments. In addition to the benefits for patients, the benefits for staff includes increased learning/personal development opportunities, and for the Trust as a whole, the potential to test and explore alternative treatments and approaches to delivering care.

4.2 Resources

4.2.1 As previously reported, the Research team is currently almost wholly funded by external sources; predominately the NIHR via the CRN allocation and the Research Capability Funding (RCF) allocation. Risks to these funding streams continue as reported previously and are outlined again below. There continues to be an ongoing risk that posts may be lost in the future.

As outlined in previous reports, the loss of research activity in the prison healthcare sector specifically in terms of NIHR grant activity will have a significant impact upon the structural resource/finance made available to the

Trust by the NIHR – particularly with regards to the RCF allocation in the future.

It is hoped that the significantly improved study accrual numbers achieved over 2016/17 will help to support a case for maintenance of our level core allocation funding from the CRN in future years, as well as provide the minimum accrual figure level (500 per year) required to qualify for minimum baseline RCF funding (£20K per annum).

4.3 Risk

4.3.2 Risk to funding for posts to deliver the strategy as outlined above in 4.2.

4.4 Legal/Regulatory

4.4.1 The Research Strategy supports the delivery of statutory requirements as an organisation for research governance and management.

5 NEXT STEPS

Over the next 6 months it will be important to;

- Link closely with the Clinical Research Network (CRN) and ascertain as far as possible any issues that might affect the levels of future funding allocation likely in 2018/19.
- Identify more portfolio studies that the Trust is has the capacity and capability to participate in – especially in areas of work that the Trust has prioritised. In particular identifying the best ways to support capacity to participate in studies within service teams.
- Continue to build links between the corporate research team and the clinical teams and their service managers, utilising any support provided by local CRN staff.
- Consolidate and develop the work undertaken with regards to the EDGE database in order to gain better overall intelligence about research activity across the Trust. In particular rolling out the use of Edge to service based active research staff
- Support the work of developing research that might form the basis for future RfPB and other NIHR bids
- Progress work to establish Patient Research Ambassadors within the Trust

6 RECOMMENDATIONS

6.1 The Board is recommended to:

- Receive reasonable assurance on the progress of Research and delivery within the Trust.
- Accept the Research and Development Strategy implementation report (period Nov 2016 – June 2017)

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (31)

Meeting Trust Board 4 August 2017	**Category of paper**	
Report title Leeds Health and Social Care Academy update	**For approval**	
Responsible director Chief Executive **Report author** Director of Workforce	**For assurance**	
Previously considered by n/a	**For information**	√

Purpose of the report

This report sets out the progress which has been made across the city of Leeds in developing the concept of a Health and Social Care Academy, and decisions made.

Main issues for consideration

In June 2017 the full Local Academic Health Partnership Board (LAHP) Board agreed to progress to the next stage of developing a city-wide academy to support learning and development for all NHS and social care staff together. The host organisation in the initial stage will be Leeds Teaching Hospitals NHS Trust (LTHT), and a transition team is being established. The next step thereafter will be the establishment of a project board, of which the Trust will be a member.

Recommendation

The Board is recommended to:

- Note the contents of the report

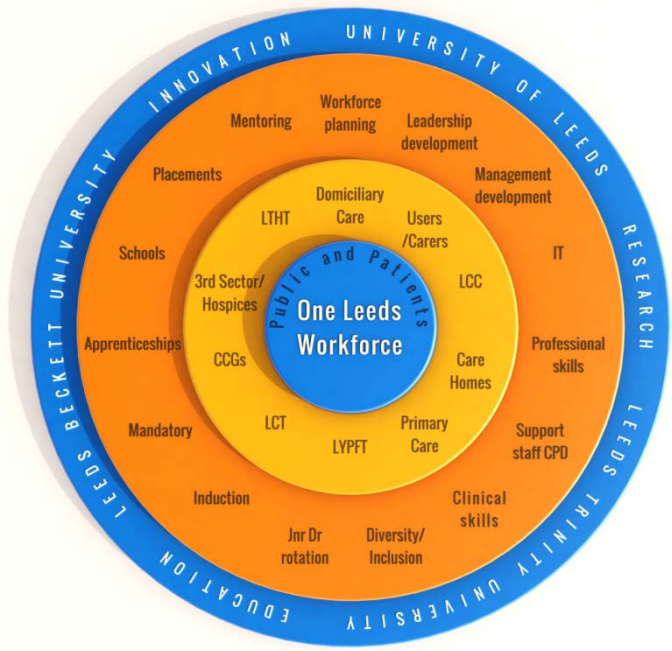
Leeds Health and Social Care Academy update

1.0 Purpose of this report

1.1 This report gives an update to the Board on the progress being made with the development of a Health and Social Care Academy of Leeds, bringing together all those involved in the coordination and delivery of the training, education and development of Health and Social care staff in Leeds under one arrangement. This has been regularly reported to the board as part of the Chief Executive's report, and an interim notification of the steps was issued to board members by email on 30 June 2017.

2.0 Background

2.1 The vision for the academy has been developing and is set out visually below



3.0 LAHP Board decisions

3.1 A number of options as to how this could be developed had been worked up using an independent consultancy, and at its meeting in June 2017, the Local Academic Health Partnership (LAHP) Board, on which Thea Stein sits as Chief Executive, agreed the following recommendations which are derived from their report.

3.1.1 that the project should proceed to the next stage (planning and implementation).

3.1.2 when it becomes operational, the Academy will, at least initially, be “hosted” by partner organisations rather than created as a stand-alone legal entity, and this host was subsequently agreed as Leeds Teaching Hospitals NHS Trust (LTHT)

3.1.3 the transition team which will be responsible for the planning and implementation phase, will be funded from a combination of investment by partners according to a fair shares model, with some use of the LAHP seed fund to cover non-staff transition costs

3.1.4 the planning and implementation stage and the operational stage of the Academy should be governed according to the recommendations of the main report

3.1.5 that, for reasons of continuity, Dean Royles should remain the senior responsible owner for the planning and implementation stage

3.1.6 the transition team should be appointed by the LTHT as an immediate action, and the planning and implementation stage should proceed at pace according to the roadmap which accompanied the main report

3.1.7 each individual LAHP Partner organisations affected directly will now begin the process of securing formal agreement to the creation of the Academy from their individual Partner boards or governing bodies. This process will be supported by the transition team as a priority activity.

4.0 Project timescales

The timeline in which it is expected this will advance is for the Transition team to start early in September 2017, and thereafter the Leeds Academy Project Board to be established. The project plan timeline is attached at appendix 1 showing a 'Go live' date of April 2018.

5.0 Impact

5.1 Quality

The creation of the Academy will provide a more consistent approach to statutory and mandatory training, as well as benefits from shared learning and development.

5.2 Resources

The transition team will be funded by contributions from organisations on a levy basis (or partly in kind by seconding staff).The amount has been determined by relative training budgets within partner organisations and as such LCH will be liable for £32k of transition cost which will likely span 12 months between 2017/18 and 2018/19 periods. Provision for this has been made within LCH accounts.

5.3 Risk and assurance

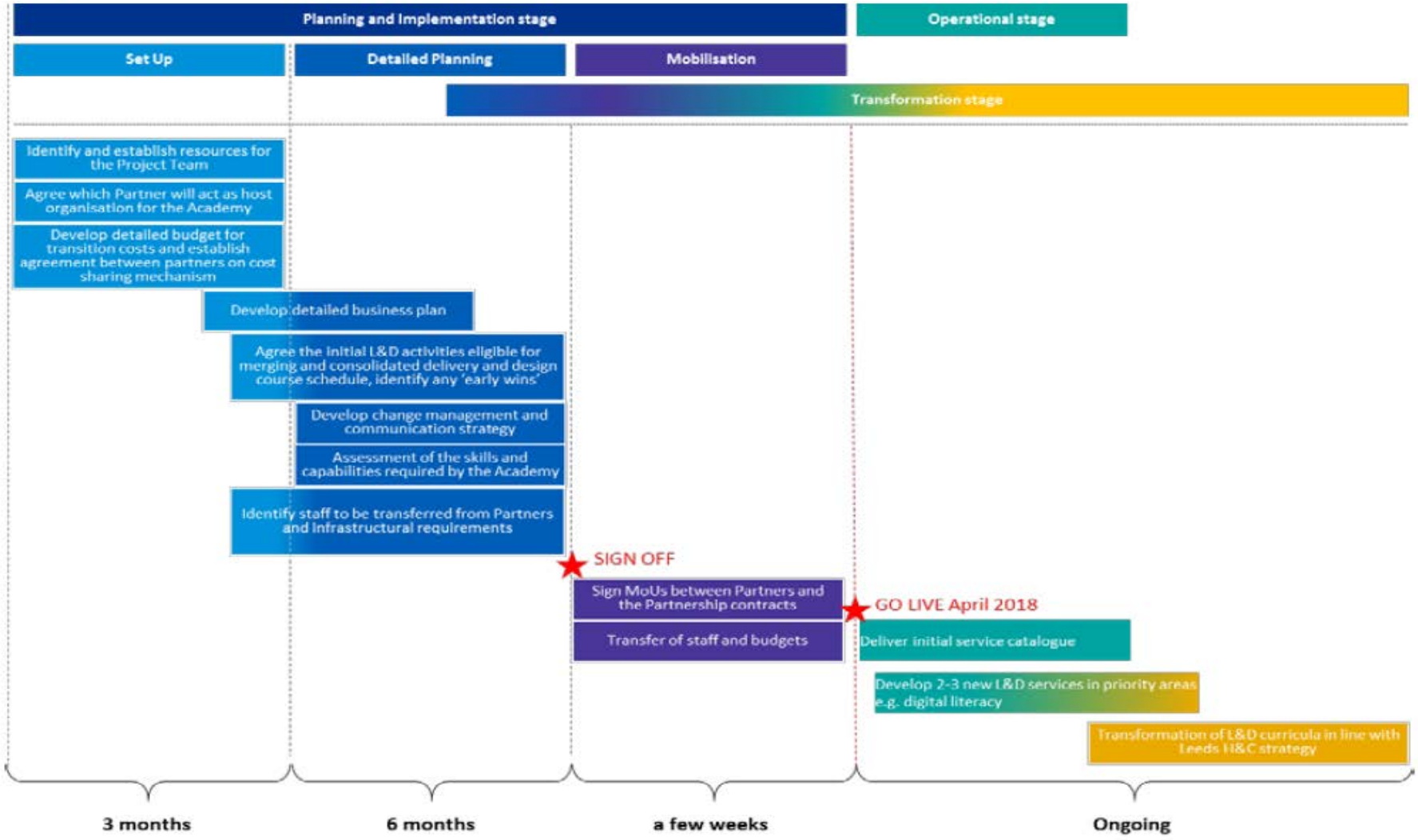
There is risk uncertainty for staff currently employed within LCH, whose roles may transfer into the Academy. This will be managed by our HR support processes.

6.0 Recommendations

6.1 The Board is recommended to:

- note the contents of this report.
- note that arising from commitments to the partnership approach, the Trust will be represented on the Academy Project Board once established

Leeds Health and Social Care Academy: project timeline



Leeds Community Healthcare NHS Trust

AGENDA ITEM 2016-17 (32)

Meeting Trust Board 4 August 2017	**Category of paper**	
Report title Executive Medical Director's Annual Report	**For approval**	✓
Responsible director Executive Medical Director **Report author** Executive Medical Director	**For assurance**	
Previously considered by: Quality Committee 26 June 2017	**For information**	

Purpose of the report

An annual Executive Medical Director's report is a requirement for the revalidation of doctors (and dentists in the future) to provide assurance of the appraisal process to the Trust Board.

Main issues for consideration

This Executive Medical Director's report covers the period of 1 April 2016 to 31 March 2017 and includes information and activity relating to medical and dental staffing appraisal and medical revalidation.

NHS England has provided guidance: 'Framework of Quality Assurance for Responsible Officers and Revalidation, June 2015' with a Board template to be completed and a Statement of Compliance from the Board. This report follows the guidance and the 2015 template format.

The report was approved for submission to the Board by the Quality Committee on 26 June 2017.

Recommendations

The Board is recommended to:

- Approve the 2016/17 annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the sign off of the statement of compliance

Executive Medical Director's Annual Report

1 Executive summary

An annual Medical Director's report is a requirement for Revalidation of doctors (and dentists in the future) to provide assurance of the appraisal process to the Trust Board. This report covers the period of 01/04/16 - 31/03/17 and includes the Annual Organisational Audit (AOA) submitted to NHS England on 25/05/2017 (**separate attachment**). Revalidation – North, NHS England acknowledged the LCH AOA and responded with '*In accordance with the Framework of Quality Assurance (FQA) and in acknowledgement of Higher Level Responsible Officer Quality Review (HLROQR) process we can confirm that we have concluded a screening review of your designated body. As we found everything to be satisfactory there is no action to be taken by us*'.

Designated Bodies are required to submit a 'Statement of Compliance' to be signed by the Chief Executive or Chairman of the Board (**Appendix C)**.

The numbers of doctors with whom the designated body has a prescribed connection at 31 March 2017 who had a completed appraisal between 01/04/2016 and 31/03/2017 was **42/42** (**100%**). This was an improvement of the 2015/16 figure of **97.7%.**

The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2016 – 2017 was **65/66** (**98.5%**). This was an improvement of the 2015/16 figure of **97.2%**.

The number of Police Custody self-employed doctors who confirmed that they had been appraised by 31/03/17 was **18/18 (100%)**.

The total number of doctors who were revalidated in this time period was **2**.

2 Purpose of this report

The purpose of this report is to provide assurance to LCH Board that LCH as a designated body has effective systems in place which comply with the requirements of the Responsible Officer regulations.

2.1 General

Medical appraisal has been a requirement for consultants since 2001, for General Practitioners (GPs) since 2002 and for salaried dentists since 2008.

2.2 Responsible Officer Regulations

The Medical Profession (Responsible Officers) regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) regulations 2013 require each body designated under the regulation to appoint a Responsible Officer who must monitor and evaluate the fitness to practise of doctors.

2.3 Revalidation

Revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. The cornerstone of the revalidation process is that doctors will participate in annual medical appraisal. On the basis of this and other information available to the Responsible Officer from local clinical governance systems, the Responsible Officer will make a recommendation to the GMC, normally every five years, about the doctor's revalidation. The GMC will consider the Responsible Officer's recommendation and decide whether to renew the doctor's licence to practise.

2.4 Medical appraisal

Medical appraisal is the appraisal of a doctor by a trained appraiser, informed by supporting information defined by the GMC, in which the doctor demonstrates that they are practising in accordance with the GMC *Good Medical Practice Framework for appraisal and revalidation* across the whole of their scope of practice.

2.5 Dental Appraisal and Revalidation

Dental appraisal has been a requirement for salaried dentists since 2008. There is currently no revalidation process for salaried dentists; however, salaried dentists employed by LCH are required to have an annual appraisal that meets the required standards set by the BDA and NHS Employers, 2008.

3 Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

4 Governance Arrangements

The RO is supported by an Associate Medical Director for Appraisals and Job Planning, a part time RO manager and during 2016/17 a part time RO administrator. The Trust has implemented the PReP system for medical appraisal for doctors with a prescribed connection and has a robust system for assurance of annual appraisal for non-designated body doctors and salaried dentists.

The RO manager and administrator link with ESR on a monthly basis to maintain an accurate list of medical and dental employees, locums and trainees. Each Associate Medical Director/ Medical Lead has a responsibility of notifying the RO team for new medical and dental staff starters and leavers.

The RO and RO manager regularly check GMC connect for an accurate list of designated body doctors and those who are under notice for revalidation or on hold pending GMC investigations. The RO has the responsibility for making timely revalidation recommendations to the GMC.

The RO provides quarterly returns with regard to appraisal activity to NHS England. In July 2015 NHS England reviewed its processes in the north region and decided that for certain designated bodies assurance could be provided on a quarterly basis by email that satisfactory achievement of appraisal rates was being achieved and the organisation was on track to achieve their trajectory, provided that they had met certain criteria to include:

1. The DB has achieved > 90% appraisal uptake in the previous year as stated in the 2015/16 AOA
2. The DB has confirmed in question 2.2 that all missed or incomplete appraisals were managed by the programme
3. The DB engages with the RO and appraisal networks
4. No concerns have been evidenced from an independent verification visit or any other source.

LCH met the criteria for 2015/16 and continues to meet the criteria 2016/17and are exempt from quarterly returns and provide assurance as statement in an email return.

The RO also provides assurance to the TDA through the Integrated Planning Checklist – Supporting a Well Led Organisation on Quality.

4.2. Policy and Guidance

The Appraisal Policy and Guidance, the Job Plan Policy and the Remediation, Reskilling and Rehabilitation Policy for Consultants, SAS Doctors and Dentists in LCH were rewritten and ratified by SMT in September 2016 and issued on 30th November 2016.

5 Medical Appraisal

5.1 Appraisal and Revalidation Performance Data

5.1.1 General

Under The Medical Profession (Responsible Officers) Regulations 2010 [Guidance, 4.5], the Responsible Officer (RO) is required to keep an accurate record of all doctors with whom the Designated Body has a prescribed connection. The prescribed connection for the LCH RO does not include:

- General Practitioners who are on the performers list in Leeds
- Trainees who have a prescribed connection to the Deanery.
- Forensic Medical Examiners (FME's) who are not directly employed by LCH.
- Secondary care locums employed by locum agencies with their own RO.

Academics with honorary clinical contracts will usually have their RO in the NHS Trust where they perform their main clinical work. LCH has 1 practitioner in this category.

5.1.2 Numbers of Doctors and Dentists

As of the 31st March 2017, LCH as a Designated Body had a prescribed connection (and reported on for the purposes of the AOA) for **42** doctors:

- **27** Consultant (including honorary contract holders)
- **9** Staff Grade/Associate Specialist/Specialty Doctors (SAS)
- **3** Temporary /short term locums /Fixed term contracts
- **3** Other doctors (directly employed FMEs) with a prescribed connection to LCH.

Non Designated Body doctors and Dentists employed by included:

- **11** salaried Dentists,
- **1** Consultant Dentist,
- **7** GPs/GPwSI (2 GPwSI, 5 GPs at YSH)
- **2** locums with a prescribed connection to a locum agency

Self-employed non designated body doctors included:

- **18** Forensic Medical Examiners in Police Custody Suites.

Staffing has not been static throughout the year with retirements, resignations and some recruitment to vacancies.

5.1.3 Appraisal activity

The Annual Organisational Audit (AOA) was submitted to NHS England on 25/05/2017. This self-assessment covered the final end of year period to 31/03/17 and the report is attached separately.

NHS England acknowledged the LCH AOA on 07/07/17 and responded with a statement: '*In accordance with the Framework of Quality Assurance (FQA) and in acknowledgement of Higher Level Responsible Officer Quality Review (HLROQR) process we can confirm that we have concluded a screening review of your designated body. As we found everything to be satisfactory there is no action to be taken by us*'.

The numbers of doctors with a prescribed connection to LCH who had a completed appraisal between 01/04/2015 and 31/03/2016 was **42/42** (**100%**)**.**

The exception report for missed or incomplete appraisals is attached at **Appendix A**.

The audit highlighted:

- All doctors completed appraisals between 01/04/2015 and 31/03/2016; therefore the exception report shows a nil return.

All Service Level Agreement (SLA) and contracted sessional doctors are all compliant within their own designated body and in addition the Self-Employed FME doctors within the Police Custody Suites were compliant in **18/18 (100%).**

The number of dentists to include the consultant dentist who completed an annual appraisal between 01/04/2016 and 31/03/2017 was **10/11** (**91%**). 1 dentist did not complete their appraisal due to maternity break.

The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2016 – 2017 was **65/66** (**98.5%**).

5.1.4 Doctors in Remediation and Disciplinary Processes

LCH does not have any doctors in a remediation process but has one doctor who has restrictions imposed by the GMC.

5.2 Appraisers

5.2.1 Appraiser Numbers

LCH had **8** appraisers for designated body doctors between 31/03/2016 and 01/04/2017. The ratio of medical appraisers to doctors being appraised remains between 1:5 -1:20 in keeping with national guidance (1.5-1.20).

5.2.2 Appraiser training

All LCH designated body appraisers have received enhanced appraisal training and **7/8** received an annual training update in February 2017. One appraiser has had a briefing on appraisals and is due to receive supplementary training in 2017.

The RO, RO manager and the AMD lead for appraisal and job planning have attended the relevant appraiser/RO network meetings.

5.2.3 Dentists

The Trust had two Dental Appraisers in addition to the ‘Associate Medical Director’ until 03/02/2017 when the Consultant Dentist left the trust. The Consultant Dentist had their appraisal undertaken by the AMD. After 03/02/2017 the AMD completed all remaining dental appraisals. The

expectation is that the new Consultant Dentist will undertake appraisals as part of their role.

Medical and Dental appraisal training was undertaken on 09/02/2017 with **11** appraisers in attendance.

5.3 Quality Assurance

5.3.1 PReP system

LCH re-procured the PReP IT system to assist with revalidation, appraisal and job planning for three years. The system went live in August 2013 and has been used for all doctors with a prescribed connection to LCH for the appraisal year 2013/14, 2014/15, 2015/16 and 2016/17.

There is currently work underway; looking at recommendations to move away from a paper based appraisal system; and instead implement a more streamlined annual appraisal process for community dentists by introducing the PReP system for all dentists working for the trust.

The PReP system contains an RO dashboard and enables storage of appraisal portfolios, output forms, PDPs, a multi-system feedback tool, an appraiser evaluation form and a job planning facility. The system provides automatic prompts and restricted access for the RO admin team, appraisees, appraisers and the RO.

All designated body doctors were provided with group and individual training for the PReP system. In addition the RO team provided individual administration support to doctors on request.

5.3.2 Quality Assurance Process

All appraisers participated in a quality assurance exercise in 2013 and 2014 which included a sample of output forms which were critiqued and 360 feedback from doctors for each individual appraiser.

As part of the NHS England Independent Verification process introduced during 2014/15 there is an expectation that the RO office will undertake a sample of appraisal output forms to check standards against evidence and identify any appraiser training needs. In October 2015 the RO Office (Dr Florence McDonagh (Associate Medical Director for Job Planning and Appraisals) and Linda Dobrzanska (former RO Manager) undertook a Quality assurance exercise using an NHS England approved monitoring tool, The EXCELLENCE QA tool (Improving and Quality Assuring appraisal output documentation).

Samples of appraisals were randomly selected, and in total 17 appraiser output forms were reviewed. Where there were low scored output forms, the Associate Medical Director then examined the appraisal input form and the appraise feedback forms to triangulate the information. Scores and comments were fed individually to appraisers, and aggregated information was provided in a quality assurance feedback session.

There is a plan to carry out a similar exercise in 2017/18.

There were no complaints or appeals and appraisers all received positive feedback.

5.3.2 RO Quality Assurance

The RO has sampled portfolios for a number of doctors with revalidation due dates, in addition to using a checklist for output forms for recommendations.

Those doctors who have been positively recommended have met the national standards for inputs and outputs.

5.4 Access, security and confidentiality

The PReP system allows restricted access for appraisees and appraisers. The RO admin team can access appraisee's portfolios to input data, to collect data and enable anonymous sampling exercises for quality assurance. The RO has full access if required to the portfolios, PDPs and output forms. The Associate Medical Director for Job Planning and Appraisals has full access to enable completion of the Quality assurance exercise. Appraisees can directly view an evidence trail of access by their appraiser and RO. Appraisees can request the evidence trail for admin access.

5.5 Clinical Governance

LCH is able to populate designated body doctor's appraisal portfolios with audits, incidents and complaints. Incidents and complaints information is dependent on the corporate services recognising when a doctor or dentist is involved and providing the relevant information to the RO team prior to an appraisal date. Where services are on SystmOne data activity can also be provided. The clinical governance process continues to be refined.

6 Revalidation Recommendations 01/04/16 – 31/03/17

The RO made **2** positive recommendations to the GMC **(Appendix B** Audit of revalidation recommendations). All positive recommendations and deferral requests were all completed on time.

7 Recruitment and engagement background checks

All designated body doctors who joined the Trust had the appropriate pre-engagement checks undertaken and appraisal information was obtained from their previous designated body via the RO.

Monitoring Performance

Doctors and Dentists are monitored for their performance through appraisal and job planning processes. Where there are concerns with regard to a doctor's performance the RO/Associate Medical Director would be informed and appropriate policies (see section 9) would be followed in discussion with the Head of Workforce and with notification to the Chief Executive.

9 Responding to Concerns and Remediation

LCH has five policies relating to concerns and remediation for doctors and dentists to include:

- Appraisal Policy and Guidance for Consultants, SAS Doctors, and Dentists in Leeds Community Healthcare NHS Trust (November 2016)
- Job Planning Policy for Consultants, SAS Doctors, Salaried GPs and Salaried Dentists, Leeds Community Healthcare NHS Trust (November 2016)
- Remediation, Reskilling and Rehabilitation Policy for Doctors and Dentists in LCH (November 2016)
- Maintaining High Professional Standards in the Modern NHS (May 2016),
- Disciplinary Policy (November 2016)

Section 5.1.4 describes the doctors in Remediation and Disciplinary Processes within the time period of this report.

10 Risk and Issues

The system has no financial resource to add newly appointed designated body doctors to the system and is reliant on the movement of doctors leaving the Trust to maintain the 45 licences purchased.

Failure of an appropriate clinical governance, appraisal and revalidation process would be viewed as a significant quality issue by the TDA, CQC and the GMC.

Currently all dental appraisals are completed in a paper format, but work is ongoing to procure a system that meets the requirement of the General Dental Council and in future for dental revalidation, this is most likely to be the same PReP system currently used by trust doctors.

11 Corrective Actions, Improvement Plan and Next Steps

- Completion of all breached appraisals.
- To submit a business proposal for a Dental electronic management system.
- To report progress on doctors with concerns, through the Cause for Concern bimonthly private Board report.

12 Medical and Dental Job Plans

Every medical and dental practitioner working in LCH is required to have a fully completed and signed off annual job plan. **84.6%** of medical job plans were completed. Incomplete job plans were due to the operational service reviews during this period, sick leave and maternity breaks. Job planning has been a focus for the first quarter of the next reporting period.

The dentists have 100% completed annual job plans.

13 Annual Medical and Dental Conference

The annual Medical and Dental conference was held on the 24th November 2016 at Weetwood Hall Leeds. The conference was attended by 50 delegates (excluding speakers and stall holders).

The conference was a mixture of workshops and presentations and during the lunch break there were exhibits from the Research Team, Service Improvement Team & Library Service in a 'breakout' area.

The morning session was chaired by Neil Franklin, Chair of Leeds Community Healthcare (LCH) NHS Trust, followed by an introduction by Thea Stein, Chief Executive of LCH.

Following on from the main introductions, the morning session was 'An introduction to New Models of Care/Delivering care through Federated Providers in Leeds from Thea Stein and Chris Mills.

After lunch the afternoon session was opened up by Brodie Clarke 'Non -Executive Director'.

The afternoon session included a talk from Mary-Ann Bruce about the 'Mazar's Report'. Mary-Ann discussed learning from and implications of; the review of deaths at 'Southern Health'.

There was also a session on analysing risk from LCHT's 'Risk Manager' Diane Allison.

The final session was led by Ryan Offutt on 'Improvisation' - The one superpower skill they didn't teach you at university (but should have).

Evaluation forms were in each delegate pack and the return rate was 33 (66%).

The event was well attended and feedback received from delegates was very positive. Delegates welcomed the opportunity to network with colleagues and feedback on the presentations confirmed that they were well received. Some delegates provided suggestions for future conferences such as facilitating a bi-annual conference to ensure better attendance.

The conference is an important part of the medical and dental calendar and provides opportunities for networking and hearing updates and presentations on relevant topics.

14 Recommendations

The Board is recommended to:

- Approve the 2016/17 Annual Executive Medical Director's Report
- Note the requirements by NHS England to include the statement of compliance from the Board.
- Approve the sign off of the statement of compliance

Appendix A

Audit report to identify reasons for missed or incomplete appraisals 2016/17 Leeds Community Healthcare NHS Trust

Doctor factors (total)	**42**
Completed appraisals 2016/17 = 42 (100%)	**42**
Maternity leave during the majority of the 'appraisal due window'	0
Sickness absence during the majority of the 'appraisal due window'	0
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	**0**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	8
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**0**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Recommendations:
Of the eight appraisals that were not signed off within 28 days, two 'Appraisal postponement application forms' were submitted, in two cases appraisals were complete but the feedback portion of the appraisal had been missed. Additional training will be arranged for appraisees to ensure that they are up to speed with the process which will improve compliance levels.

Appendix B

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2016 to 31 March 2017	
Recommendations completed on time (within the GMC recommendation window)	2
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	2
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	0

Appendix C
Designated Body Statement of Compliance

The board of Leeds Community Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comment: LCH is fully compliant

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: accurate records of all licenced medical practitioners with a prescribed connection to LCH is maintained

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: There are sufficient numbers of trained appraisers in LCH

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: All appraisers have an annual on-going training session and received appraise feedback

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: All missed or incomplete appraisals are noted and reported to the RO

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Comments: All incidents /complaints notified to the RO office are followed up and information is uploaded into their individual portfolios. All doctors are aware of and are compliant with obtaining patient and colleague feedback

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: The RO is notified of any areas of concern

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: LCH is compliant

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: LCH is complaint

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: A development plan is in place

Signed on behalf of the designated body

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date: _ _ _ _ _ _ _ _ _ _

[3] Doctors with a prescribed connection to the designated body on the date of reporting.

NHS England

Annual Organisational Audit (AOA)
End of year questionnaire 2016-17

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	06491
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Lynda Norton
Publication Date	24 March 2017
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	The AOA (Annex C of the Framework for Quality Assurance) is a standardised template for all responsible officers to complete and return to their higher level responsible officer via the Revalidation Management System. AOAs from all designated bodies will be collated to provide an overarching status report of progress across England.
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2015/16 AOA cleared with Publications Gateway Reference 04543
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Lynda Norton Professional Standards Team Quarry House Leeds LS2 7UE 0113 825 1463

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2016-17

Version number: 4.0

First published: 4 April 2014

Updated: 24 March 2015, 18 March 2016 & 24 March 2017

Prepared by: Lynda Norton, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA is designed to assist NHS England regional teams to assure the appropriate higher level responsible officers that designated bodies have a robust consistent approach to revalidation in place, through assessment of their organisational system and processes in place for undertaking medical revalidation.

Learning from the experience of the Organisational Readiness and Self-Assessment (ORSA) the AOA has a dual purpose to provide the required assurance to higher level responsible officers whilst being of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2016/17;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2017** for the year ending 31 March 2017. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2017.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 29 September 2017.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 31-32
and www.england.nhs.uk/revalidation

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2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Leeds Community Healthcare NHS Trust	
	Head Office or Registered Office Address if applicable line 1 Stockdale House	
	Address line 2 Headingley Office Park	
	Address line 3 Victoria Road	
	Address line 4 Headingley	
	City Leeds	
	County	Postcode LS6 1PF
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☑
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Improvement, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

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1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☑
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

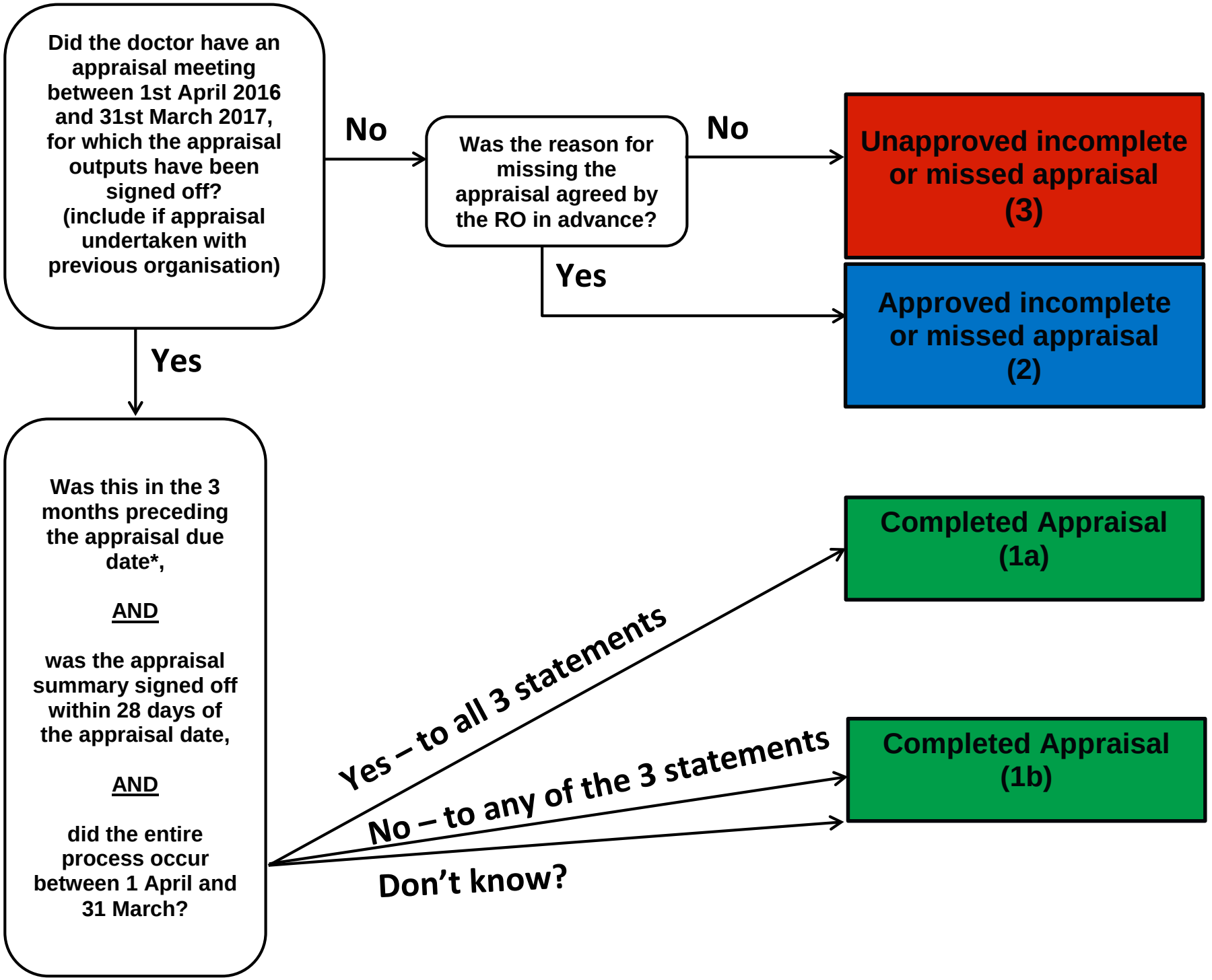
1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken (requirement being NHS England's face to face responsible officer training & the precursor e-Learning). • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission, the Human Fertilisation and Embryology Authority or Monitor, now part of NHS Improvement). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☐ Yes ☑ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2017 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	27	21	6	0	0	27
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	9	8	1	0	0	9
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	3	3	0	0	0	3
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	3	2	1	0	0	3
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	42	34	8	0	0	42


Did the doctor have an appraisal meeting between 1st April 2016 and 31st March 2017, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2017** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2017. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England 2015).	

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2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the= responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and= unapproved) for the appraisal year 2016/17 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☐ Yes ☐ No ☑ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

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	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See Good Medical Practice: Supplementary Guidance: Writing References (GMC, 2007) and paragraph 19 of Good Medical Practice (GMC, 2013) for further details. The responsible officer regulations and GMC guidance make it clear that there is an obligation to share information about a doctor when required to support the responsible officer's statutory duties, or to maintain patient safety. Guidance, published in August 2016, on the flow of information to support medical governance and responsible officer statutory function (2016) therefore aims to promote improvements to these processes: • setting out the common legitimate channels along which information about a doctor's medical practice should flow, describing the information that might apply and arrangements to support its smooth flow • providing useful toolkits and examples of good practice The guidance on information flows to support medical governance and responsible officer statutory functions can be accessed via the link below. https://www.england.nhs.uk/revalidation/ro/info-flows/	

7 Section 5 – Comments

Section 5	Comments	
5.1		

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Revalidation: A Statement of Intent* (GMC and others, 2010)
8. *Good Medical Practice* (GMC, 2013)
9. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
10. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
11. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
12. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
13. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
14. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012, updated 2014)
15. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
16. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
17. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
18. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
19. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
20. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
21. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
22. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
23. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
24. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002, updated in 2012)
25. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011, updated in 2012)

26. *How to Conduct a Local Performance Investigation (National Clinical Assessment Service, 2010)*
27. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12 (National Clinical Assessment Service, 2011)*
28. *Return to Practice Guidance (Academy of Medical Royal Colleges, 2012)*
29. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (33)

Meeting Trust Board 4 August 2017	**Category of paper**	
Report title Nurse revalidation	**For approval**	
Responsible director Executive Director of Nursing **Report author** Deputy Director of Nursing	**For assurance**	√
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

This report provides an overview of the last year since the introduction of nurse revalidation. The paper describes the support and systems put in place to prepare and support staff for the revalidation process.

MAIN ISSUES FOR CONSIDERATION

Monitoring systems are in place and appear to be effective.
Feedback from nurses indicates that they are not finding this a difficult process and indeed welcome the additional scrutiny this adds to the role.
Updates for staff continue to be provided on a regular basis.
During the course of the last year, two nurses failed to comply with the process and one nurse let her registration lapse as it was not required for the role that she occupied.

RECOMMENDATION

The Board is recommended to:

- Note this update on nurse revalidation

Nurse Revalidation

1.0 Introduction

1.1 Revalidation for nurses became mandatory in April 2016. Revalidation and review of process was one of the key actions undertaken in the aftermath of the events at Mid Staffordshire Hospitals NHS Foundation Trust and criticism of the regulatory bodies. A programme of work lead by the Executive Director of Nursing commenced in September 2015 in order to prepare nurses for the process and ensure that they were ready for revalidation.

1.2 The Trust currently employs a total of 1003 nurses and 354 were due to revalidate since 1 July 2016. A previous report to the Trust Board covers the first quarter of 2016.

2.0 Preparation

2.1 A programme of work commenced in September 2015. This had a number of strands:

- A programme of workshops over five months across the Trust covering requirements and preparation for revalidation
- Each nurse received a letter from the Executive Director of Nursing
- Presentations at professional forums with questions and answers
- Two blogs in weekly messages
- Each business unit also covered the topic in a number of meetings
- Work was undertaken to ensure this work fitted with new appraisal process although being clear that these are two distinct processes
- Workshops have continued during 2016 and into 2017 now led by the Deputy Director of Nursing

2.2 Generally, feedback was that staff felt they understood the requirements and were welcoming of the support and information.

2.3 Meetings were held to ensure that internal monitoring systems were in place. It was agreed that staff would receive an additional new reminder at three months prior to revalidation. Provided staff have registered with the Nursing and Midwifery Council (NMC) on-line, they will also receive multiple e-mail reminders. It is important to note that the Trust has received regular feedback from the NMC that systems for ESR matching with NMC records are at 100%.

3.0 Information regarding detail of revalidation for nurses

3.1 This information covers the full year 1 July 2016 to 30 June 2017 as a previous report to the Trust Board covers the first quarter of 2016.

3.2 A total of 354 nurses were due to revalidate in this period. The nurses were from a cross section of all the services that employ nurses across the Trust.

3.3 In this time period, two nurses have failed to revalidate. The alert systems in place worked. The reasons these nurses failed to revalidate were due to sickness and subsequently ceasing to work for the Trust and a change in role that no longer required a nursing registration. In addition another nurse chose to let the registration lapse as they did not require registration for the current role.

4.0 Conclusion

4.1 Feedback from a number of nurses has been that revalidation has been a straightforward process. The systems in place within the Trust are effective in that there was early and timely alert where individuals were not complying with the requirements and managers made multiple efforts to support and advise these individuals. Monitoring of the processes will continue within the Trust.

5.0 Recommendation

5.1 The Board is recommended to:

- Note this update on nurse revalidation

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (34)

Meeting: Trust Board 4 August 2017	**Category of paper**	
Report title: Significant risks and board assurance framework (BAF) summary 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 summary report is part of the governance processes supporting risk management in that it provides the Board with updated information about the effectiveness of the risk management processes and that adequate controls are in place to manage risks.

The summary report provides the Board with information about risks currently scoring 15 or above (extreme risks), after the application of controls and mitigation measures. It also provides a description of any risk movement of risks scoring 12 (high risks) since the last register report was received in May 2017.

The board assurance framework (BAF) summary advises the Board of the current assurance level determined for each of the Trust's strategic risks.

Main issues for consideration:

This summary report shows changes to the risk register (for risks scoring 15 or above) since May 2017:

- One new extreme risk scoring 15 or above (risk 906 community intermediate care beds retender)
- No risks with a revised score of 15 or above
- One risk with a deescalated score from 15 or above (risk 868 audiology staff capacity).
- Two new risks scoring 12 (high) (risk 905 child and adolescent mental health bed availability within a shortened timescale and risk 911 insufficient availability of registered nurses on community intermediate care unit)
- One escalated risk now scoring 12 (high) (risk 862 clinical capacity in adult speech and swallow team)

The board assurance framework summary (BAF) 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.

Recommendations

The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

Significant risks and board assurance framework (BAF) summary report

1.0 Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures.

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks). This report provides a description of risk movement since the last register report was received by the Board (31 May 2017), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk.

1.3 Summary reports (such as this one) are produced on a frequent basis and alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report is produced on a less frequent basis, and describes and analyses all risk movement, the risk profile, themes and risk activity. The benefit to the senior governance structure is that the summary reports will note significant changes to the risk register and discussions can be focused around these changes.

1.5 This paper provides a summary of the current board assurance framework (BAF) and an indication of the assurance level that has been determined for each of the Trust's strategic risks.

2.0 Summary of current risks scoring 15 or above

2.1 There are three risks with a current score of 15 (extreme) or above on the Trust's risk register. These are as follows:

Risk ID	Risk description	Risk score	Risk movement
Risk 906	*Reduction in funding for neighbourhood teams as a result of community intermediate care beds retender (see section 2.2 of report)*	20 (extreme)	**NEW**
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)	⟷

2.2 There is one new risk scoring 15 (extreme) or above:

Risk: 906	Initial risk score **20**	Current risk score **20**	Target risk score **4**
***Possible reduction in funding for neighbourhood teams as a result of community intermediate care (CIC) retender*.** As a result of a possible reduction in funding for neighbourhood teams associated with community beds retender there is a risk that resources available for neighbourhood teams will be reduced having an impact on service delivery, service quality and patient and staff experience. Controls in place are: • Discussions underway with commissioners to seek solution. Planned actions include: • Paper to business development board to outline risk and potential solutions if immediate negotiations are unsuccessful.			

2.3 There are no escalated risks currently scoring 15 (extreme) or above.

2.4 There is one deescalated risk, which previously scored 15 (extreme) or above:

Risk: 868	Risk description: ***Six-week waiting times breach risk in children's audiology due to reduced clinical staff capacity.***	Current risk score **9 (high)**	Previous risk score **15 (extreme)**
Reason for de-escalation: Additional capacity to meet demand is in place. Better forecasting in place to identify any future spikes in demand and add further capacity.			

3.0 Risks scoring 12 (high)

3.1 Two new risks scoring 12 have been added since May 2017.

Risk: 905	Initial risk score **12**	Current risk score **12**	Target risk score **3**
Risk of lack of child and adolescent mental health services (CAMHS) bed availability within shortened timescale following a detention of a patient in a 'place of safety'. The Policing and Crime Act 2017, due to be implemented in July 2017, reduces the length of time that a person may be detained for the purposes of assessment from 72 to 24 hours. This is amending the timescales set out in section 136 of the Mental Health Act 1983. Section 136 gives the police authority to take a person from a public place to a 'place of safety', either for their own protection or for the protection of others, so that their immediate needs can be properly assessed. The Act also requires police officers to consult with mental health practitioners (where practicable) before exercising a section 136 power. There is a risk that a CAMHS bed will not be available to transfer a young person from the S136 suite (the place of safety) within 24 hours. The impact of this could be an out of area placement or an inappropriate discharge from care and resultant			

harm to the young person or a member of the public.
There is a risk that if the Trust fails to implement the legislative changes, it will be acting unlawfully and could incur financial loss (litigation or fines) and reputational damage (non-compliance with CQC regulations).
There is a risk that the police will increase the frequency of obtaining advice from consultants out of hours, which will reduce consultants' availability to meet demand for urgent cases, fewer clinics and an increase in waiting times for appointments, all of which could affect outcomes for patients. There is a risk of increased work pressure on staff; an impact on staff wellbeing and on recruitment and retention.
Controls in place are:

- Act provides for an extension of 24 hour limit for up to 12 hours for medical reasons

Planned actions include:

- Discussions with commissioner and local healthcare partners (LTHT and LYPFT)

Risk: 911	Initial risk score **25**	Current risk score **12**	Target risk score **6**

Risk of insufficient availability of registered nurses on community intermediate care unit (CICU).

There is a lack of availability of registered nurses on CICU due to vacancies and staff absence. There is a risk that safe staffing levels may not be maintained, and a risk there will be no directly-employed staff on some shifts due to a reliance on temporary staffing. There is a further risk that as the tendering process for CIC beds progresses, existing staff may leave prior to the conclusion of the tendering exercise. The impact could be on patient care, staff wellbeing, and financial control.
Controls in place are:

- Regular agency staff used to mitigate some of the risk; working closely with CLaSS to cover shifts
- Existing staff working flexibly to meet needs and cover gaps, including working extra hours
- Daily review of rotas and ability to accept admissions and maintain safety
- Induction and support processes for temporary staff
- Staff support through regular team meetings and 1:1's
- Senior manager presence on unit
- Review of incidents and feedback for early identification of emerging trends
- Management of new admissions in line with staffing availability

Planned actions include:

- Analysis of temporary staff spend to be discussed at performance meeting and Senior Management Team
- Acting unit manager post to be appointed
- Review and monitoring of expected and actual staffing levels and type of staff for early detection if issue is escalating
- Regular meetings with staff and senior managers
- Regular reports for Executive Director of Nursing; early escalation of issues

4.0 Risks escalated to a score of 12 (high)

4.1 One risk has been escalated to a score of 12 since May 2017:

Risk: 862	Risk description: ***Clinical capacity in adult speech and swallow team.***	Current risk score **12**	Previous risk score **6**
Reason for escalation: Team continues to work with 48% clinical staff absence (vacancies and maternity leave). Locums continue to be sought but few suitable candidates. Waiting list currently 199 with one patient waiting over 18 weeks. Face to face activity is 34% down. Action being taken to mitigate risk: Recruitment is taking place with the agreement that service can over-recruit should there be more than one appointable candidate. Additional hours are being worked by existing staff. Additional temporary support is in place. Risk and information escalated to senior managers through situation reports.			

5.0 Risks deescalated from a score of 12 (high)

5.1 No risks have been deescalated from a score of 12 since May 2017.

6.0 Risk added to risk register – score to be determined

6.1 Concerns about the e-rostering project have been brought to the attention of the Business Committee in the form of project flash reports. The Director of Workforce and the Risk Manager have recently added this risk to the risk register (Risk 909). The agreed risk description is:

E-rostering project is now reporting as six months behind the original scheduled roll out. This is due to issues of core system functionality taking time to be developed to the required standard. This is preventing the pilots from attaining full benefits from the software. The Carter Review and existing NHS Improvement guidance requires that each Trust will have e-rostering systems by autumn 2018.
The risks are

- *Continued delays with roll out due to system updates not being appropriately developed and/or delivered on schedule*
- *In house project team and external development team resourcing may provide inadequate support to recover project timetable*
- *Lack of N3 connection may cause further challenges*
- *Dissatisfaction from services with the current system*
- *Delay in operational benefits as we approach winter period and longer term benefits realisation*
- *Future investment with legislation changes such as Lord Carter recommendations*

The impact will be financial and reputational.

6.2 It is currently not possible to score this risk accurately, as controls and actions are still being worked through. A further update will be provided in the September 2017 risk report.

7.0 Risks with an out of date review date

7.1 Risk owners are asked to update their risks where a review date had passed. If risks review dates remain outstanding, further reminders are sent and any risks remaining out of date by more than a month are escalated to the relevant director for intervention.

8.0 Board assurance framework summary

8.1 The purpose of the board assurance framework (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; this is achieved through the application of controls and the scrutiny of sources of assurance.

8.2 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).

8.3 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.

8.4 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.

8.5 The BAF summary **(appendix 1)** 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 2** (BAF risk assurance levels).

8.6 Since the last BAF summary report in May 2017, the current level of assurance for the following BAF risks has been adjusted as follows:

- BAF risk 1.2 (relating to implementing and embedding lessons from reviews and reports) assurance level is ‘reasonable’, however there has been a number of positive assurance sources received which means the assurance level is improving further.
- BAF risk 2.1 (relating to achievement of principal internal projects) assurance level is now ‘limited’ as the e-rostering project is failing to achieve satisfactory delivery progress.

- BAF risk 2.3 (relating to productivity, efficiency and value for money) is 'reasonable' but moving towards 'substantial' as the Business Committee received a high level of assurance from a report on the triangulated management of quality, productivity and cost.
- BAF risk 2.4 (relating to retaining and winning business) is still 'reasonable' but moves towards 'limited' as the Business Committee was not fully assured by the business and commercial developments report received June 2017.
- BAF risk 2.5 (relating to delivering income and expenditure position) is 'reasonable' but moving towards 'limited' as cost improvement plans (CIP) delivery continues to be a concern.

9.0 Reporting schedule

9.1 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		Summary		Summary		Summary	Mid-year review	Summary	
	QC/BC										Mid-year revised		
	AC		Full		Summary			Full			Summary		
	Board		Summary		Summary		Summary		Summary		Summary		Summary

Full	= Complete BAF
Summary	= BAF overview
Mid-year review	= Mid-year review
	= Information flow

10.0 Recommendation

10.1 The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

Appendix 1

Board Assurance Framework Summary 2017/18

Risk		Risk ownership		Risk score				Level of Assurance					
Corporate Objective	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
Ensure consistent delivery of high quality care	**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	3	4	12	⟷			◆			None
	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 priorities reasonable achievements made. Duty of candour good compliance. More streamlined action plan needed for Hannah House.	→
	RISK 1.3 If the Trust does not achieve a 'good' CQC rating then there will be an impact on reputation and a greater degree of oversight and scrutiny.	AT	QC	3	3	9	⟷			◆			None
	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	⟷				◆		None
Create sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects (integrated neighbourhood teams, EPR, E-rostering, estates rationalisation) then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	2	4	8	⟷		◆			E-rostering failing to achieve satisfactory delivery progress. Key projects progress updates and assurance arrangements are limited. EPR is continuing as scheduled.	←
	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	2	3	6	⟷			◆			None
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	SP	BC	3	4	12	⟷				◆	Quality, productivity and cost paper presented to Business Committee provided a high level of assurance on management of these three key matrices.	→
	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 and commercial developments report provided limited assurance June 2017.	←
	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	⟷				◆	CIP delivery continues to be a concern. The Business Committee noted that the finance approach felt appropriate. Procurement report shows satisfactory performance	←

Continue to improve staff engagement and morale	**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.	SE	BC	3	4	12							None
	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.	SE	BC	4	4	16							None
	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	SMT	4	3	12							None
	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							None
Take a lead role in delivering new models of care in the city through system integration with GPs, LYPFT and tier one hospital services	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (STP 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	TB	3	3	9							None
	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)							None
	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							None
	RISK 4.4 If there is insufficient capacity across the Trust to deliver all planned change programmes and strategic projects, including the Leeds Plan, then organisational priorities may not be delivered.	TS	BC	3	3	9							None

Board assurance framework: glossary

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 2017-18 (35)

Meeting: Trust Board 4 August 2017	**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 updated arrangements, including:

- New appointment to the Board of Directors
- Membership of Board sub-committees
- Committees' terms of reference: Nominations and Remuneration Committee

Recommendations

The Board is recommended to:

- Note changes to the non-executive membership of the Board
- Note membership of Board committees
- Approve changes to the terms of reference of Board sub-committees

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 Board membership: appointment of non-executive directors

3.1 Over the course of 2016/17, the Trust has enjoyed a full complement of non-executive directors who have brought a wealth of skills and experience to the work of the Board. Each non-executive director is appointed to the Board by NHS Improvement for a specified term of office as set out in a letter of appointment. On expiry of a term of office, a non-executive director may be considered for a further term of office up to a maximum of ten years.

3.2 One non-executive director, Elaine Taylor-Whilde, chose to step down from the role as at 30 June 2017.

3.3 After a successful recruitment campaign, a new non-executive director has been appointed to the Board, with a term of office from 1 July 2017 to 30 June 2019.

3.4 The new appointee is Professor Ian Lewis. Ian is a senior clinician by background. He was Executive Medical Director of Alder Hey Children's NHS Foundation Trust in Liverpool between 2011 and 2015, having previously been a Divisional Medical Director and Consultant Paediatric Oncologist at Leeds Teaching Hospital NHS Trust. He also co-chaired the Children and Young People's Health Outcomes Forum – an independent group of professionals who advised the government, which operated between 2012 and 2016. He has also served as a Trustee of The Candlelighters Trust (1985-2011), Martin House Children's Hospice (1990-2010) and Bone Cancer Research Trust (2006-present) within the charitable sector.

3.5 The Trust continues to participate in the Insight Programme aimed at supporting individuals who would wish to apply and be appointed to future non-executive director posts. As part of this programme, the Trust will welcome Shamaila Quereshi on a six months attachment to the Trust with effect from 1 September 2017.

4 Committees' terms of reference

4.1 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 2017, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. The Board, at its meeting on 31 May 201, approved a number of changes.

4.2 Subsequent to this agreement, the Nominations and Remuneration Committee has considered a further amendment related to extending the role and duties of the Committee and this is contained (in red text) in the table below. The Board's approval to this change is therefore requested.

Nominations and Remuneration Committee	
Section	**Change**
1.3	The Committee also discharges a function in relation to the oversight of employee relations cases of high risk to the Trust.
5.1: Role of Committee	Remuneration and employment matters Monitor and review (on behalf of the Board) and report to the Board on any exceptional and/or significant employee relations cases of high risk to the Trust including those relating to: employment cases of high cost or of reputational significance.
5.2: Duties of the Committee	Employment issues To receive reports on significant employee relations issues on an exceptional basis, review these on behalf of the Board and report to the Board (in private session) as appropriate. Those cases that will be considered by the Committee will be assessed on the grounds of value for money, reputational risk, impact or precedent or as deemed otherwise to be novel or contentious. The case may relate to current or immediately past employees.

5 Board committees: membership

5.1 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.

5.2 In order to reflect the best distribution of Board membership across the committees so that they are able to fully discharge their respective responsibilities and to take into account the substantive changes to Board membership as described in section 4 above, committee membership has been reviewed and the membership for 2017/18 is shown in the table below.

	Non-executive directors	Executive directors
Audit Committee	Jane Madeley (chair) Richard Gladman **Ian Lewis**	
Quality Committee	Dr Tony Dearden (chair) Neil Franklin **Ian Lewis**	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 Director of Workforce
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	

5.3 In addition, the Quality Committee has a number of sub-committees, one of which, the Mental Health Act Governance Group, is chaired by a non-executive director; this function rests with **Ian Lewis.**

5.4 These changes (shown in bold) will be captured in changes to terms of reference for the relevant committee.

6 Recommendations

6.1 The Board is recommended to:

- Note changes to the non-executive membership of the Board
- Note membership of Board committees
- Approve changes to the terms of reference of Board sub-committees

Leeds Community Healthcare NHS Trust

Agenda item
2017-18
(36)

Trust Board public workplan 2016 -17
Version 2 3 July 2017

Topic	Frequency	Lead officer	2 December 2016	3 February 2017	31 March 2017	31 May 2017	4 August 2017	6 October 2017	1 December 2017
Preliminary business									
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X	X
Patient story	every meeting	EDN	X	X	X	X	X	X	X
Quality and delivery									
Chief Executive's report	every meeting	CE	X	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X	X
Serious incident report	4 x year	EDN	Report considered in private	Report considered in private	Report considered in private	Report considered in private	X	X	X
Operational plan including financial plan	2 x year	EDFR	Draft considered in private		X			X	
Care Quality Commission inspection reports	as required	EMD		X					
Quality account	annual	EDN				X			
Staff survey	annual	DW			X				
Service strategy	as required								
Safe staffing report	2 x year	EDN		X			X		
Infection prevention control annual report	annual	EDN						X	
Emergency preparedness and resilence report and major incident plan	annual	EDO						X	
Patient experience: complaints and incidents report	2 x year	EDN	X			X			X
Freedom to speak up annual report	annual	CE					X		
Guardian for safe working hours annual report	annual	EMD					X		
Safeguarding annual report	annual	EDN						X	
Equality annual report	annual	EDN	X						X
Strategy									
Service strategy	as required	EDFR	X						
Quality strategy	annual	EDN		X					
Professional strategy	annual	EDN						X	
OD strategy	2 x year	DW			X	X		X	
Research and development strategy	annual	EMD					X		
Other strategic developments	as required	EDO					X Digital strategy		
Governance									
Well-led framework	2 x year	CS				X CE report			
Medical Director's report: doctors' revalidation	annual	EMD					X		
Nurse revalidation	annual	EDN					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				
Annual governance statement	annual	CS			X	X			
Going concern statement	annual	EDFR			X				
Committee terms of reference	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/gifts and hospitality	annual	CS			X				
Board workplan	every meeting	CS	X	X	X	X	X	X	X
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X	X
Corporate governance update	As required	CS	X		X	X	X		
Decisions for ratification	as required	CS	X						
Reports									
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board	every meeting	CS	X	X	X	X	X	X	X

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 28 April 2017
9.00am – 11.30am

Agenda item 2017-18 (37ai)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Jackie Rae	External Audit Manager (KPMG)
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Diane Allison	Risk Manager(for Company Secretary)
	Richard Slough	Assistant Director of Business Intelligence (for Item 2d)
Apologies:	Elaine Taylor-Whilde	Non-Executive Director
	Clare Partridge	External Audit Partner (KPMG)
	Vanessa Manning	Company Secretary
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2017-18 (1)	**Welcome, introductions and preliminary business** The Chair welcomed members and others in attendance.	
2017-18 (1a)	**Apologies** Apologies were received from Non-Executive Director (ET-W), Clare Partridge, External Audit Partner (KPMG) and Vanessa Manning, Company Secretary.	
2017-18 (1b)	**Declarations of interest** There were no declarations of interest.	
2017-18 (1c)	**Minutes of the previous meeting 17 February 2017** The minutes of the meeting held on 17 February 2017 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the meeting held on 17 February 2017.	
2016-17 (1d)	**Matters arising and actions' log** The following outstanding actions were discussed and an update provided: **2016-17(41b): Internal audit recommendations update-audit on data quality** The Executive Director of Finance and Resources advised that currently the majority of staff used paper diaries as the primary method of recording activity but as Electronic Patient Record (EPR) was rolled out across the Trust this would change. The Chair of the Committee asked what were the latest EPR roll out targets. The Executive Director of Finance and Resources explained that roll out was on target	

	to be completed in the neighbourhood teams by 31 October 2017 and across other services in the Trust by the end of the 2017/18 financial year. **2016-17(42a): External Audit technical update–development of Vanguards** The External Audit Manager advised that she had found nothing of significant importance to report with regard to the development of 'vanguards' either locally or nationally. **Outcome:** The Chair of the Committee agreed that both these actions should be closed on the actions' log.	
2017-18 (2a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that three reviews had been completed since the Committee's last meeting on 17 February 2017, each with a reasonable assurance opinion, and a follow up review of implementation of previous recommendation had been completed and results reported. These reports were received by the Committee. **Progress against the annual plan for 2016/17** The Internal Audit Manager introduced the report; noting there was one outstanding audit for 2016/17, this related to statutory and mandatory training. The Chair of the Committee asked whether a significant amount of work needed to be progressed before the outstanding report could be completed. The Internal Audit Manager explained that fieldwork was underway and the delay in completion had been escalated to the Director of Workforce. The Chair of the Committee said that it was essential that the final report was completed and signed off by 12 May 2017 at the latest, in order to fulfil year end audit assurance requirements. **Action:** The Internal Audit Manager to liaise with the Director of Workforce to ensure that the final report on statutory and mandatory training was completed and submitted to Audit Committee members by 12 May 2017. The Chair of the Committee referred to the audits which had been carried forward to 2017/18 and raised concerns about the number of audit days lost in 2016/17 as a consequence. It was noted that three planned audits (26 days of audit work) had not been completed or were postponed to next year, with additional days being included in the 2017/18 plan. The Committee asked that, in future, any proposed changes to the internal audit plan 'in year' should include proposals for replacement audits, in order to ensure that sufficient audit work took place within the year to provide the necessary level of assurance to the Committee. It was also agreed that any proposed changes to the internal audit plan in year must be considered and approved by the Audit Committee by December each year. **Action:** The Internal Audit Manager to ensure that any changes to the internal audit plan in year are considered and approved by the December Audit Committee at the latest. The Committee discussed the follow up review of management actions taken in respect of priority 1 and 2 recommendations arising from internal audit reviews.	**Internal Audit Manager** **Internal Audit Manager**

	The Chair observed that seven recommendations were reported as 'considered but not implemented' and asked for a further explanation to be provided as to the reasons behind these decisions. She also expressed surprise to see the frequency of that response as an update to recommendations/actions previously agreed by the Executive. **Action:** The Internal Audit Manager to provide further explanation and background on the recommendations annotated as 'considered but not implemented' at the meeting on 26 May 2017.	**Internal Audit Manager**
2017-18 (2b)	**Outcome:** The summary of internal controls assurance report and the progress against the 2016/17 annual plan was noted. **Internal audit annual report 2016/17 and Head of Internal Audit 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 that there were adequate and effective management and internal control processes to manage the achievement of the Trust's objectives. 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 the one outstanding audit (statutory and mandatory training) but this was not expected to change the overall audit opinion. **Outcome:** The Head of Internal Audit opinion was noted.	
2017-18 (2c)	**Internal audit recommendations update** The Executive Director of Finance and Resources presented the report. He referred to the summary report for all internal audit recommendations that were overdue as at 31 March 2017 and the more detailed report on the outstanding actions. He noted that there were five recommendations to report this month that had not been completed by the due date. The overdue recommendations were reported in detail with an update on progress from the responsible manager; the current position had been RAG rated which indicated whether the action was considered completed or that the required action had not progressed sufficiently. He added that overdue recommendations had been reviewed by Senior Management Team (SMT). The Committee discussed the overdue recommendations. Referring to the audit on the contract bid process the Chair of the Committee asked for a further update on the outstanding actions to be reported to the Committee on 26 May 2017. **Action:** The Executive Director of Finance and Resources to provide an update report on 26 May 2017. **Outcome:** The internal audit recommendations update report was received and the progress against the internal audit recommendations noted.	**Executive Director of Finance and Resources**
2017-18 (2d)	**Internal audit follow up** The Assistant Director of Business Intelligence presented the report which provided an update of the progress made in response to the management action plans associated with the previous review of the cyber security arrangements and the review of SystmOne service resilience. He explained that the report identified actions which had been completed and discussed the reasons behind those which had taken longer to be completed than originally expected for both reviews.	

	Cyber security The Assistant Director of Business Intelligence explained that many of the recommendations from the review had been implemented quickly but some were delayed due to complexity, the scale or the need to complete a formal process e.g. conducting a procurement exercise. The Chair referred to the recommendation which related to penetration testing and it was explained that the Trust had arranged a test at no cost as an early adopter of a scheme released by NHS Digital. The Chair noted the position of Non-Executive Director (RG) as Programme Director at NHS Digital and the potential conflict of interest in this discussion. The Assistant Director of Business Intelligence advised that the penetration testing had been completed on 16 February 2017 and a written report had been received by the Trust on 25 April 2017. The report contained five high, six medium and 15 low level recommendations which would need to be considered in detail. The Chair of the Committee noted that all the recommendations within the internal audit report had now been actioned. It was agreed that the Committee would receive a further report on the outcome and recommendations of the penetration testing on 26 May 2017 when the content of the report from NHS Digital had been analysed. **Action:** A report on the outcome and recommended actions from the NHS Digital penetration testing to be provided to the Committee on 26 May 2017. *SystmOne service resilience* The Assistant Director of Business Intelligence advised that many of the actions within the report related to the robustness of business continuity plans. He explained that the initial set of recommendations provided in the internal audit report had been actioned and there was now a greater confidence in the SystmOne resilience business continuity plan. The Chair of the Committee asked about information governance compliance across the Trust and asked for an up to date figure on the percentage of staff that had completed information governance training. The Assistant Director of Business Intelligence advised that 96.2% of staff had current compliance with information governance training requirements. The Chair of the Committee questioned why this figure was not closer to 100% given that information governance training was a mandatory requirement for all staff in the Trust. The Executive Director of Finance and Resources explained that the SMT had made a decision that it was not a mandatory requirement for staff in the neighbourhood teams to re-new or complete initial information governance training whilst the Trust remained at REAP level 4. The Chair of the Committee noted this but asked that the Committee be informed when staff in the neighbourhood teams were re-included and encouraged the executive to enact this as soon as possible.	**Executive Director of Finance and Resources**

	A Non-Executive Director (RG) remained concerned about the readiness of the SystmOne external provider (TPP) to implement the business continuity plan and thought that more assurance should be requested about TPP's ability to maintain service in the event of a major failure. The Chair of the Committee noted the next step in relation to the testing of business continuity plans was a Trust wide exercise involving a cyber security incident to be led by the Emergency Planning Manager. She asked for an update on the outcome and learning from the exercise to be reported to the Committee following completion of the exercise. **Action:** A report on the outcomes and learning form the cyber security exercise to be provided following completion of the exercise in June 2017. **Outcome:** The Committee received and noted the report.	**Executive Director of Finance and Resources**
2017-18 (2e)	**Internal audit annual plan 2017/18** The internal audit annual plan for 2017/18 was presented by the Internal Audit. Manager. He explained that he had held meetings with each of the Executive Directors to discuss their areas of responsibility, associated risks and specific audits. The plan set out the reviews that were planned, the proposed timings, the outline scope, rationale and reference to the BAF and risk register risks for each review. The Committee considered the draft internal audit plan for 2017/18, and commented that: • There was insufficient focus on data quality (one audit of 10 days); the Committee proposed a minimum of three data quality audits each year and therefore a greater allocation of audit days to this area of the plan. • The scope of some audits should be refined e.g. external communications, research and development and tender readiness. • The scope of the corporate governance and the board assurance framework (BAF) audits to be determined once the feedback from the Care Quality Commission report on "well led" domain was received. • There was positive linkage to the BAF and risk register for each review. • Board sub-committees should receive the finalised internal audit plan for 2017/18 for information, highlighting audits which are assigned to their committee for consideration. **Action:** The Internal Audit Manager to make the agreed changes to the internal audit plan for 2017/18 and the Executive Director of Finance and Resources to ensure that the final version of the internal audit plan 2017/18 is made available to the Business and Quality Committees. **Outcome:** The internal audit annual plan for 2017/18 was approved subject to the changes agreed by the Committee.	**Executive Director of Finance and Resources/ Internal Audit Manager**
2017-18 (3a)	**External Audit** **External audit annual plan 2016/17:progress report** The External Audit Manager reported that the audit was proceeding to plan and the external audit annual report for 2016/17 would be presented to the Audit Committee on 26 May 2017. There were no issues of concern to report. **Outcome:** The Committee received and noted the update.	

2017-18 (3b)	**External audit technical update** The External Audit Manager presented the technical update for April 2017. **Outcome:** The Committee received and noted the update.	
2017-18 (4a)	**Annual report and accounts: progress report** The Executive Director of Finance and Resources said that all aspects were being completed to timescale. The draft annual report and accounts for 2016/17 would be made available to Committee members at the informal meeting on the 12 May 2017 and the formal meeting on 26 May 2017. **Outcome:** The Committee noted the update.	
2017-18 (5a)	**Financial controls** **Losses, claims and special payments report** The Executive Director of Finance and Resources presented the report which covered any such transactions made between January 2017 and March 2017. The Chair of the Committee noted that the total value for the reporting period was £33,488 and for the year £84,584. The Chair of the Committee noted that two losses related to petty cash floats. The Executive Director of Finance and Resources advised that systems and processes across the Trust had been re-checked and no significant problems or major concerns had been identified. He said that where possible the level of petty cash floats had been reduced. **Outcome:** The Committee received the losses, claims and special payments report.	
2017-18 (5b)	**Tender and quotations waivers report** The Executive Director of Finance and Resources introduced the report. He advised that the report represented an extract from the 2016/17 register of waivers completed during the financial year. He noted there had been six waivers since the last report in February 2017; the report contained details of the supplier, the rationale for the waiver and the authorisation process within the Trust. **Outcome:** The Committee received the report and the content was noted.	
2017-18 (5c)	**Changes to accounting policy** The Executive Director of Finance and Resources presented the report which provided details of all the changes to the Trust's accounting policies that would be used to present the Trust's annual accounts for 2016/17, having been discussed with Chair of Committee and approved by Chair's Action between meetings of the Committee. **Outcome:** The Committee received the report and noted the changes in accounting policies and annual reporting requirements adopted by the Trust, in order to comply with the Department of Health Group Accounting Manual 2016/17.	
2017-18 (5d)	**Treasury management procedure** The Executive Director of Finance and Resources presented the report and advised that the procedure had been updated as required by the Trust's governance timetable. He said that there had been minimal changes to the procedures since it was last approved by the Committee in 2012 and the Trust's treasury management function was subject to regular audit.	

	The Chair referred to the table containing information on monitoring compliance and effectiveness and asked that the responsibilities assigned to lead officers be reviewed to ensure segregation between the role of monitoring and the role of reviewing compliance of each procedure . **Action:** The Executive Director of Finance and Resources to review the responsibilities assigned to lead officers in monitoring compliance and effectiveness of the procedures. **Outcome:** The Committee noted the changes to the procedures and, subject to a review of the responsibilities of lead officers in relation to monitoring and compliance, the Treasury management procedure was approved.	**Executive Director of Finance and Resources**
2017-18 (6a)	**Board assurance framework 2017/18** The Risk Manager presented the report which provided details of the work undertaken to revise the Board Assurance Framework (BAF) for 2017/18 and the oversight responsibilities of the Senior Management Team and the Board. The Committee noted that the strategic risks had been reviewed and updated by the executive team to ensure full alignment with the strategic risks contained in the operational plan for 2017/18. **Outcome:** The Committee noted the revised BAF 2017/18 and the oversight arrangements.	
2017-18 (6b)	**Committees' annual reports and review of terms of reference** The Chair referred to the reports prepared by the Company Secretary. This item contained the Audit Committee's annual report, annual reports from other committees, annual review of committee effectiveness and a proposed change to the terms of reference for the Audit Committee. The Chair reviewed the reports for each committee. *Nominations and Remuneration Committee* The Chair of the Committee asked for the table recording attendance to be corrected to reflect that she did not attend in March 2017. *Audit Committee annual report 2016/17* The Chair of the Committee asked for a typographical error to be corrected in paragraph 4.7.1 and a stronger reference to be included in the internal audit section to the Committee's role in relation to the increasing cyber security risk. **Action:** The Executive Director of Finance and Resources to include a stronger reference to the Committee's role in relation to the cyber-security risk. *Audit Committee terms of reference* The Committee noted the paper prepared by the Company Secretary which set out a change to the Committee's terms of reference to accommodate the establishment of the information governance group as a sub group of the Audit Committee. The proposed change was agreed. **Outcome:** The Committee noted the annual reports from the other committees and the assurances they contained, approved the change to the terms of reference of the Audit Committee and recommended that the Audit Committee annual report be submitted to the Board for approval.	**Executive Director of Finance and Resources**

2017-18 (6c)	**Non–compliance with standing orders and standing financial instructions** There were no matters of non-compliance to report.	
2017-18 (7a)	**Minutes for noting** Information governance group: 22 February 2017 The Chair of the Committee referred to Item 6(b) on the minutes and requested a paper setting out the responsibilities of the Information Governance Group in relation to the Caldicott principles for 26 May 2017. **Action:** A paper setting out the responsibilities of the Information Governance Group in relation to the Caldicott principles to be available to the Committee on 26 May 2017.	**Executive Director of Finance and Resources**
2016-17 (8)	**Audit Committee work plan** There were no matters removed from or changes made to the work plan.	
2016-17 (9)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to be referred to Board colleagues: • 2016/17 Internal audit progress • IT cyber security update and resilience/business continuity planning • Finalised internal audit plan 2017/18; committees to receive the finalised plan • Board and sub-committees' annual reports 2016/17	
2016-17 (10)	**Any other business** There were no matters for discussion.	
	Date and time of next meeting Friday 12 May (internal meeting) 2017 9.00am-11.00am, Boardroom, Stockdale House Leeds Community Healthcare LS61PF Friday 26 May 2017 9.00am-11.30am Boardroom, Stockdale House Leeds Community Healthcare LS61PF	

Leeds Community Healthcare NHS Trust

Agenda item 2017-18 (37aii)

Audit Committee

Room 1, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Friday 26 May 2017
9.00 am – 11.00 am

Present:	Jane Madeley (JM)	Chair
	Richard Gladman(RG)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Vanessa Manning	Company Secretary
	Jackie Rae	External Audit Manager (KPMG)
	Peter Harrison	Head of Internal Audit (TiAA Limited)
	Tim Norris	Internal Audit Manager (TiAA Limited)
	Cherrine Hawkins	Deputy Director of Finance and Resources
	Sue Ellis	Director of Workforce (for Item 16b)
	Richard Slough	Assistant Director of Business Intelligence, Systems and IT (for Item 19)
Apologies:	Elaine Taylor-Whilde	Non-Executive Director
	Clare Partridge	External Audit Partner
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2017-18 (15)	**Welcome, introductions and preliminary business** The Chair welcomed members and attendees.	
2017-18 (15a)	**Apologies** Apologies were noted from Elaine Taylor-Whilde and Clare Partridge.	
2017-18 (15b)	**Declarations of interest** There were no declarations of interest.	
2017-18 (15c)	**Minutes of the previous meeting 28 April 2017** The minutes of the meeting held on 28 April 2017 were reviewed and agreed as an accurate record. Committee members had met informally to review the draft annual report and accounts in detail on Friday 12 May 2017; no minutes had been taken of this meeting.	
2017-18 (15d)	**Actions' log** The completion of actions from previous meetings was noted. **Matters arising from the previous meeting held 28 April 2017** There were no further matters raised from the minutes of the previous meeting.	

2017-18 16(a)	**Internal audit 2016/17** **Progress against internal audit annual plan 2016/17: management actions against priority 1 and 2 recommendations** The Internal Audit Manager presented a paper prepared in response to the Committee's request for further explanation and background on the seven priority 1 and 2 recommendations from the 2016/17 audits annotated as considered but not implemented. The Committee noted the explanations, actions taken and internal auditor's conclusions against each of the recommendations. The Chair of the Committee said that in future for this exercise Internal Audit should be reviewing the implementation of agreed actions not necessarily their original recommendations. In the future where agreed actions are no longer judged to be relevant to implement by the Executive member responsible, the Committee should have the opportunity to review the rationale for that conclusion and determine whether it was appropriate or not. In response, the Internal Audit Manager said that that a different approach would be adopted for audits completed during 2017/18 to ensure that a similar situation did not occur again. **Outcome:** The Committee accepted the explanation and rationale behind the management decisions not to implement the seven priority 1 and 2 recommendations for audits completed during 2016/17. A different approach would be developed for recommendations which fell into the same category in future to ensure the Committee was sighted on the decisions made.	
2017-18 16(b)	**Statutory and mandatory training audit** The Internal Audit Manager presented the final audit report for 2016/17 on the statutory and mandatory training. The executive summary and management action plan were included in the report which indicated a limited assurance opinion and contained three urgent and three important recommendations. The Internal Audit Manager highlighted the key findings: • Compliance level had dropped from 90.3% in January 2017 to 86.7% in February 2017 against a target of 95%. • IT issues were preventing staff accessing and completing e-learning on fire safety and a number of safeguarding topics. • Compliance was based on topic and not on individual employees and thus over inflated the compliance percentages reported in the monthly performance report. • Four out of a sample of five agency staff had not been appointed through CLaSS and subject to the contractual requirement that agency staff must have relevant and up to date statutory and mandatory training. The Chair of the Committee welcomed the Director of Workforce to the meeting and invited her to comment on the key findings from the audit. The Director of Workforce reported that between January 2017 and May 2017 national changes had been made to the Electronic Staff Record (ESR), these changes had affected its compatibility with local IT systems and impacted on the ability of staff to access e-learning packages. She advised that the Trust's IT department was working to resolve the problem and she hoped a solution would be in place to resolve access to fire safety training by the end of June 2017. She explained that on safeguarding and Mental Capacity Act topics staff could access	

	alternative training to provide and evidence compliance without completing the modules on ESR. The Chair of the Committee asked about steps being taken to remind staff about the requirement to keep up to date with statutory and mandatory training and, that if they were unable to access the training through ESR, how managers encouraged them to be pro-active in accessing the alternative training available. The Director of Workforce advised that a communication had been placed on the Trust's intranet directing staff to the appropriate alternative training modules. The Director of Workforce advised that the decision to report compliance by the topic and not by employee had been taken by the Senior Management Team (SMT). Following the recommendation made by the internal auditors, SMT would discuss the future recording of compliance in June 2017. The Chair of the Committee expressed support of the internal audit position that compliance data should be based on employee rather than topic in order to obtain an accurate picture. The Chair of the Committee referred to the recommendation about agency staff engaged outside the CLaSS framework and asked how confident the Trust was that these staff had relevant and up to date statutory and mandatory training prior to engagement. The Director of Workforce advised that a communication had been sent to all managers and staff reiterating that agency staff must be engaged through CLaSS in order to secure the correct quality of staff and to help ensure compliance with statutory and mandatory training requirements. For agency staff employed outside the CLaSS framework, checks would be introduced every six months. The Committee noted the recommendation relating to nine topics that feature on the statutory and mandatory training needs analysis but were not currently recorded on ESR. The Chair of the Committee observed that not recording these courses provided an incomplete view of the Trust's compliance. The Director of Workforce advised that this recommendation would also be escalated to SMT for discussion in June 2017. In conclusion the Chair of the Committee urged the SMT to consider all the audit recommendations without delay and asked for a further short report to be brought to the Committee on 21 July 2017. **Action**: A further report to be brought to the Committee on 21 July 2017. **Outcome:** The Committee received and noted the audit report on statutory and mandatory training, the priority 1, 2 and 3 recommendations and the management action plan.	**Director of Workforce**
2017/18 16(c)	**Internal audit annual report 2016/17 and Head of Internal Audit opinion** The Head of Internal Audit introduced the final year-end report and stated that the opinion was that reasonable assurance could be given that there were adequate and effective management, control and governance processes to manage the achievement of the Trust's objectives. **Outcome**: The internal audit annual report and overall opinion for 2016/17 was noted.	

2017-18 (17a)	**Annual report 2016/17** The Executive Director of Finance and Resources advised that the Chief Executive had attended the informal meeting on 12 May 2017 to present the Trust's draft annual report to the Committee. He invited the Company Secretary to update the Committee on developments since that meeting. In introducing the report, the Company Secretary advised that the draft annual report 2016/17 retained annotations to reflect the actions taken in response to comments made by the Committee's members on 12 May 2017. The Chair asked the auditors for their comments. Both the external auditors and internal auditors indicated that the contents of the annual report showed a consistent picture with their own findings and observations of the Trust. In reply to the External Audit Manager, the Company Secretary confirmed that directors had provided confirmation that all relevant information had been disclosed. The Chair thanked officers for the work in drafting the annual report**.** **Outcome:** The Committee: • noted the draft annual report, including the annual governance statement • received assurance from external auditors that the draft annual report was compliant with guidance as set out in the manual for accounts • recommended the draft annual report for adoption by the Board at its meeting on Wednesday 31 May 2017.	
2017-18 (17b)	**Annual accounts 2016/17** The Executive Director of Finance and Resources introduced the annual accounts for 2016/17. He explained that the annual accounts would be made available to the public as part of the Trust's annual report; the content of the report and the accounts being prescribed by the Department of Health. He added that the accounts were to be presented to the Board and subsequently submitted to the Department of Health on Wednesday 31 May 2017. The Executive Director of Finance and Resources also reported that the external auditors had undertaken a detailed examination of the annual accounts and reviewed mandatory disclosures in the annual report; their findings being contained in the ISA 260 audit memorandum to KPMG's audit of the 2016/17 financial statements. The report from KPMG had contained no significant issues. The Executive Director of Finance and Resources referred to the informal meeting held for the Committee's members on Friday 12 May 2017 which had provided members with the opportunity for detailed consideration of elements within the accounts. The Chair agreed that the informal meeting had proved very helpful and thanked the director and his team for their work in producing the accounts. The Executive Director of Finance and Resources introduced the required statements and certificates for signature and inclusion in the annual report and accounts to be approved at the Board meeting on Wednesday 31 May 2017.	
2017-18 (17c)	**Financial statements 2016/17: letter of representation** The Executive Director of Finance and Resources referred to the draft formal letter of representation made by the Trust to the external auditors.	

2017-18 (17d)	**Financial statements 2016/17: ISA 260 audit memorandum** The External Audit Manager reported that all audit work had been completed. She introduced the report and said that the external auditors intended to issue an unqualified audit opinion on the accounts following adoption by the Board. She added her thanks to the Trust's finance team for their work to support the audit work plan. The External Audit Manager reported that there were no unadjusted audit differences. She added that three recommendations had been made as a result of work on; timely review of bank reconciliations, fixed assets revaluation and authorisation of journals. None of which were fundamental or material. She confirmed that the annual governance statement and the annual report had been reviewed and there were no matters to be raised. The External Audit Manager expanded on a number of areas in the report: • The reporting of property, plant and equipment values and impairments in the financial statements • The level of prudence within key judgements in the financial statements and the strength of the statement of financial position given the additional expectations on NHS Trusts in 2016/17 • The findings from the significant risk based value for money work. The Chair of the Committee said that she had been pleased to receive the satisfactory report and that this evidenced robust financial management during the course of the year. **Outcome:** The Committee received the annual accounts and (subject to the ISA 260) recommended the adoption of the accounts by the Board at its meeting on Wednesday 31 May 2017.	
2017-18 (18a,18b &18c)	**Charitable funds annual report and accounts 2016/17** It was confirmed that the Audit Committee would receive the Trust's charitable fund's accounts at a subsequent meeting. The charitable funds accounts were to be presented to the Audit Committee on 21 July 2017 and then be received by the Charitable Funds Committee in September 2017.	
2017-18 (19) **2017-18 (19a)**	**Internal audit follow up actions** The Chair of the Committee welcomed the Assistant Director of Business Intelligence, Systems and IT to the meeting. *Item 19a(i) Contract bid process* The Executive Director of Finance and Resources reported that to address concerns about external stakeholder management an external communications strategy was being developed including plans to increase capacity within the Communications Team to allow for more external engagement. *Item 19a(ii) NHS Digital penetration testing report* The Assistant Director of Business Intelligence, Systems and IT presented the report which provided an update on the progress made to complete the actions identified in the Penetration Testing Report conducted on behalf of the Trust by Info-Assure. The Committee discussed the outcomes from the report and the Trust's responses to the findings and recommendations.	

	A Non-Executive Director (RG) referred to the number of recommendations which identified updating out of date software to mitigate the risks identified in the report. He expressed concern that the Trust was unable to install the most up to date software packages because they were not compatible with the outdated systems which currently supported the Electronic Staff Record and the Leeds Care Record. The Executive Director of Finance and Resources explained that the Trust had no authority to request that Leeds Care Record up-date their systems but the issue could be raised with the Leeds Informatics Board which runs the system. **Action:** The Chair of the Committee asked the Executive Director of Finance and Resources and the Assistant Director of Business Intelligence, Systems and IT to consider problems related to the interaction between the IT systems and how this could be resolved. Referring to the recommendation to update the remote access software the Chair of the Committee noted that the delivery of the new remote access solution was scheduled for September 2017 and she asked if this date could be brought forward. **Action:** Consideration to be given to delivering the new remote access solution earlier than scheduled. The Chair of the Committee observed that one recommendation made reference to a weak password policy and asked what steps the Trust was taking to encourage staff to use more complexity when selecting passwords. **Action:** The Assistant Director of Business Intelligence, Systems and IT said that he would consider including an item in Community Talk and the next edition of Risky Business. *<u>Item 19a(ii) SystmOne resilience</u>* The Assistant Director of Business Intelligence, Systems and IT advised that the Trust's Emergency Planning Manager would lead a Trust wide cyber security test designed to further test the business continuity plan in June 2017. The outcome and learning from the exercise would be reported back to Committee at the meeting on 21 July 2017. The Chair of the Committee said that in light of the events on 12 May 2017 the Trust should consider conducting the cyber security exercise as a matter of urgency and also seek a formal assurance from the SystmOne external provider (TPP) on their ability to maintain service in the event of a major failure. **Action:** The Executive Director of Finance and Resources agreed to raise the possibility of escalating the cyber security exercise with the Chief Executive and approach TPP for the assurance requested by the Committee. *<u>Item 19a(iii) Information governance group: responsibilities under the Caldicott principles</u>* The Executive Director of Finance and Resources presented a paper prepared in response to a request from the Committee for clarity on the background, context and responsibilities of the Information Governance Group in relation to the Caldicott principles.	**Executive Director of Finance and Resources** **Executive Director of Finance and Resources** **Assistant Director of Business Intelligence, Systems and IT** **Executive Director of Finance and Resources**

	Outcome: The Committee received and noted the: • update on contract bid process • update on the NHS Digital penetration testing report • update on the cyber security exercise • report on the information governance groups responsibilities under the Caldicott principles	
2017-18 19(b)	**Internal audit annual plan 2017/18** The Internal Audit Manager presented the internal audit annual plan for 2017/18. He explained that the plan had been revised to take account of the comments made by the Committee at the meeting on 28 April 2017. All audits were aligned with the BAF and risk register and assigned to an executive lead and a board sub-committee. A total of 240 audit days had been factored into the plan. The Company Secretary confirmed that this version of the internal audit plan for 2017/18 had been made available to the Business and Quality Committees. **Outcome:** The internal audit annual plan for 2017/18 was approved.	
	Peter Harrison (TiAA) Tim Norris (TiAA) withdrew from the meeting for item 20.	
2017-18 (20)	**Internal audit: Contract bid extension** The Executive Director of Finance and Resources introduced the paper which had been prepared to support the extension of the contract with TiAA Ltd for the provision of internal audit services for 12 months. The Executive Director of Finance and Resources advised that the Trust had tendered for internal audit services in 2015 and TiAA Ltd had been appointed. The contract duration was for two years with an optional extension of one year. The contract formally ceased on 31 March 2017, although provision was made to ensure the work relating to the 2016/17 financial year was concluded. The Executive Director of Finance and Resources proposed that the Trust take up the option to extend the contract with TiAA Ltd to continue providing internal audit services for the financial year 2017/18. **Outcome:** The Committee approved a one year extension of the TiAA Ltd contract.	
2017-18 (21)	**Committee's Workplan** There were no matters removed or changes made to the workplan.	
2017-18 (22)	**Matters for the Board and other committees** The Chair noted the annual report and accounts would appear as substantive items on the Board agenda for the meeting on Wednesday 31 May 2017.	
2017-18 (23)	**Any other business** <u>*Cyber security incident*</u> The Chair of the Committee Assistant invited the Director of Business Intelligence, Systems and IT to reflect on the cyber security incident on Friday 12 May 2017. The Assistant Director of Business Intelligence, Systems and IT said he was pleased to report that the Trust had no reported incidents of the ransom-ware virus which had affected many NHS organisations. He said that, thanks to the informatics staff, general managers and on-call managers the Trust's clinical and business systems had operated as normal and the business continuity plan had worked well.	

	The Chair of the Committee asked what more could be done to improve communications to staff following a cyber-security incident. The Assistant Director of Business Intelligence, Systems and IT said that a report on 'lessons learnt' would be presented to the SMT in due course and if necessary an action plan developed. The Chair of the Committee advised that the Committee would seek further periodic assurance on the implementation and compliance with guidance issued by NHS Digital and NHS Improvement and asked for the report on 'lessons learnt' and the SMT's response to be made available to the Committee in due course. **Action:** The report on 'lessons learnt' and to be shared with the Committee following consideration by the SMT.	**Executive Director of Finance and Resources**
	Date and time of next meeting Friday 21 July 2017 9.00 am – 11.30 am Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	

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NHS
Leeds Community Healthcare
NHS Trust

Quality Committee
Monday 24 April 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

AGENDA ITEM 2017-18 (37bi)

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Caroline McNamara	Clinical Lead for Adult Services
	Karen Worton	Clinical Lead for Children's Services
	Elaine Goodwin	Clinical Lead for Specialist Services
	Vanessa Manning	Company Secretary
	Debbie Myers	Professional Lead for Nursing and Head of Clinical effectiveness (item 2 only)
	Karen Benton	Service Lead, SLIC and CICU (item 2 only)
	Sarah Crabtree	Unit Manager, SLIC (item 2 only)
	Rhian Wheater	Unit Manager, CICU (item 2 only)
Minutes	Vanessa Manning	Company Secretary
Apologies	Elaine Taylor-Whilde	Non-Executive Director
	Dr Amanda Thomas	Executive Medical Director
	Stephanie Lawrence	Deputy Director of Nursing
	Mo Drake	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (1a)	**Welcome and Apologies** The Chair opened the meeting and welcomed everyone, particularly representatives from the adults' inpatients' units. He indicated that a significant focus for the meeting would be the key issues in the Director of Nursing's report along with a number of further items presented to provide assurance. Apologies were received from Elaine Taylor-Whilde, Mandy Thomas, Steph Lawrence and Mo Drake.	
2017-18 (1b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (1c)	**Minutes of meeting held on 20 March 2017** The minutes were reviewed for accuracy. The Trust Chair raised the matter of a letter to be written to staff making presentations to the Committee. The briefing letter to be written, in the Committee Chair's name, by the Deputy Director of Nursing (item 2016-17 (82)). The remaining minutes were agreed as a true record of the meeting.	

2017-18 (1d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. In addition, the following were noted: <u>2016-17 (56a) Service spotlight: young offenders institutions</u> The Executive Director of Nursing explained that two courses of action were being explored with the Service Lead in relation psychological support for staff; once evaluated, the best approach would be implemented. (The action remains open).It was confirmed that the 'Schwartz round' principle was not suitable in this service. <u>2016-17 (77a) Board members' service visits</u> The Executive Director of Nursing reported that she anticipated holding a further discussion with SMT colleagues. (The action remains open).	
Service spotlight		
2017-18 (2)	The Executive Director of Nursing introduced colleagues from South Leeds Independence Centre (SLIC) and Community Intermediate Care Unit (CICU). The representatives from SLIC and CICU described a range of quality initiatives, including: monthly governance meetings, use of performance dashboards and quality boards, safety huddles, service visits, engagement with Quality Challenge+ and clinical audits. The units' 'plan for excellence' was also noted. Data was shared in relation to: adherence to safer staffing levels, appraisal rates, statutory and mandatory training, patient feedback, incidents and outcome measures. Measures to minimise falls, pressure ulcers and medication errors (which had previously figured significantly in incident reporting) were discussed. The Trust's Chair observed that the presentation reflected considerable achievement; he particularly welcomed the quality initiatives and noted the reductions in avoidable pressure ulcers and fall causing harm. The Committee was also apprised of the sickness absence and vacancy position and learnt that whilst there were high numbers of agency staff these nurses were often on longer term assignments and so provided good continuity of care. The units' shift patterns were explained; the preference for a 12 hours' shift pattern was seen to offer benefits to staff and patient care. In response to the Trust's Chair, the unit managers explained steps being taken to manage sickness absence; they noted an improvement in short term absences. SLIC and CICU unit managers also explained that the individual patient-centred documentation had been overhauled. The unit had been working to extend patient and family engagement initiatives and the units' representatives outlined developments including the sign up to 'John's Campaign' which enabled visiting to dementia patients at any time. The Committee's Chair thanked the staff members from SLIC and CICU for attending the meeting and he noted the receipt of awards and the positive feedback from the CCGs following recent quality visits.	

Quality governance and safety		
2017-18 (3)	**Director of Nursing: quality and safety report** The Executive Director of Nursing presented the report and highlighted the main areas of focus: • Incident reporting: low and no harm incidents • Pressure ulcers' incidence • Medication administration errors • Venous thromboembolism (VTE) risk assessment recording • Quality governance issues at Hannah House • Duty of candour (DoC) • Quality Challenge + ***Incident reporting: low and no harm incidents*** The Committee discussed the reporting of no harm and minimal harm patient safety incidents, whilst numbers had been lower through 2016/17 an improved position had been noted in March 2017. The Committee examined the benchmarked position with other community trusts (based on nationally reported data for nine months from April 2016). During April to September 2016 the Trust had been in the top 25% for no harm patient safety incidents and amongst trusts of similar size and demographics the Trust had the highest reporting rate. The Trust's Chair welcomed the information and indicated that he felt this offered **reasonable assurance** in relation to the Trust's procedures. The current target of reporting 70% of incidents as no harm incidents was being reviewed; but an alternative based on learning from incidents would need to be defined in measurable terms. In reply to the Committee's Chair, it was confirmed that a revised or new measure would be agreed in May 2017. **Action:** Revised or new measure for low and no harm incident reporting to be advised to Committee at meeting on 22 May 2017 ***Duty of candour (DoC)*** From March 2017, compliance with requirements was being reported against investigated and closed cases. This had resulted in 100% compliance (19 incidents). The Committee was **reasonably assured** that actions to improve compliance had proved effective. The Trust's Chair noted the previous request for a full report for October 2017 to evidence best practice was embedded amongst staff at all levels. ***Quality Challenge+*** The Committee was informed about progress with the implementation of theTrust's quality assessment framework as at March 2017. 52 services had submitted a self-assessment (13 rated as good and 39 as requires improvement) against the 10 standards. 12 services had rated themselves as inadequate against one standard; all of which were now the subject of additional planned support. The Executive Director of Nursing explained that self-assessments were validated by quality visits; 18 had taken place between September 2016 and March 2017. The visits process was welcomed by staff teams; it validated the work of teams and was proving helpful in shaping action plans.	**MP**

	The Chief Executive said that the overall approach and the range of resources (including completed self-assessments) available to staff on the intranet was impressive. The Clinical Lead for Specialist Services indicated to the Committee that the process was not applicable in police custody settings. The Committee's Chair commented on the fact that issues at Hannah House had not been identified through the Quality Challenge+ process prior to the recent CQC inspection. ***Pressure ulcers*** The Committee noted the continued work on reducing the incidence of pressure ulcers; the total number reported in March 2017 was 74 and represented an increase. The Executive Director of Nursing outlined a review of the number and conversion rates of unstageable pressure ulcers for 2016/17 which had shown that of 135 unstageables, eight had debrided to category 3 or 4. However, a further 49 were still subject to investigation. The Committee's Chair stated that the concern lay in the fact that category 3 or 4 pressure ulcers may remain 'hidden' in the categorisation of unstageable; the Executive Director of Nursing undertook to discuss this further with the Executive Medical Director outside of the meeting. **Action:** Further discussion on the conversion rate of unstageable pressure ulcers to be held with the Committee's Chair. The Clinical Lead for Adult Services added that document audits were indicating regular re-assessment and a greater level of scrutiny. The Trust's Chair reinforced the need for sustained progress in the face of service pressures and he asked that this message be conveyed to staff. In this context, the update was deemed to provide **reasonable assurance.** ***Venous Thromboembolism (VTE) risk assessments*** The Committee was informed that the percentage VTE risk assessments completed as reported in the safe and caring domains' report of the performance brief had shown some improvement. However, the Committee noted the continued delay in reporting and requested confirmation of timely access to IT systems for new clinical staff so as to mitigate the risk of system-related delay in recording. Following an enquiry at an earlier meeting, it was confirmed that the recording of assessments by administrative staff was not appropriate. Due to the fact that the recorded figure was still significantly under target, the Committee concluded that the update provided only **limited assurance.** ***Medication errors: insulin administration*** The Committee was advised that there had been 281reported medication incidents in the three month period to March 2017 (175 attributable to the Trust of which 165 resulted in no harm). The administration of insulin remains the main concern featuring in three out of the incidents relating in harm. There was also a total of seventeen missed insulin administration visits by neighbourhood teams in the third quarter of 2016/17.	**MP**

	The Head of Medicines Management explained that there had been changes in national guidance and practice and the matter remained a complex area. The Committee's Chair said that performance, whilst in the context of severe service pressure, remained disappointing, needed to receive renewed focus and only offered **limited assurance.** He asked that a fuller standalone report be brought to Committee in July 2017. It was noted that he Clinical Effectiveness Group was to hold a workshop on this topic in May 2017. **Action:** A report on medication errors be presented to Quality Committee, 24 July 2017 ***Hannah House*** The Executive Director of Nursing reported on progress with action plans related to medication administration, instigated following the CQC visit to Hannah House, was reviewed. Actions to remedy issues had included: medicines management training and review of competencies, review of standard operating procedures, record keeping and parental roles and responsibilities. The Committee's Chair questioned how the Trust had missed the issues until the CQC inspection. The Executive Director of Nursing agreed that this needed scrutiny and agreed to the proposition that a small multidisciplinary group be set up to consider this as a system failure and to identify any further lessons. Taking account of the significant amount of work, the Committee noted only **limited assurance** **Action:** A small multidisciplinary group be set up to consider the system failure that led to the non-identification of issues at Hannah House. ***Adult services business unit*** The Clinical Lead for Adult Services referred to the increased use of quality board and safety huddles; and indicated that these were becoming embedded in neighbourhoods' governance. One neighbourhood had celebrated a 'harm free' month. She also reported on progress with clinical supervision and clinical skills competency assessment. The Clinical Lead for Adult Services went on to outline challenges, particularly sickness absence. Absence in teams varied from 3% to 10%. The Executive Director of Operations added that continuing focus was bringing about results in both absence management and recruitment but that capacity was still constrained. In reply to the Trust's Chair, the Clinical Lead for Adult Services said that additional initiatives were proving beneficial; deployment of leadership resource at weekends was improving confidence in out of hours' decision making. The Chief Executive agreed that access to senior staff, seven days a week was essential for effective leadership of caseload and capacity management. ***Children services' business unit*** The Clinical Lead for Children's Services reported on positive recruitment in some services eg ICAN and speech and language therapy. Linked to recent demand and capacity analysis pathway development work was being extended. She added that, in March, there had been significant focus on clinical supervision statutory and mandatory training and sickness absence management.	**MP** **MP**

	The Committee's Chair noted that a significant number of overdue incidents were attributable to the CAMHS inpatients' unit; he added that this was not acceptable. The Clinical Lead for Children's Services confirmed that there was a large number of open and not processed incidents but there was an action plan and timeline in place to address the issue and avoid further backlog. ***Specialist services' business unit*** The Clinical Lead for Specialist Services reported on the recent, well-received visit of a non-executive director to police custody sites. She also referred to the positive feedback following the CQC inspection of YOI locations in March 2017. The Clinical Lead for Specialist Services also reported on services challenges: recruitment and morale in dental services, sickness absence and a planned delay in the roll out of the electronic patient record. The Executive Director of Operations referred to recent incidents whereby deaths had been recorded for a small number of patients who had been waiting for routine speech and language therapy. Following further work, assurance was provided that deaths were due to unrelated issues and that no areas of concern had been identified. The matter of reporting deaths on caseloads but not as incidents was being discussed at the Mortality Surveillance Group. **Outcome:** The quality and safety contents were noted and actions endorsed.	
2017-18 (3b)	**Performance brief and domain reports** The Committee reviewed the document. In relation to the safe and caring domains, the Committee's Chair noted the year-end forecasts. The Executive Director of Nursing referred to the venous thromboembolisms (VTE) risk assessment and the current delay between assessments and reporting; improvement in March 2017 would need to be sustained. The reporting of low and no harm incidents also had improved in March 2017, but was still significantly below target. The Executive Director of Nursing informed the Committee that the CQUIN outturn data for quarter 4 2016/17 was not available and work to refine CQUIN requirements for 2017/18 was still progressing. The Head of Medicines Management outlined discussions with the Head of Business Intelligence about the NICE compliance guidance measure for 2017/18. **Outcome:** The Committee noted the contents of the performance report for March 2017.	
2017-18 (3c)	**Risk register: clinical risks** The Company Secretary presented the report which was written in a summary style and recorded the changes since the last report (March 2017). She noted that there were no new clinical risks There was one escalated clinical risk (waiting times for podiatry for diabetic patients); the score had been increased for 9 to 12. Three risks had been de-escalated whereby capacity and caseload situations had improved and had been determined to be of a lesser risk.	

	The Trust's Chair indicated that there were clear themes related to staff capacity resulting from recruitment and retention challenges and that these, in turn, could impact on waiting times for care services. He added that he had urged the Business Committee to ensure that all avenues were explored sufficiently. The Committee's Chair concurred and noted that this was a national as well as a local concern. **Outcome:** The Committee noted changes in clinical risks	
2017-18 (3d)	**Board assurance framework (BAF) 2017/18** The Committee received the Board assurance framework (BAF) for 2017/18 and scrutinised in detail those strategic risks which were aligned with the work of the Committee. The Company Secretary explained that, on an ongoing basis, the Committee would review the sources of assurance presented and determine assurance in line with the risk assurance levels. The Trust's Chair welcomed the clarity of: risk descriptions, controls to prevent or reduce risk and sources of assurances which would evidence that the Committee was considering items related to identified risks. The Committee's Chair particularly noted the risk related to patient and public engagement; he added that he felt that this topic was under-represented in Committee's discussions and he requested a full report for September 2017. **Action:** A full paper on patient and public engagement activity and outcomes to be developed for Committee on 25 September 2017 **Outcome:** The Committee noted the contents of the BAF 2017/18 and those risks assigned to the Committee for oversight.	**MP**
Clinical Effectiveness		
2017-18 (4)	**Clinical audit programme 2017/18** The Executive Director of Nursing introduced the clinical audit programme for 2017/18. The Committee heard that the programme had been developed following a robust and consultative process and comprised: 33 mandatory audits, 40 recommended audits and a further 44 audits which had been determined locally. Further audit work (up to an additional 10%) may be required in year for additional high risk or essential audit. The Committee's Chair said that the programme should show alignment with the Trust's main risks and that, within the programme, prioritisation should be given to audits linked to known risk areas in order that the programme (and its subsequent outcomes) would provide assurance about the quality of services. The Executive Director of Nursing agreed that alignment of audits with risk factors was important. She referred to the skills audits and holistic assessment audits which were underpinned by staff capacity issues.	

	The Trust's Chair noted the volume of audits and said that there should be some ranking in priority order linked to areas of greatest concern and that audits were a means of providing assurance that risks were being managed. The Executive Director of Nursing replied that national audits were of the highest priority followed by those that would have the most impact on services. **Outcome:** The clinical audit programme for 2017/18 was approved.	
Reports and minutes for approval or noting		
2017-18(5a)	**Board members' service visits** The paper was received for assurance and the contents of reports from visits were noted. The Executive Director of Nursing confirmed that reports were seen by services prior to inclusion in the report by way of feedback. The Committee's Chair indicated that it would be valuable to see a forward programme of visits for the next six months **Action:** A six month schedule of visits to be developed for 26 June 2017 meeting **Outcome:** The report of recent service visits and schedule of future visits was noted and provided **reasonable assurance.**	**VM**
2017-18 (5b)	**Visits to service by clinical commissioning group (CCG)** The Committee received the reports from two informal visits to the Trust by representatives of the commissioning CCG. The visits had been to: • Community Intermediate Care Unit (CICU) service on 9 November 2016 • Community Eating and Drinking service on 20 January 2017 **Outcome: The reports and recommendations were noted.**	
2017-18 (5c)	**Mental Health Act Governance Group: draft minutes 17 March 2017** The Committee's Chair raised three items from the draft minutes and asked that these outstanding matters be addressed without delay, the items related to: • The need to clarify whether peer review of record-keeping is good practice or mandatory • Overdue training requirements • Outstanding memorandum of understanding: Mental Health Act Managers **Action:** The Clinical Lead for Children's Services to investigate and email the Committee's Chair **Outcome:** The draft minutes were received.	**KW**
2017-18 (5d)	**Patient Safety and Experience Group: draft minutes 16 December 2016** The Committee's Chair noted that there had been cancelled meetings. He asked that the group be reconvened and develops a clear workplan for subsequent meetings. **Action:** The group's workplan and schedule of meetings be updated **Outcome:** The draft minutes were received.	**MP**

2017-18 (5e)	**Clinical Effectiveness Group: draft minutes 16 February 2017** **Outcome:** The draft minutes were received.	
2017-18 (5f)	**Safeguarding Children and Adults Group: draft minutes 17 February 2017** ` **Outcome:** The draft minutes were received.	
2017-18 (5g)	**Mortality Surveillance Group: draft minutes 3 February 2017** **Outcome:** The draft minutes were received.	
2017-18 (6)	**Quality Committee workplan** Future work plan was received for information	
2017-18 (7)	**Matters for the Board and other committees** It was agreed that the Committee's Chair would produce the assurance report for the Board, covering: • Incident reporting: low and no harm incidents • Medication administration errors • Venous thromboembolism (VTE) risk assessment recording • Quality governance issues at Hannah House • Duty of candour (DoC) • Quality Challenge + • Clinical audit • Board assurance framework	
2017-18 (8)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 22 May 2017 Monday 26 June 2017 Monday 24 July 2017 Monday 25 September 2017 Monday 23 October 2017 Monday 20 November 2017	

NHS
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AGENDA ITEM 2017-18 (37bii)

Quality Committee
Monday 22 May 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair
	Marcia Perry	Executive Director of Nursing
	Dr Amanda Thomas	Executive Medical Director
In Attendance	Carolyn Nelson	Head of Medicines Management
	Caroline McNamara	Clinical Lead for Adult Services
	Karen Worton	Clinical Lead for Children's Services
	Sam Childs	Clinical Lead for Specialist Services
	Vanessa Manning	Company Secretary
	Mo Drake	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience
	Lucy Hall, Kirsty Jones & David Jennings	Chapeltown & Middleton Neighbourhood Team (Item 10)
	Rebecca Le-Hair	Clinical Governance Manager (Items 11a – 11d)
	John Walsh	Freedom to Speak Up Guardian (Item 12a)
	Dr Steve Bradley	Guardian for Safe Working Hours (Item 12b)
Minutes	Bridget Lockwood	Business Support Manager
Observer	Nicola Wood	PA to Executive Director of Nursing
Apologies	Thea Stein	Chief Executive
	Elaine Taylor-Whilde	Non-Executive Director
	Sam Prince	Executive Director of Operations
	Stephanie Lawrence	Deputy Director of Nursing
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (9a)	**Welcome and Apologies** The Chair opened the meeting. Apologies were noted from Thea Stein, Sam Prince, Elaine Taylor-Whilde, Stephanie Lawrence and Elaine Goodwin. Sam Childs attended for Elaine Goodwin.	
2017-18 (9b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (9c)	**Minutes of meeting held on 24 April 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting	

	The Trust Chair asked for clarification as to whether a letter to staff making presentations to the Committee had been drafted and agreed. The Company Secretary agreed to establish this. **Action:** Company Secretary to clarify if a letter to staff making presentations to the Committee had been drafted and agreed.	**VM**
2017-18 (9d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. In addition, the following were noted: 2016-17 (77a) – Board members service visits – The Executive Director of Nursing confirmed that a discussion had taken place at the Senior Management Team where it was agreed that the Executive Director of Nursing would work alongside the Board Administrator and the Clinical Leads to ensure that feedback was provided to the Non Executive Directors following visits. The Committee's Chair asked that the new process be reviewed by the Quality Committee. The Trust Chair also requested that information regarding services be sent to the Non Executive Directors and himself prior to scheduled visits. 2017-18 (5c) Mental Health Act Governance Group – The Committee's Chair stated that he felt that further work was required to establish the requirement for peer review of Mental Health Act record keeping and whether this was being undertaken. The Clinical Lead for Children's Services agreed to follow this up. **Action:** The Clinical Lead for Children's Services to report back directly to the Committee Chair and the Executive Director of Nursing on this matter	**KW**
Service spotlight		
2017-18 (10)	Colleagues from the Chapeltown and Middleton Neighbourhood Teams attended to present an overview of progress, work underway and current challenges. In attendance were Lucy Hall (Service Manager for Chapeltown and Seacroft), Kirsty Jones (Clinical Pathway Lead for Middleton and Kippax) and David Jennings (Clinical Pathway Lead for Chapeltown and Seacroft). The team began by providing an overview of the populations, caseload cluster size, number of referrals and staff profile for both the Chapeltown and Middleton Neighbourhood Teams. The position in the Chapeltown Team was outlined, in summary, as: the rate of leavers had markedly reduced, the team was almost fully staffed, additional leadership had been sourced to support staff, sickness rates had reduced significantly, the appraisal completion rate was above target, handovers took place daily and consistently, and the patient Friends and Family Test returns had increased with plans in place to improve further this year. The Committee noted there had been a reduction in the number of pressure ulcers by one this year and there had been a dramatic reduction in falls. There had been no increase in the number of medication errors and a change in reporting culture had been demonstrated in relation to incidents. On average one complaint was received by the team every two months, not all these were upheld. The team were due to go live on EPR on 17 June 2017 and new ways of working had been rolled out prior to the go live date. Further work was underway in the team included streamlining information and implementing triage systems with clinical co-ordinators, New Models of Care as part of the Leeds	

	Plan, a project to attract staff to work in Chapeltown and Harehills, the Primary Care Home plan, staff safety devices and the launch of the flu campaign in the next quarter. The Committee noted that the team had recently moved to Tribeca House (an Adult Social Care building) and this had assisted in improving staff morale. The position in the Middleton Neighbourhood Team was outlined, in summary, as: a static position regarding sickness over the last year but a much improved position recently following significant sickness rates over the winter period. The vacancy rate was similar to that in the Chapeltown team and it was noted that five new staff nurses were commencing work between May and September which would bring the team up to full establishment. The team had a higher proportion of Band 6 staff in post. Recruitment and retention remained a challenge. Plans were in place to improve appraisal completion rates, it was noted, however that clinical supervision had increased dramatically due to the implementation of weekly safety huddles. The team highlighted a significant improvement in both Friends and Family Test response rates and the proportion of patients who would recommend the service. The position regarding pressure ulcer and falls rates remained similar to the previous year. The Committee noted an increase in the number of medication errors but it was felt that the culture around reporting incidents was improving. A 'shout out' board for staff to highlight those colleagues who had gone above and beyond was going well. The Middleton Neighbourhood Team were in the process of implementing EPR and a new initiative on joint working in care homes was due to commence with Villa Care. Allocation and embedding a named clinician model were additional pieces of work underway. The Trust Chair observed that the team had portrayed a very positive and encouraging position, with significant improvements demonstrated in comparison to the position last year, particularly in Middleton. He acknowledged the amount of work that had been undertaken to get to this position, both within the teams and by the Executive Director of Nursing, the Deputy Director of Nursing and the Clinical Lead for Adult Services. The Trust Chair referred to the data relating to the Neighbourhood Teams shown in the heat map in the Performance Brief and highlighted a concern that the data for February 2017 was out of date by the time it was presented to the Quality Committee. The Clinical Lead for Adult Services commented that this was to allow for the data to be reviewed prior to full consideration of the data by committees. The Trust Chair asked the team to clarify the vacancy rates in each team and went on to ask if deferred appointments remained a challenge. The Clinical Pathway Lead for Middleton responded that the team were not able to cover all non-essential appointments currently. The Service Manager assured the Committee that all appointments were being covered in Chapeltown. The Clincial Lead for Adult Services added that the review of caseload analysis assisted with managing appointments more effectively. The Trust Chair enquired as to progress made relating to self care and self management. The Service Manager confirmed that a large piece of work was underway in the Gateway, particularly regarding Tinzaparin. Work relating to caseload analysis and the roll out of EPR also supported this with a view to	

	standardising across the city. The Trust Chair expressed an interest in reviewing evidence of the impact of this campaign. The Executive Director of Nursing confirmed that the Deputy Director of Nursing was the lead for this piece of work. The Head of Medicines Management also highlighted that information was also collated by the Neighbourhood Team Pharmacy Technicians. The Committee's Chair referred to the disparity between population size and caseload size in the two Neighbourhood Teams. The Clinical Pathway Lead for Middleton responded that a new additional caseload had recently been created in one of the clusters in order to address this issue and the team were part way through a full review of all patient records. The Clinical Lead for Adult Services added that this would assist in planning staff caseloads and would reduce historical practice where patients had been seen routinely without a review of how frequently these visits should occur and when. The Clinical Lead for Adult Services added that a review of the evidence base and clinical practice, led by Pathway Leads, included a review of new to follow up appointments and assured the Committee that this would not be at the expense of clinical judgement. The Executive Director of Nursing reflected on the journey undertaken by the team, and highlighted the importance of data in highlighting referral rates, demand and capacity. The Committee's Chair thanked the team for their time in preparing for and attending the meeting. The Trust Chair asked if a sustainable long term strategy for the Neighbourhood Teams was in place. The Executive Director of Nursing responded that a clear programme of was in place, a new nursing associate role was being introduced, work was underway with the universities on recruiting and training staff for community services, and an improved offer for the third year pathway all demonstrated that a strategy was in place. The Trust Chair highlighted the number of nurses due to retire and the Executive Director of Nursing and Clinical Lead for Adult Services confirmed that work was underway to engage with these staff in exploring options available to them. **Outcome:** given the risk relating to Neighbourhood Teams remained on the risk register at an extreme level, and pressures remained high in other Neighbourhood Teams, the Committee was provided with **limited assurance**.	
Quality governance		
2017-18 (11a)	**Director of Nursing: quality and safety report** The Executive Director of Nursing presented the report, the format of which had been revised in order to ensure the Committee received a broad overview of current issues and concerns, drawing attention to a number of key quality improvement and professional matters. This was supplemented by an enhanced section on quality in the Performance Brief. The Committee were to receive a more comprehensive Director of Nursing quality and safety report on a quarterly basis, including more detailed analysis on trends. The Executive Director of Nursing highlighted the following as the main areas of focus within the Performance Brief and Director of Nursing's quality and safety report: • New indicators relating to low and no harm incidents • Progress against year end summary relating to end of life and preferred	

	place of death indicators • Progress regarding reducing the incidence of pressure ulcers • Update on falls prevention process • Update on reducing the incidence of catheter acquired urinary tract infections • Nursing associate and assistant practitioner roles • Developments in the clinical education team ***Falls*** The Executive Director of Nursing outlined a new approach to falls prevention and falls review in line with the learning acquired from the work relating to pressure ulcer reduction. This included the creation of an action plan which would include actions to be taken in order to achieve an improvement for those in an inpatient setting, and matrix reporting. The Committee's Chair asked that the Committee have the opportunity to review the action plan and associated evidence. **Action:** Falls action plan to be submitted for consideration at the Quality Committee meeting in July 2017. ***Catheter Associate Urinary Tract Infection (CAUTI)*** The Executive Director of Nursing informed the Committee that a group had been formed, led by the Deputy Director of Nursing, in order to establish a more robust means of collating CAUTI data and learning from lapses in care. An action plan would be developed by the group. The Executive Medical Director asked if it was felt that incidences of CAUTI were a particular concern within the Trust. The Executive Director of Nursing responded that to date such incidences were not reported or recorded in a way to establish if this was an area of concern. ***Professional Strategy for clinical staff*** The Executive Director of Nursing referred the Committee to the section in the report on the strategy, including the development of a professional forum for clinical staff. ***Nursing Associate Pilot and Assistant Practitioners*** The Executive Director of Nursing outlined the two workstreams which would look to enable different career structures and career progression into registered posts. It was noted that work was still being undertaken at a national level on the regulatory framework and job descriptions for these roles. The Trust Chair sought clarification on the difference between the Community Matron and Advanced Practitioner roles which the Executive Director of Nursing provided. He also sought assurance that the Assistant Practitioner role would not create any concern amongst the medical workforce. The Executive Director of Nursing confirmed that medical staff had been involved in discussions regarding the new role and areas of responsibility had been clearly defined. The Trust Chair acknowledged that the roles would increase capacity and would attract staff to work within the Trust. The Committee's Chair asked how the Nursing Associate roles were funded. The Executive Director of Nursing responded that the pilots were currently funded through academic institutions.	**MP**

	The Professional Lead for Allied Health Professionals highlighted that a Physician Associate role was also being developed and work was needed to clarify the opportunities this role presented for the Trust. ***Developments in the Clinical Education Team*** The Executive Medical Director asked how successful the move to bring the resuscitation training function in house had been. The Executive Director of Nursing responded that the team had enabled the Trust to enhance the training offered and were assisting in the standardisation of policies. ***Serious Incidents*** The Committee noted that there had been six serious incidents in April 2017 – four Category 3 pressure ulcers and two fractures. The Committee Chair referred to the action plan status summary in Appendix 1 of the report and asked if the figures quoted were cumulative. The Executive Director of Nursing responded that the figures quoted were at a particular point in time. The Clinical Governance Manager confirmed that four out of seven actions currently reported as open were overdue. ***Pressure ulcer prevention*** The Executive Director of Nursing informed the Committee that the Category 3 action plan continued to deliver. The Committee's Chair queried the conversion rate quoted in Appendix 1 of the report. The Executive Director of Nursing outlined a new process which had been implemented which meant that once a pressure ulcer became stageable it would be re-entered on the Datix system. It was agreed to review this process outside the meeting to ensure there was no double counting. The Executive Medical Director observed that it was still not possible to deduce the conversion rate and the emerging information indicated that pressure ulcers could easily be re-categorised as Category 2 when historically it had been felt that they would move to Category 3 or 4. ***Clinical Leads' Quality Reports*** The Clinical Leads for each business unit provided a summary of the reports appended to the Director of Nursing's quality and safety report. It was noted the report relating to Specialist Services needed to be updated. The Committee Chair asked the Clinical Lead for Specialist Services to clarify if the diabetic foot prevention project referenced in the report was funded by commissioners. **Action:** Clinical Lead for Specialist Services to clarify funding for diabetic foot prevention project. **Outcome:** The Committee: • noted the detail, updates and progress within the report • accepted the new report format and detail • agreed that the report provided **reasonable assurance**	**EG**

2017-18 (11b)	**Performance brief and domain reports** The Committee reviewed the document and the following were raised as items for discussion. ***Low and no harm incidents: new indicators*** The Committee noted the introduction of a statistical process control (SPC) chart as a means of identifying trends, with an aggregated range reported monthly, and a quarterly analysis by Business Unit. The Professional Lead for Allied Health Professionals provided clarification regarding how a trend would be identified and at what point a variation needed to be reviewed. The Executive Director of Nursing informed the Committee that the team would continue to benchmark against NRLS data as it is released and that structured interviews were taking place with clinical teams to further understand low and no harm incidents. **Action:** Executive Director of Nursing to include an analysis of interview outcomes in the June 2017 report. ***End of Life care*** The Executive Director of Nursing highlighted the progress made in the Trust's ability to achieve a patient's preferred place of death and the significant increase of verification of death by registered nurses. A number of letters received by the Trust in recent months demonstrated the care shown to families by clinical teams. ***Duty of Candour*** The Trust Chair asked how it was evidenced that an apology had been sent. The Clinical Governance Manager responded that there was a mechanism on Datix when Duty of Candour applied. The Executive Director of Nursing added that the majority of cases related to pressure ulcers, and as part of the root cause analysis a discussion took place about how Duty of Candour was followed. The Trust Chair was assured regarding the process. **Outcome:** The Committee noted the contents of the performance report for April 2017 which provided **reasonable assurance**.	**MP**
2017-18 (11c)	**Risk register: clinical risks** The Company Secretary presented an in depth report which outlined risk movement since the last report received in April 2017. The Committee noted that there were three extreme risks and no new, closed or de-escalated clinical risks. The Company Secretary informed the Committee that in a number of instances it had not been possible to attribute risks as clinical or non–clinical and it was therefore proposed that from June 2017, reports to the Quality and Business Committees would include all operational risks. **Outcome:** The Committee noted the contents of the risk register and the proposal around the future reporting of all operational risks to the Quality and Business Committees.	
2017-18 (11d)	**Quality Account 2016/17** The Committee's Chair reflected that to date the report was the best draft Quality Account he had reviewed at this stage in the process.	

	The Committee noted the accompanying report which outlined the end of year position of the last Quality Account and feedback from commissioners and key stakeholders on the report for 2016/17. Four out of fifteen outcomes remained a concern (zero category 4 pressure ulcers, duty of candour, appraisals and staff engagement). The Clinical Governance Manager informed the Committee that joint Leeds CCGs' feedback on the document had been received and a response would be drafted and signed off by the Executive Director of Nursing shortly. **Outcome:** The Committee: • received the report • noted the final position of the quality improvement priorities for 2016/17 • approved the final version of the Quality Account for 2016/17, with one further addition, for recommendation to the Board for approval on 31 May 2017.	
Safety		
2017/18 (12a)	**Freedom to speak up: guardian's report** The Trust's Freedom to Speak Up Guardian attended the Committee to present the first overview of the work undertaken to date, broad themes which had emerged and recommendations on how the role could be taken forward and developed further. The following were identified as themes that had emerged from work to date: • Issues of capacity and demand • The effects of commissioning decisions and demands, and the resulting impact on patient care • Leadership and culture • Space for people to be heard and share The Committee noted that in the cases reported to the Freedom to Speak Up Guardian staff appeared to be reluctant to speak up under formal routes. It was felt that this was due to concern as to what would happen if an issue was dealt with as whistleblowing, and acknowledged that this was not unique to this Trust. The Committee's Chair asked how the role might be taken forward. The Freedom to Speak Up Guardian responded that he wished to spend more time with teams and working on links between this work and workstreams underway in Human Resources and Organisational Development. He referred to the work that was currently underway regarding culture mapping and how this linked with the role. **Outcome:** The Committee noted the report, activity to date and supported the work to embed the work across the Trust.	
2017/18 (12b)	**Guardian for safe working hours' report** The Trust's Guardian for Safe Working Hours attended to present the report. The Committee noted that there were 25 junior doctors in the Trust. The Guardian for Safe Working Hours had been in post since November 2016 and had devised a system for trainees to report working hours exceptions. He felt that morale was good within the Trust and that the junior doctors had good relationships with their supervisors.	

	The Committee noted the low proportion of time the trainees had within the Trust due to the commitment needed in relation to the acute trust on call rota. This was a particular problem for the Paediatric Service. A discussion took place around how this could be resolved, including a need for the culture to change in order to encourage trainees to report where they were unable to commit sufficient time to training within the Trust. The Committee's Chair asked whether the issue had been reported to The Deanery. It was noted that insufficient evidence had been compiled to enable this. The Associate Medical Director for Children's Services had been charged with progressing this work. The Executive Medical Director thanked the Guardian for Safe Working Hours for his hard work in establishing the processes required under the Guardian role. It was noted that recruitment to find a replacement was underway. The Guardian for Safe Working Hours highlighted the need for administrative support to the role in order to enable the Guardian to spend time working with trainees. The Committee recommended that the Senior Management Team review the position and establish if support could be secured. **Action:** Executive Medical Director to ask the Senior Management Team to review the position regarding the Guardian for Safe Working role The Committee Chair thanked Guardian for Safe Working Hours for his time in presenting the report to the Committee. **Outcome:** The Committee: • Noted the need to appoint a new Guardian for Safe Working Hours • Recommended an SMT review of administrative support to the Guardian • Noted that a shortened version of the report would be submitted to the Trust Board on 4 August 2017	**MT**
Clinical Effectiveness		
2017-18 (13a)	**National Institute for Health and Care Excellence (NICE) guidance compliance update** The Executive Medical Director introduced the Head of Medicines Management, as the author of the report, to provide a summary. It was a requirement that an update on the current NICE compliance status be submitted to the Committee twice a year. The Head of Medicines Management highlighted that, given that the Trust no longer provided the service, York Street Health Practice had been removed from historical reporting. The report format had been changed in order to demonstrate the breadth of the work underway in services in achieving compliance. The Trust Chair asked if the Care Quality Commission's inspection at Hannah House had highlighted any issues in relation to compliance. The Head of Medicines Management confirmed that it had not. The Committee's Chair reflected on the challenge in establishing a meaningful measure and target in terms of implementation. He observed that not all guidance applied to the organisation as a community trust.	

	Outcome: The Committee: • received the report and noted progress to date with implementation of NICE guidance within the Trust • noted the assurance relevant to the dissemination of NICE guidance within the Trust • noted the work underway to reframe the NICE guidance indicator within the effective domain of the Performance Brief.	
2017-18 (13b)	**Patient group directions (PGDs)** The Executive Medical Director introduced the report and provided assurance that all PGDs had been thorough the correct process prior to submission to the Quality Committee. The Committee noted that there were no new PGDs for consideration, and that all were the documents were revised PGDs. The Head of Medicines Management highlighted that the PGD relating to Sayana Press now allowed patients to self-administer which, the Committee was pleased to note, had assisted in managing attendances within the Integrated Sexual Health Service. **Outcome:** The Committee ratified the five approved PGDs as follows: • 037-09 PDD for the administration of Triamcinolone with Lidocaine for Musculoskeletal conditions • 109-04 PGD for Medroxyprogesterone Acetate (Depo-Provera administration only and Sayana Press administration and supply • 070-07 PGD for the administration or supply of Azithromycin • 071-07 PGD for supply of Doxycycline • 072-07 PGD for supply of Erythromycin	
Reports and minutes for approval or noting		
2017-18(14a)	**Internal audit plan 2017/18** The Committee noted the internal audit plan for 2017/18 which outlined 24 audits and associated work, totalling 240 days, an increase from 212 days in 2016/17. Outcomes from relevant audits would be reported to the Quality Committee once available. **Outcome:** The Committee noted the internal audit plan for 2017/18	
2017-18(14b)	**Board members' service visits** The Company Secretary introduced the report which outlined reports received to date and an updated schedule of visits for the next six months. The Trust Chair requested that suggestions be made to Non --Executive Directors regarding which services should be visited. The Trust Chair also requested that clinical leads ensure that information regarding the service be made available to the Non-Executive Directors prior to each visit, and where appropriate, key people within the service be present for the visit. **Action:** Suggestions to be requested as to which services the Trust Chair and Non-Executive Directors should visit. Information regarding services to be visited to be sent to Trust Chair and Non-Executive Directors prior to the date of the visit. **Outcome:** The Committee received the report on non-executive directors' service visits January to June 2017	**VM**

2017-18 (14c)	**Clinical Effectiveness Group: draft minutes 20 April 2017** The Head of Medicines Management had chaired the meeting in the absence of the Executive Medical Director. The Committee was asked to note the Community Diabetes Service Protocol: Adjustment of insulin dose by diabetes specialist nurses which was appended to the minutes and had been approved by the Clinical Effectiveness Group. The Head of Medicines Management outlined the process and possible requirement for nurses to adjust the insulin doses, alongside the patients who were often self managing their condition. The Committee noted that a number of Diabetes Services across the country were operating in this way. **Outcome:** The draft minutes were received.	
2017-18 (14d)	**Safeguarding Committee: draft minutes 21 April 2017** The Committee noted that a number of Serious Case Reviews and homicide reviews had been undertaken. The Executive Director of Nursing highlighted the good work evidenced regarding training and development support to teams. **Outcome:** The draft minutes were received.	
2017-18 (15a)	**Quality Committee workplan – items from work plan not on the agenda** Nothing further to note on this occasion.	
2017-18 (15b)	**Quality Committee future workplan** The future work plan was received for information. The Committee noted that an update on the Quality Strategy was due for consideration the following month, and agreed that the Executive Director of Nursing and Company Secretary would establish if this was to be reported to the Quality Committee on a quarterly basis. **Action:** Frequency of reporting updates to the Committee on the Quality Strategy to be established.	**MP**
2017-18 (16)	**Matters for the Board and other committees** It was agreed that the Committee's Chair would provide a verbal update to the Board at the meeting on 31 May 2017. Items to be reported in include: • Service spotlight on neighbourhood teams • Renewed focus on falls prevention • Clinical professional strategy and new clinical roles • Low and no harm incident reporting • End of life care indicators • Reports from Guardians	
2017-18 (17)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 26 June 2017 Monday 24 July 2017 Monday 25 September 2017 Monday 23 October 2017 Monday 20 November 2017	

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AGENDA ITEM 2017-18 (37biii)

Quality Committee
Monday 26 June 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair
	Marcia Perry	Executive Director of Nursing
	Thea Stein	Chief Executive
	Elaine Taylor-Whilde	Non-Executive Director
In Attendance	Sam Prince	Executive Director of Operations
	Caroline McNamara	Clinical Lead for Adult Services
	Karen Worton	Clinical Lead for Children's Services
	Elaine Goodwin	Clinical Lead for Specialist Services
	Maureen Drake	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience
	Benita Powrie	Head of Service ICAN (Item 19)
	Caroline Schonrock	Business Planning Manager (Item 20e)
Observer	Tim Norris	Internal Audit Manager
Minutes	Nicola Wood	PA to Executive Director of Nursing
	Bridget Lockwood	Business Support Manager
Apologies	Carolyn Nelson	Head of Medicines Management
	Vanessa Manning	Company Secretary
	Stephanie Lawrence	Deputy Director of Nursing
	Dr Amanda Thomas	Executive Medical Director

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (18)	**Welcome and Apologies** The Chair opened the meeting. Apologies were noted from Vanessa Manning, Steph Lawrence, Dr Amanda Thomas and Carolyn Nelson.	
2017-18 (18b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (18c)	**Minutes of meeting held on 22 May 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following amendments: The Trust Chair wished to extend his acknowledgement of the hard work undertaken by the Adult Business Unit and particularly acknowledged the contribution of the leadership team. The Trust Chair asked for assurance that the long term strategy for the neighbourhood teams would provide adequate levels of staffing. The Executive Director of Nursing provided assurance that a number of workstreams were underway including workshops for those nearing retirement age and recruiting nursing students to community services. However, there remained a risk in relation to the success of recruitment campaigns and initiatives.	

2017-18 (18d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. In addition, the following were noted: <u>2017-18 (11a) Director of Nursing quality and safety report</u> The Clinical Lead for Specialist Services confirmed NHS funding had been received for the diabetic foot prevention project. *Action closed.* <u>2017-18 (12b) Guardian for safe working hours' report</u> The Senior Management Team (SMT) have agreed to increase the number of hours funded for this post in order to attract further interest to the role. *Action closed.* <u>2017-18 (15b) Quality Committee future workplan</u> The frequency of reporting updates to the Committee on the Quality Strategy has been agreed as twice yearly. *Action closed.*	
Service spotlight		
2017-18 (19)	The Executive Director of Nursing welcomed Benita Powrie, Head of Service ICAN to the meeting to provide an update on the Special Educational Needs and Disability (SEND) inspection. The Head of Children and Family Services provided some background to the Children and Families Act SEND Reforms which were introduced in September 2014 and explained that the purpose of the session was to provide the Committee with an update on Leeds Community Healthcare NHS Trust's (LCH) progress towards implementing SEND reforms in light of the recent inspection in 2016. The presentation provided an overview of the inspection outcome, highlighting the areas of strength and areas that require improvement. The areas of strength included partnership working and leadership, information sharing and records access and multi-agency involvement in child protection plans. The areas that required improvement included high waiting times for some services, consistency of outcome measures and attainment of young people with SEND. The Head of Children and Family Services outlined the areas of progress made, in summary: • The SEND Health Steering Group involves clinical and management representatives from services across LCH, Leeds Teaching Hospitals NHS Trust (LTHT) and local authority. This Steering Group was in place prior to the inspection. The sessions are well attended with good staff engagement and a strong commitment to drive this forward. • There are weekly multi-agency panels held with other agencies. • Staff training, including health coaching, guidance on completion of EHC1b and writing outcomes. • Work is underway to improve the provision of information on the website to allow patients to enable self-help where possible. • Information flow has improved. • Systems are being developed to allow outcome measures at service level as well as clinical level; this is being piloted in the Integrated Children's Additional Needs (ICAN) Service. • There is now a single point of contact for LCH for the Special Educational Needs Statutory Assessment and Provision (SENSAP) Team.	

- Adult Services involvement, particularly Dental and Dietetics Services, has been working well.
- EPR is now in place for all services.

Next steps include joint working with SENSAP on targeted training, finalising and implementing systems to allow outcome measures at service level and further work on conversions / reviews and the centralisation of administration.

The health offer into schools will be revisited with a co-produced revised offer based on mutually agreed priorities.

The Head of Children and Family Services informed the Committee that progress was being made; however staffing continued to provide the largest challenge. There have been a large number of school places added to the Leeds portfolio and resources had not increased to meet this demand. Increased pressure had been added to the service due to the requirement to assess within six weeks, the time involved in EHC completion and the weekly multi–agency panels.

The Head of Children and Family Services requested support from SMT to provide the additional resource required regarding training and outcome measures to implement the changes across the teams.

The Committee Chair highlighted that there appeared to be three themes for improvement following the inspection, and he requested clarification on what actions had been put in place to make these improvements.

- <u>The awareness of the offer by Children and families</u>
  The Head of Children and Family Services advised that understanding the local offer can be confusing for families; to address this, the website has been updated to provide details. One minute guides are being set up by the local authority to provide key information for professionals. The Trust is implementing similar one minute guides to be made available on the website.
- <u>Action being taken to address high waiting times for some services, particularly the ASD service</u>
  Work is being undertaken internally and with commissioners to address demand, service models and capacity.
- <u>Outcomes</u>
  In children's services, the occupational therapy service had introduced the Canadian outcomes framework. The Informatics and SystmOne Teams have been conducting further analysis of the data. The main focus has been on what is important to children and families.

The Trust Chair sought clarification regarding the involvement of the Children's Nursing Service. The Executive Director of Nursing responded that all children's services were involved, particularly the children in Specialist Inclusive Learning Centres (SILCs). The main concerns were the staffing issues in school nursing and ensuring there was no compromise to the delivery of care, with the resources available.

The Executive Director of Operations reiterated that the number of children been seen by the service has increased significantly without any additional resources. Historically nurses would attend mainstream schools to deliver specialist care for children with additional needs. However, with new models of care, there is opportunity to revise this provision.

	The Executive Director of Operations commended the Head of Children and Family Services for her work in this area, which has been in addition to her substantive role. In summary, progress is being made and positive signs are being seen. Staff are fully engaged and the steering groups are well attended. The local authorities are fully engaged and there is involvement from the Citywide steering group. The challenges are resources and demand. Support has been requested from SMT to implement the changes required and the Executive Director of Operations expressed this support where needed. Further (quarterly) updates on progress (particularly in relation to the three themes above) to be included in the clinical lead's report in the director of nursing's report.	
Quality governance		
2017-18 (20a)	**Director of Nursing: quality and safety report** The Executive Director of Nursing presented the report and highlighted the following as the main areas of focus within the Performance Brief and Director of Nursing's quality and safety report: • Low/no harm incidents: interview outcomes • Duty of Candour • CQUINs • Staffing • Children's Services • Hannah House ***Low/no harm incidents*** The Executive Director of Nursing provided an overview of the results following the recent interviews carried out around staff awareness of the incident reporting policy and process. The themes were consistent across the business units; staff were aware of the process and understood how to report incidents. Assurance was received that incidents are being reported. Staff were less confident in differentiating between whether an incident was moderate or severe. There was a discrepancy around those patients admitted to hospital with disease progression and whether these should be captured as an incident. The survey results had helped to provide focus on training and the training programme was being reviewed. Action plans are on track and progress is being maintained. Further updates to form part of routine reporting. ***Falls*** The Executive Director of Nursing stated that work to implement the work plan and to address the Quality Account priority was continuing. ***Duty of Candour*** The Executive Director of Nursing informed the Committee that progress continued to be maintained in relation to Duty of Candour for the third consecutive month with 100% compliance in month. ***CQUINS*** CQUINS are reported quarterly at SMT and performance issues escalated to Quality Committee as required. ***Staffing*** The Executive Director of Nursing informed the Committee that there had been a number of areas of work progressed in month. She noted that the Trust had agreed to work in partnership with Leeds Teaching Hospitals NHS Trust (LTHT) and other partners including primary care to commence delivery of the nursing degree apprenticeship and nursing associate apprenticeship from 2018.	

	The Clinical Lead for Specialist Services requested clarification around the nursing degree apprenticeship and nursing associate apprenticeship. The Executive Director of Nursing stated that the apprenticeships are work based learning over a 3-4 year programme. The associates are experienced band 3 clinical support workers, who were already employed by the Trust. To support the neighbourhood teams whilst recruitment is ongoing, a number of actions have taken place: • The Executive Director of Nursing and the Head of Bank Office have met with six agencies to source suitable registered staff, with early positive signs in terms of the number of appropriate CVs being received. Appropriate staff are being identified to support Wetherby Young Offenders Institute (YOI), where there are additional requirements. • The Trust has entered into week three of a short term partnership with Villa Care. Two small teams supporting Middleton and Armley neighbourhood teams, taking a cohort of work for patients in residential settings. There has been a large amount of preparatory work involved, including a significant training programme. Positive feedback has been received with a small number of training competency issues that are being closely monitored. • The Executive Director of Nursing is working with LTHT on a trusted assessor model. The Trust Chair noted that there was encouraging ongoing work in improving the position with recruitment. Figures on sickness were reassuring, the current position felt more stable than it had done more recently. He also commented on the challenge to accept every patient on a daily basis which was a concern. The Executive Director of Nursing informed the Committee that the Integrated Nursing Group was now established and being jointly chaired by the Trust and the Clinical Commissioning Groups. A programme of actions had been developed. One of the challenges was being able to provide sufficient community placements for nurses. It was noted that workforce groups in Leeds, West Yorkshire and the wider STP area were all involved in these areas of work. The Trust Chair acknowledged the good work being done and requested assurance that historical practice in relation to the appropriateness of visits was being reviewed and self-help, where possible, was being encouraged. The Executive Director of Nursing assured the Committee that the focus remained on caseload reviews and work was underway to put a project plan in place to challenge variation and historical practice. The Executive Director of Operations informed the Committee that visits were only subject to cancellation in line with clinical protocol. The Committee Chair referred to the management of deferred visits and the agreement with other stakeholders around deferring work. The Clinical Lead for Adult Services stated that reinforcing the offer and embedding caseload reviews were an important part of managing the capacity and demand within the teams. The Executive Director of Nursing invited the Committee to review the quality dashboard and pointed out that the review of caseloads had now been added to the quality metrics. The Trust Chair noted that there was work going on consistently within the neighbourhood teams and the position was positive. Non-Executive Director (ET-W) stated that it was a strikingly improved picture overall and a positive story of the ongoing work compared with last year.	

	Children's Services The Executive Director of Nursing highlighted the key areas of work that have begun within the Children's Business Unit. There is a large amount of work ongoing at Hannah House following recent internal and external reviews. The reviews highlighted a number of areas for improvement that were reported in action plans. A single action plan was now being developed to consolidate the required improvements. The Executive Director of Nursing and the Clinical Lead for Children's Services were working to develop the nursing pathway, particularly within the ICAN Service, and have a number of engagement events planned. The Children's Business Unit now have quality boards in a number of areas, with specifically modified dashboards to meet individual service needs. The Executive Director of Nursing and Clinical Lead for Children's Services are developing a quality meeting to review metrics in a similar way to Adult Services. The Trust Chair raised two concerns on behalf of the Child and Adolescent Mental Health Service (CAMHS) Eating Disorders Service. Discussions with the unit manager at a recent follow up visit highlighted that there were some unresolved issues around accommodation, in particular space for consultations to take place, and IT to support training via Skype. The Executive Director of Operations informed the Committee that the unit administrator was in the process of carrying out a scoping exercise to determine what space is occupied at particular times. The Clinical Lead for Children's Services agreed to follow up the issue around IT and provide assurance to the Trust Chair outside the meeting. The Committee Chair noted that there were a range of issues to be addressed and felt assured that work was ongoing to address these issues. Limited assurance was taken, in respect of Hannah House, until a more streamlined action plan was in place. ***Clinical Leads' Quality Reports*** The Clinical Leads for each business unit provided a summary of the reports appended to the Director of Nursing's quality and safety report. *Adult Services:* Ongoing capacity pressures were impacting on staff being able to access training. This was a potential concern when entering into the winter months. The Committee agreed that a plan should be put in place to address this and should be treated as a priority. *Specialist Services:* There was good work ongoing with pathway development, particularly the Parkinson's, stroke and cellulitis pathways. The citywide recovery rate of 54.9% exceeded the national target for Improving Access to Psychological Therapies (IAPT) services. The key challenge remained the staffing issues within the Speech and Swallowing Service. The Chief Executive and Trust Chair queried what impact this had on waiting lists, and what the risks and consequences were. It was agreed that SMT were to discuss this further. *Children's Services:* There is a large piece of work ongoing around the nursing strategy in the ICAN Service and ongoing work to support CAMHS. The business unit is benefiting from the additional support provided by SMT.	

	Actions: • Clinical Lead for Adult Services to put a plan in place to address access to training by neighbourhood teams' staff. • SMT to discuss the staffing issues in the Speech and Swallowing Service, around the impact on waiting lists and potential risks. • Clinical Lead for Children's Services to review any issue regarding IT and the use of Skype for training (in CAMHS eating disorders service); assurance to then be provided to the Trust Chair. **Outcome:** The Committee: • Noted the contents of the performance brief and the highlighted areas. • Reviewed and support the work which is developing in the Children's Business Unit. • Reviewed and noted the ongoing work in relation to quality safety and patient experience in the Adult Business Unit. • Agreed that the report provided reasonable assurance with the exception of the ongoing work at Hannah House which provided limited assurance.	**CMc** **SP** **KW**
2017-18 (20b)	**Performance brief and domain reports** The Committee reviewed the document and focused on the safe, caring and effective domains. The Executive Director of Nursing pointed out that the new version report will go to Business Committee. The Trust Chair acknowledged the progress that had been made. The Trust Chair highlighted the increase in referrals to SPUR and queried how this data could inform discussions with commissioners regarding activity within the Neighbourhood Teams. The Executive Director of Operations responded that the increase in the number of referrals was partly due to better recording by clinicians but there was evidence of an upward trend. Activity remained static; the challenge was to demonstrate the increased complexity of the patients on the case load. The Committee noted that the West Yorkshire and Harrogate STP workstream was looking to design a tool to establish acuity/complexity on caseloads that could be used within community services to demonstrate this increased complexity. The Committee acknowledged that all other areas had been discussed as part of the previous item and/or covered in the Director of Nursing Report. **Outcome:** The Committee: • Noted present levels of performance • Determined levels of assurance on specific points • The Committee noted the contents of the performance report for May 2017 which provided reasonable assurance.	
2017-18 (20c)	**Risk register: operational and clinical risks** The Chief Executive presented a report which outlined risk movement since the last report received in May 2017. The Committee noted that there were three extreme risks, no new clinical risks, six new operational risks (with a potential clinical impact) and one closed clinical risk. The Committee Chair queried risk ID905 (CAMHS inpatient care) and the change to the guidance, in that the person detained must now be assessed in 24 hours instead of 72, noting that this significant change could create a challenge for the service. The Clinical Lead for Children's Services informed the Committee that work was ongoing around this and discussions were taking place with Leeds and York Partnership Foundation Trust (LYPFT) and LTHT.	

	The Trust Chair raised a concern over risk 899 – staff capacity due to sickness absence in custody suites and the risk that the 60 minute response rate may not be achieved. The Clinical Lead for Specialist Services provided assurance that staffing levels are improving. The Executive Director of Operations informed the Committee that increased stability has been experienced more recently. The Executive Director of Nursing was reviewing BAF risk 1:1, relating to processes for assessing quality, with the Risk Manager and would bring back further information to this meeting. **Outcome:** The Committee: • Noted the recent revisions made to the risk register • Noted the negative movement of a strategic risk (BAF)	
2017-18 (20d)	**Quality Strategy: implementation update** The Executive Director of Nursing introduced the Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience who provided an overview of the progress against the actions identified. Of the sixteen, actions four have been completed, five are progressing on track and seven are not due for completion. It was proposed that the Quality Strategy report be presented to Quality Committee twice per year. The Committee agreed with the proposal with the caveat that if there is an indication that any of the actions are off track they would be escalated by exception. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience assured the Committee that the actions were monitored by other groups and reports more frequently, such as Patient Safety and Experience Group, the Director of Nursing Report and Quality Account priorities. **Outcome:** The Committee: • Noted and accepted the update of the implementation of the Quality Strategy	
2017-18 (20e)	**Quality impact assessments: refresh update** The Executive Director of Nursing introduced the Business Planning Manager who provided highlights from the quality impact assessment (QIA) refresh progress report. The Business Planning Manager informed the Committee that processes and good practice used in other trusts were being reviewed. Metrics are being used to monitor reporting and a two tiered approach is proposed. The Clinical Leads are the QIA leads within each business unit. The proposed process is being piloted over the summer and will be reported back to Quality Committee in September 2017. The Trust Chair pointed to the challenge in progressing transformation whilst ensuring there is no compromise to the quality of service delivered. The Executive Director of Nursing responded that the way the process was designed ensures that clinicians are balanced and systematic in their reviews. The Committee Chair expressed his support for the redesigned process and acknowledged that this version ensured clinical involvement was leaner, more efficient, and carried out jointly between business and clinical teams. The Committee Chair noted the good work undertaken and the need to identify learning from the pilot which will be evaluated in due course.	

	Action: • The Committee to receive a final proposal in September 2017 which will reflect the findings of the trial **Outcome:** The Committee: • Considered the proposed QIA process	**AT**
2017-18 (20f)	**Medical Director's report** The Executive Director of Nursing presented the report on behalf of the Executive Medical Director and highlighted that this report included the activity relating to the medical and dental staffing appraisal and medical revalidation. This report will provide assurance to the Trust Board regarding the appraisal process. The Committee Chair noted that the numbers were commendable compared to previous years. The Committee were happy to recommend the report to the Trust Board in August 2017. **Outcome:** The Committee: • Noted the contents of the 2016/17 Annual Executive Medical Director's Report • Noted the requirements by NHS England to include the statement of compliance from the Board. • Approved the report and submission to the Board.	
2017-18 (20g)	**CIC beds tender: quality aspects** The Executive Director of Operations updated on the CIC beds tender. The Trust has entered into a partnership with LTHT and Leeds City Council (LCC) to look at a provision of 100-120 out of the 190 beds tendered. The Trust would be the lead contractor and would provide physiotherapy and some occupational therapy input. Work was ongoing with Tenders UK which is working with the Trust in preparing the bid. The timescales are tight as the submission date is 5 July 2017. A discussion took place regarding the potential issues regarding quality and safe staffing. It was noted that the current model of care provided at CICU and SLIC will be decommissioned from 31 October 2017. Discussions were taking place with commissioners regarding funding changes that the tender outcome could create. The Committee noted the potential impact on service delivery over winter months. In response to a query by Non-Executive Director Elaine Taylor-Whilde the Chief Executive advised that the CCG would be responsible for monitoring KPIs.	
Clinical Effectiveness		
2017-18 (21a)	**Research and development strategy: implementation update** The Executive Director of Nursing introduced the Research Manager who provided the Committee with an overview of the progress against the research and development strategy 2015-18. The Trust had been successful in over recruiting to studies and exceeding the target accrual number. There had been a reduction in the core allocation given this financial year and the challenges faced were predominantly financial.	

	Over the last six months steady progress has been made in most areas and there are ongoing plans to meet the outstanding issues. The Committee Chair asked about the revised strategy with reference to capacity and capability. The Research Manager stated that there had been an impact on research and development due to reduced capacity. The Research Manager pointed out that forward planning can be challenging due to uncertainty regarding organisational changes and what services will be delivered in the long term. The Committee Chair noted that positive progress was being made and highlighted the need to work more closely with our academic partners. A paper would be presented to the Trust Board in August 2017. The Committee indicated that it would look forward to consideration of proposals for a revised strategy for the period 2018-2021. **Outcome:** The Committee: • Received reasonable assurance on the progress of the Research and delivery within the Trust • Accepted the Research Strategy implementation report to June 2017	
2017-18 (21b)	**Outcome measures** Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience informed the Committee that work continued with the Head of Business Intelligence regarding the logistics of the EQ-5D license and Therapy Outcome Measures (TOMs). A business case would be presented to SMT regarding the resource needed to support. The Committee Chair requested that a written update paper be presented to Quality Committee in July 2017. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience stated that each business unit identified outcome measures and a roll out plan, these have been approved by the CCG. **Action:** • Update paper to be written for Quality Committee in July 2017 by the Executive Medical Director.	**AT**
2017-18 (21c)	**National Institute for Health and Care Excellence (NICE) guidance compliance indicators** The Executive Director of Nursing highlighted to the Committee the key items for note and for decision. The Trust continues to achieve the target regarding NICE technology appraisals within three months of publication. The Executive Director of Nursing directed the Committee to option three in table 3.2.4 which outlined an option regarding compliance with all other relevant NICE guidance within 12 months of publication: • Report on implementation progress status (rather than by guidance) • Remove the percentage target from the indicator • Report on 12 and 24 month implementation progress The Executive Director of Nursing advised the Committee that the processes undertaken by other community trusts have been explored.	

	The Committee was in agreement with the proposal and noted that further work was to be carried out around the detail and development of the proposal. The Committee Chair queried if there would also be a category where the guidance is not applicable to the service. The Executive Director of Nursing confirmed that there would be and that this was in development. **Outcome:** The Committee: • Received this report and agreed the proposed new measure for assessing organisational compliance with NICE guidance • Agree that the preferred option is developed further, reporting to the Quality Committee in July 2017 through the effective domain of the performance brief	
Reports and minutes for approval or noting		
2017-18(22a)	**Clinical Effectiveness Group: insulin workshop 18 May 2017** The Executive Director of Nursing encouraged the Committee members to take the time to read the report following the workshop regarding the administration of insulin and provided a brief summary of the work undertaken at the workshop. The Committee Chair noted that there were a lot of actions and queried how these would be refined. The Clinical Lead for Adult Services assured the Committee that these were already being managed under other workstreams. The potential for improvement was noted. **Outcome:** The Committee • Received and noted the report.	
2017-18(22b)	**Patient Safety and Experience Group: 25 May 2017** The Executive Director of Nursing informed the Committee that the workplan was being reviewed and there would be a refreshed programme of work for 2017/18. The Executive Director of Nursing stated that the group would be scrutinising the Director of Nursing Report in more detail prior to submission of key elements to the Quality Committee. **Outcome:** The draft minutes were received.	
2017-18 (22c)	**Mortality Surveillance Group: 1 June 2017** The Executive Director of Nursing informed the Committee that the policy for reviewing deaths was being drafted, and there was a large piece of work underway around how data is collected and where and how it is reviewed. All mortality data collected by the business units would be included in a report to SMT for review. The Trust are required to send four members of staff for training around the LeDeR work (learning difficulties), and it was noted this may have an impact in terms of workload across the organisation. The Clinical Lead for Adult Services informed the Committee that the lead Coroner for West Yorkshire was attending the Mortality Governance Meeting in August 2017. The membership for that meeting will be opened to a wider audience. **Outcome:** Verbal update noted.	

2017-18 (23a)	**Quality Committee future work plan** The future work plan was received for information. The Committee Chair noted that there appeared to be an imbalance across the business units with reference to the spotlight on services. The Executive Director of Nursing and the Committee Chair are to review this at the next agenda setting meeting. **Action:** • The Executive Director of Nursing to review the spotlight on services, at the next agenda setting meeting.	**MP**
2017-18 (24)	**Matters for the Board and other committees** It was agreed that the Committee's Chair would provide a verbal update to the Board at the meeting on 4 August 2017. There is no board meeting in July 2017. Items to be reported include: • Speech Therapy Service staffing risk • Low / no harm – to be noted and closed • Hannah House action plan • Focus on Children's Services	
2017-18 (25)	**Any other business** The Executive Director of Nursing advised the Committee that the Leeds CCGs Quality Review Meeting had been cancelled for the last three months due to the reorganisation taking place. The Committee Chair highlighted that it was the last meeting for the Non-Executive Director Elaine Taylor-Whilde and the Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience. They were both thanked for their hard work and the Committee members wished them well.	
	Dates and times of next meetings (09:30 – 12:30) Monday 25 September 2017 Monday 23 October 2017 Monday 20 November 2017	

Leeds Community Healthcare NHS Trust

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 26 April 2017 (9.00 – 12.00 noon)

Agenda Item 2017-18 (37ci)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD
	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Liz Hindmarsh	Business Manager
	Victoria Douglas	Head of Business Intelligence (for item 02e only)
	Anita Simey	Project Manager (for item 04b only)
	Anne McGee	Service Improvement Lead (for item 04b only)
	Samantha Childs	Head of Service, HCP (for item 05 only)
	Debra Gill	Service manager for HV and FIS (for item 05 only)
Observer:	Liz Hindmarsh	Business Manager
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(01)**	The Chair welcomed everyone to the meeting. **01a - Apologies**: None recorded. **02b - Declarations of Interest**: None recorded. **01c - Minutes of last meeting:** The minutes of meeting dated 22 March 2017 were approved by the Committee. **01d - Matters arising from the minutes and review of actions:** *Item 2016/17 (69a) – Performance brief and domains report* The Executive Director of Operations reported that she had identified a lead to develop the children's strategy and the first draft would be presented to the Business Committee meeting in July 2017. The Chair asked that the first draft be emailed out to the Committee members before July for comments so that the strategy could be fully considered and signed off at the meeting on 26 July 2017. *Item 2016/17 (81c) – Estates rationalisation* Progress with estates strategy was noted. A board workshop on estates strategy was scheduled on 5 May 2017. The Chair, the Chief Executive and the Executive Director of Finance & Resources agreed to meet to discuss the strategy.	SP BM
2017/18	**Performance management**	

(02)	**02a – Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain report. The cover report summarised the year end position as being positive, having made good progress in a number of areas. The Executive Director of Finance & Resources was pleased to report that the final accounts for 2016/17 had been submitted on 25 April 2017 with all targets being achieved. There was particularly positive movement in relation to the safe and caring domains reflecting close scrutiny by Quality Committee of key performance issues as follows: • Harm free care (Safety Thermometer) achieved the target in the final month of the year. • The Trust achieved its target to reduce avoidable category 3 pressure ulcers by 15% and avoidable category 4 pressure ulcers was also met with only 1 reported category in the second half of 2016/17. • The Quality Committee had reviewed and discussed the progress update for venous thromboembolism risk assessments which were increased by 20%. • There was an improvement in duty of candour in March 2017 from 62% to 100%. The Executive Director of Finance & Resources said that in the effectiveness domain a proposal was being considered to change the way of recording compliance in accordance with the National Institute for Health and Care Excellence guidance. Workforce related indicators remained below target with the exception of agency staff expenditure target which the Trust had achieved. It was noted that work continued to develop the black and minority ethnic (BME) networks. The Chief Executive said that the Chair of the Trust was the BME Champion for the Trust and that the Deputy Director of Workforce was leading on work with Patient Experience & Inclusion Manager. She said work was on-going and moving forward. The Director of Workforce added that the Workforce Race Equality Standard (WRES) required the Trust to have a Board Champion across the organisation for a variety of groups which was still to be explored. Following a detailed discussion on Commissioning for Quality and Innovation (CQUIN), the Chair suggested considering a RAG rating status, as part of the report. The Executive Director of Finance & Resources agreed to the suggestion. He said the risk on each was assessed in terms of overall financial risk and would be reported periodically on quarterly basis on CQUIN income in the overall financial position. In response to the Chair's question about sickness absence meetings, the Executive Director of Operations said that the analysis had not been concluded; but there were examples of some good practice to note. As an extension of this initiative, SMT would be examining performance in the deteriorating teams rather than teams in the worst position and would be looking at trends. *Finance* The Committee was advised that the Trust had met all of its financial	BM

	requirements and achieved all financial targets in 2016/17 across the range of different measures (subject to audit). The financial prospects for the year ahead also looked encouraging although the challenges of permanent staffing numbers and consistent performance delivery remained significant. The Executive Director of Finance & Resources informed the Committee that the Trust had received a strategic transformation fund allocation of £490k. The money was a planned re-distribution to trusts. This sum would be added to the surplus figure and be held as part of reserves. The Executive Director of Finance & Resources was happy to consider the ideas on possible spend but he said that the Trust needed to be aware that capital expenditure would invariably generate revenue costs. **Outcome:** The Committee reviewed the performance brief and domain reports and noted good progress in a number of areas **02b – Neighbourhoods' report and dashboard** The Committee noted a more positive position in the neighbourhood teams. Sickness absence had come down significantly and there had been an increase in the number of staff available. The overall vacancy figure standing at 50.8 (whole time equivalents) had improved since March 2017. Sickness absence in neighbourhood settings had also reduced marginally to 5.7%. The Executive Director of Operations said that following the assessment centre event for newly qualified staff, 18 people had been confirmed as joining the Trust from the first cohort, but unfortunately this had now reduced to 15. From the second cohort four had confirmed joining. The Executive Director of Operations said that a number of welcome initiatives were being developed. A paper was to be submitted to the Joint Negotiation Consultation Forum for consideration of "introducing a friend" scheme. The Chief Executive suggested asking neighbourhood team staff to consider retention initiatives. The Director of Workforce said that the retention work stream had already considered a number of retention schemes. She said that a new preceptorship programme was being launched from 1 May 2017 and staff would be welcomed with an offer of development and support. The Chair noted the work was underway, to try and retain staff. He invited a more substantial proposal for the next meeting in May 2017 to consider all the options together with the suggestions discussed in the meeting today. He expressed disappointment that such had not been made available for today's meeting. The Chair queried the short term sickness absence during March 2017, particularly in the Beeston neighbourhood team. The Executive Director of Operations said she would email the Chair with an explanation. The Executive Director of Finance & Resources noted the financial risk from the staff in post figure still being 50.8 below establishment. He said the financial concern would be if the recruitment position improved and the bank and agency use and overtime continued at the same level. The Chief Executive said that the Trust was not able to demonstrate full staffing position to meet demand.	SE SP

	A Non-Executive Director (RG) referred to the bar chart showing establishment, vacancies, absence and use of temporary staff. He said it would be helpful to see a bar showing minimum staff requirements to meet demand. This was a major deficiency and a matter of considerable concern.	SP
	The Chief Executive said that because the Trust was able to articulate much more clearly about delays in hospital beds caused by lack of capacity in the community, and that this needed to be modelled. A careful analysis would be carried out in one neighbourhood team at a time.	
	The Chair was in support of the undertaking of analysis, looking at one neighbourhood team at a time and getting a more effective measure of staffing requirements.	
	Outcome: The Committee welcomed a more stable position in the neighbourhood teams. The continuing pressure on staff capacity and the committed associated work was acknowledged.	
	02c – Retention: key action areas The Committee had previously indicated that significant priority needed to be given to targeting a reduction in leavers. The Director of Workforce reported that there were two main retention initiatives. Firstly, work to improve exit interview processes and to understand reasons for leaving; there was significant under-reporting and a target had been set to reduce the recording of 'not known' or 'other' to 10%. Secondly, schemes to improve staff and professional development, preceptorship and career progression.	
	The Director of Workforce said that those two things needed prioritising. Further work would be carried out to help managers with exit interview process and analysis on lack of development and career progression trends would also be reviewed.	
	The Committee's Chair expressed disappointment about the absence of new proposals and the lack of a fully effective exit interview procedure; this having been the subject of previous Committee meetings' discussions. There was limited assurance from the measures offered and the executives were invited to propose something more substantive and comprehensive.	
	The Director of Workforce said that there were various development programmes put in place to support specific staff groups. The Executive Director of Operations added that the Trust was in a much better position in terms of understanding issues. There was a commitment by individual managers to coaching and leadership development.	
	A Non-Executive Director (RG) indicated the importance of managers identifying those staff who might be considering learning and initiatives to encourage staff continuing with the Trust.	
	Action: The Director of Workforce was asked to come back with clear definitions of some of the retention issues, actions and outcomes.	SE
	Outcome: The Committee note staff retention initiatives, but required more urgent and immediate actions to resolve.	
	02d – Agency staff expenditure The paper provided a record of a medical staff member being paid above the	

	agency staff expenditure cap and explaining the continuity of service reasons. The Chair said that in any future instances he would welcome clearer explanation of efforts made to recruit at a lower rate. **Outcome:** The Committee noted the engagement at a rate above cap which would be reported weekly in the NHSI return. **02e – Key performance indicators (KPI) 2017/18** The Executive Director of Finance & Resources provided an updated list of key performance indicators for 2017/18 taking into consideration comments received from the Committee at its previous meeting in March 2017. A Non-Executive Director (TD) added that the patient safety incidents reporting whereby 70% of incidents resulted in 'no harm' had been left in the set of indicators. It was noted that there was now information from national benchmarking. He said work was continuing to decide on the most appropriate measure before it went back to the Quality Committee for approval. In relation to sickness absence, the Committee noted that the aim was to work towards the national average for community trusts (4.7%). The Trust's target for 2017/18 was agreed at 5.2%. The Committee discussed the staff turnover target and agreed to an indicator of 15% for 2017/18. The Committee agreed to a maximum 20% target for the number of staff leaving the organisation within 12 months. The Executive Director of Finance & Resources said that the target on bank and agency expenditure spend was on the list because it was part of the single operating framework that the Trust was measured against. Last year's base line would be considered as the target for 2017/18.	
2017/18 **(03)**	**Business planning and commercial development** **03a - Business and commercial developments update** The Committee received the paper to note the updates on business and commercial development. It was noted that there would be further exploration following attendance of a market engagement event in Scarborough. Scarborough and Rydale multispecialty community provider was currently engaged with the market for a range of community based health and care services. A Non-Executive Director (TD) queried the decision made on the rationale for not bidding for an opportunity for a North and North East Lincolnshire integrated sexual health service based on learning in Leeds. The Executive Director of Finance & Resources said that the outcome had been determined following a 'bid no bid' process. **Outcome:** The Committee note the updates on business and commercial developments. **03b – Operational plan 2016/17: end of year report** The Committee received the report which recorded the completion of priorities	

	and objectives contained in the operational plan for 2016/17. The executives were asked to reconsider some of the output conclusions. Objectives for 2017/18 were to be significantly more measurable and smarter aligned to the priorities and objectives. The cover paper explained the targets not achieved on the grounds of internal and external factors. **Action:** The Chair asked the Executive Director of Finance & Resources to review two measures rated green at year end. He would write separately to the Executive Director of Finance & Resources. **Outcome:** The Committee noted progress at year-end in delivering the 2016/17 priorities and considered the assessment of the reasons for not achieving target. Further recommendation to be given to a number of year end scores.	BM/BC BM
2017/18 **(04)**	**Project management** **04a - Projects' flash reports** The Committee received flash reports which provided monthly updates on the progress of projects; e-rostering, new ways of working/electronic patient record and neighbourhood teams activity. **Outcome:** The Committee noted the contents of projects flash reports. **04b – Electronic patient record (EPR): in depth review** (presentation) Members of the EPR project team updated the Committee on progress with the roll out of EPR. The presentation slides reminded the Committee about the EPR project, current situation and future developments followed by a benefits realisation update. The implementation had been redesigned in Autumn 2016 and now was a phased approach comprising: integration of neighbourhood team, introduction of mobile working, introduction of EPR and consolidation of new ways of working; the approach was proving successful in terms of allowing time for learning, sustaining good practice and realising benefits. The non-executive directors particularly welcomed the collaborative aspects of the project and significant staff engagement. It was noted that the remaining neighbourhoods will 'go live' for EPR between May and October 2017 and with new ways of working by February 2018. The Service Improvement Lead provided an update on 'benefits realisation'. She said there were three areas of focus: acceptance by staff, impact on safety and impact on efficiency. The Chair asked about what had impeded full implementation in neighbourhood teams. The Project Manager said that in a minority of instances progress had been slowed by the capacity to introduce change. A Non-Executive Director (RG) said that, with his past experience relating to benefits realisation, he offered to work with the EPR team to discuss some of those difficult frameworks and angles. The Chair thanked both the Project Manager and the Service Improvement Lead for a comprehensive presentation.	

	Outcome: The Chair said that the presentation provided a reasonable level of assurance on how the work was being progressed.	
2017/18 **(05)**	**Service area focus – health visiting** (presentation) The Committee welcomed staff from the health visiting service. A universal service which provided public health focused care across two pathways; one for 0 to 5 year olds and one for 0-19 year olds. The Head of Service said that it was an integrated service, called early start in the community, a universal service offered to every child in Leeds. A public health focused and evidence based care service that gave every child in Leeds the best start in life. She said it was a service focused on reducing health inequality by delivering early intervention. The service had received positive outcomes from CQC and Ofsted inspections and had received Unicef's baby friendly initiative accreditation. A number of challenges were outlined, including: delays in establishing a single point of access, recruitment and retention, workforce capacity to meet demand, changes in contracted services, reduction in contract income and discussions with Commissioners related to potential re-procurement. The Chair thanked the health visiting representatives and said that the team had left the Committee with a strong and positive impression of work in the service. **Outcome:** The Committee saw evidence of an effective and well-regarded integrated service to children and families in Leeds.	
2017/18 **(06)**	**Governance** **06a - Non-clinical risk register 8+** The Company Secretary reported that the risk register report summarised the changes to the register since March 2017. **Outcome:** The Committee noted the revisions made to the risk register. **06b – Board assurance framework 2017/18** The Committee received the Board assurance framework (BAF) for 2017/18, providing assurance to the Trust Board, and noted that the report set out those strategic risks which were aligned with the work of the Committee. The executive directors had reviewed the strategic risks on the BAF in line with operational plan for 2017/18 so that the Trusts objectives were effectively managed. It was noted that there were a total of nine risks out of the 17 risks assigned to the Business Committee. On an ongoing basis, the Committee would review the sources of assurance presented and determine assurance in line with the risk assurance levels. **Action:** Board assurance framework 2017/18 to be added to next month's agenda. **Outcome:** The Committee proposed to go through the risks in more detail at the next meeting in May 2017.	VM
2017/18 **(07)**	**Business Committee's work plan** **07a – Items from work plan not on agenda** - No items were noted.	

	07b – Future work plan - The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(08)**	**Matters for the Board and other Committees** • Good progress in a number of performance areas • Financial position • A positive position in the neighbourhood teams • Staff retention initiatives • Operational plan 2016/17 • Agreement of outstanding KPIs • Board assurance framework	
2017/18 **(09)**	**Any other business** • A service change briefing paper was received by the Committee to note. • The Chair felt that there was a need to review the balance of the Committee's agenda.	

Leeds Community Healthcare NHS Trust

MINUTES

Item 2017/18 (37cii)

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 24 May 2017 (9.00 – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD
	Richard Gladman	Non-Executive Director (RG)
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Richard Slough	Assistant Director of Business Intelligence, Systems & IT (for items 15 & 16)
	Steve Keyes	Head of Organisational Development (for item 14)
Apologies:	Thea Stein	Chief Executive
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(10)**	The Chair welcomed everyone to the meeting. **10a - Apologies**: Please see above. **10b - Declarations of Interest**: None recorded. **10c - Minutes of last meeting:** The minutes of meeting dated 26 April 2017 were approved by the Committee. **10d - Matters arising from the minutes and review of actions:** *02b – Neighbourhood report and dashboard* The Executive Director of Operations said that the increase in sickness absence in the Beeston team was the result of one person being on long term sickness absence. *02d – Key performance indicators 2017/18* The Executive Director of Finance & Resources reported that the details of targets on bank and agency expenditure were not released yet by NHS Improvement.	
2017/18 **(11)**	**Review of Business Committee's agenda framework** The Chair invited members of the Business Committee to consider the Committee's structure and framework. He said the Committee currently focused on three key areas of Trust activity. Firstly, immediate performance issues, which were then challenged to receive assurance and considerations and occasionally the Committee requested further work arising from that conversation. Secondly, work around organisational business and thirdly, commercial developments, transformation programme and project management work streams.	

	The overriding challenge was to ensure alignment and to make sure that cross-cutting issues were well managed in order to ensure delivery of the Trust's overarching strategy.The Chair welcomed Committee member's views and the following comments were noted: • The Committee would continue with scheduled 'deep dives' into service areas, focusing on those with a particular business imperative. • The Committee would continue to focus on transformational projects. • The Committee considered establishing a project management sub-group; it was concluded that this would be discharged as an executive function. • Executive oversight of projects would need to be reported to Business Committee in order that the Committee could gain sufficient assurance. • The Committee would extend its scrutiny of the enabling strategies which support the Trust's overall strategy, the Leeds Plan and STP; scrutiny to include assurance that strategies are fully aligned with each other. • The four main enabling strategies being: OD/workforce, estates, digital and business development. • The Committee would continue its appraisal of performance management • The performance brief, received at each meeting, would be supplemented with commentary from SMT considerations. • More in depth consideration of: data, analysis of trends, conclusions and measurable outcomes from agreed actions was sought, for example through a quarterly workforce report. • The Committee would continue its role in relation to business planning and commercial developments. The proposal would be pulled together and presented for agreement at the next meeting in June 2017. Further sign off would be necessary.	
2017/18 **(12)**	**Performance management** **12a – Performance brief: 2016/17 year-end report** The year-end report provided the position at March 2017 and reflected on the year-end position. **Outcome:** The Committee noted levels of performance as at year end 2016/17. **12b – Performance brief and domain reports: April 2017** This was the first performance brief for the new year (April 2017). The high level performance summary report highlighted main issues for consideration. The overall position was similar to last month in the caring, effective, responsive and well led domains. The safe and caring domains were considered at the Quality Committee meeting on 22 May 2017. **Heat map** The Committee reviewed the quarterly heat map reports which indicated those services with the highest number of red-rated indicators. It was noted that the data related to February 2017. The Executive Director of Finance & Resources reported that the delay was to facilitate analyses of data but that he wished to review the timelines of future reporting. **Action:** The Executive Director of Finance & Resources to review timing of heat map reports. **Responsive** The Executive Director of Operations drew the Committee's attention to the responsive domain report showing amber for patients waiting for more than 6 weeks for diagnostic tests; a recovery plan was in place.	BM

	Well-led The Director of Workforce said that as a result of the audit of statutory and mandatory training performance, the report had limited assurance relating to risks which were within existing processes. The report would be part of the summary of audit reports for Business Committee in June 2017.	VM
	Finance The Executive Director of Finance & Resources introduced the finance section of the performance report and said that the immediate concern was the over spend on pay in April 2017. The senior operational meeting on 23 May 2017 had concluded that the management team was to consider all aspects and decide on the next steps to try and secure the financial position by the year end; whether to put controls on discretionary spend as was applied last year or to consider the deployment of reserves. A Non-Executive Director (RG) referred to a number of previous discussions around children's business unit and whether it was set up for the longer term operating model or staffing model. The Executive Director of Operations responded to say that she was actively considering the changes and the resource requirement in the service. Work was progressing in a number of services; Child and Adolescent Mental Health Service (CAMHS), Integrated services for Children with Additional Needs (ICAN) team and speech and language therapy team. **Action:** The senior management team to consider the next steps to secure financial balance by the year-end. The Executive Director of Finance & Resources would report back to the July 2017 Meeting.	BM
	Outcome: The Committee reviewed the performance brief and domain reports and noted progress.	
	12c – Neighbourhoods' report and dashboard The neighbourhood team paper provided an update on the position within the adult business unit for April 2017. The Executive Director of Operations said that the report for meeting in June 2017 would include progress against monthly recruitment and retention numbers. She said for this month six people were recruited and one had left. The June 2017 report would include analysis on fully staffed teams and changed practice as a result of the experience during the winter pressure period which was being discussed at systems resilience group on 8 June 2017. The Chair welcomed an update. **Action:** A neighbourhood teams' systems resilience report to be received by the Committee in June 2017 meeting.	SP
	Outcome: The Committee received the updated neighbourhood services report. It was noted that the available staff was close to the required establishment.	
	12d – Sickness absence update The Executive Director of Operations reported that from the recent 'deep dive' undertaken by her and the Deputy Director of Workforce there were no obvious trends, issues or concerns to note for staff sickness absence.	

	Further work was progressing. She said that they were now looking at teams where there was a declining trend. **Outcome:** The Committee noted the work being undertaken. **12e – Recruitment and retention** The purpose of the paper was to provide an update on the approach to recruitment and retention and workforce planning and the discussions were based on the following initiatives: • Approaches to attract newly qualified staff to join the Trust for their first employment. • Potential employment through advertising to the market of those already qualified, but working elsewhere. The Director of Workforce said that the focus was to be fully established by February 2018. In respect of neighbourhood teams, the aim was to reduce use of bank and agency staff and focus on those initiatives to try and reduce leavers and succeed in recruitment. She said the current number of newly qualified staff who had been offered posts from September 2017 was 21. The Director of Workforce would be writing separately to the Chair of the Business Committee on sustainability issues relating to nurse numbers. She said that the Trust was engaging in the Health Education England International recruitment for India and keeping in touch with other local providers. The Chair said that he would welcome an update on a quarterly basis on the number of developments initiated by the Director of Workforce reflecting on the initiatives, cost, outcome and risks. **Action:** The Director of Workforce to include information on recruitment and retention initiatives costs, outcomes and risks in quarterly workforce report. **Outcome:** The Committee received updated information and delivery against agreed focus of the work for 2016/17. The Chair felt that the level of assurance identified at this stage was limited. **12f – Activity delivery plan** The report provided the Committee with information on the activity variances and the final service line activity report for 2016/17 that had been requested at its previous meeting. The Executive Director of Finance & Resources explained that the report showed the order of variance along with commentary on the variance. He said most of the variances were under review and he was pleased to say that nothing stood out to cause concern. He said that where the Commissioners were working with the Trust to review the profile there might be changes to the profile and level of variance. The Chair said that he had two reasons to be concerned; contract risk and cost risk but he was not unduly alarmed because of work with Commissioners to resolve historical anomalies to mitigate those two risks. **Action:** The Chair asked to see evidence on the activity profile work on a quarterly basis. **Outcome:** the Committee noted the activity variances and the actions being taken to mitigate risks.	SE BM

	12g – Procurement report The paper provide an end of year report on procurement which had been prepared in line with the Trust's procurement strategy to give the Committee an oversight of the procurement activity and performance during 2016/17. It was noted that not all of the national standards were applicable to the Trust. The Chair was content with the actions being taken to improve processes and achievements. **Outcome:** The Committee noted good progress made in terms of procurement practice and the work that will be undertaken in 2017/18 to implement the procurement strategy.	
2017/18 **(13)**	**Business planning and commercial development** Please see private minutes.	
2017/18 **(14)**	**Organisational development strategy (OD)** Revised strategy and action plan 2017/18 The Director of Workforce introduced a refreshed OD strategy which the Trust would develop over the next two years. She said this piece of work reflected progress against the earlier strategy presented to the Board workshop in January 2017. One piece of work within the OD strategy picked up in the May 2017 Board workshop related to staff pledges; this was still being refined. The Head of Organisational Development said that the paper outlined progress with work undertaken over the last two years. The original OD strategy had five objectives and now there are four key objectives. He said the prioritisation of key objectives were recruitment and retention and staff health and wellbeing. The strategy incorporated a detailed action plan that covered all the actions and outcomes related to objectives. The Chair was pleased to note that a lot of work had gone into defining what had been delivered so far. But felt that the strategy would benefit from a clear vision of the future workforce reflecting full recruitment, staff flexibility, training and development and staff wellbeing; this would make the strategy more meaningful. The Chair also felt that there needed to be a greater emphasis on: specific of objectives (including costs and timescales), measurable outcomes, and risks to achievement. He added that the Committee would wish to see evidence of outcomes in terms of impact on the Trust's business in future monthly reports. The Head of Organisational Development noted the request. He said that the plan had a number of key metrics and the activity and outcome would be reported to SMT on a regular basis. The Committee was asked to recommend the refreshed OD strategy and action plan to the Board for approval and to provide the Trust Board with a verbal update in respect of progress against the OD strategy. It was agreed that the workforce report and the OD strategy was closely linked and a quarterly workforce report would include update against objectives. **Outcome:** The Committee recommended the refreshed OD strategy and action plan subject to the caveats raised at this meeting to the Board for approval as the focus of the work from 17/18 onwards.	
2017/18 **(15)**	**Digital strategy** The Business Committee received the revised digital strategy which reflected the technology and information priorities.	

	A Non-Executive Director (RG) said it was a good paper which met Trust's immediate needs and priorities linking to the Trust's strategy. The Committee discussed the degree to which the strategy fully met future aspirations and recognised that the Trust would need to continue to consider innovative approaches; including working with partner organisations. In reply to a Non-Executive Director (RG), it was confirmed that the Executive Director of Nursing had been assigned as the Trust's Chief Clinical Information Officer. **Outcome:** The strategy was welcomed and seen to meet all current priorities. The Committee recommended the strategy to be presented to the Trust Board on 4 August 2017 for approval.	
2017/18 **(16)**	**Cyber security** Recent national incident: update An update was provided by the Assistant Director of Business Intelligence, Systems and IT on the recent national cyber-attack. A time line had been created throughout the incident from the start of the cyber-attack on Friday 12 May 2017. He said that there were critical issues and concerns but he gave assurance to the Committee that things were well dealt with and well-handled and that the Trust had not been adversely impacted. The Assistant Director of Business Intelligence, Systems and IT reflected on lessons learnt and the following comments were noted: • Communication - internally and externally with NHS England and NHS Digital. • Most communication relied on email system; the Trust needed to be able to instigate a facility to send a text message to all staff. • Issues around accessibility of the server. • The role of an emergency planning manager. A de-briefing and a review of business continuity plan was to be assessed by the senior management team. **Outcome:** The Committee noted that the Trust had responded well to the cyber security incident.	
2017/18 **(17)**	**Project management** <u>Projects' flash reports</u> The Executive Director of Finance & Resources advised the Committee that he would like to close the neighbourhood team activity project. He said that this had been initiated in response to the risk which had arisen in the last financial year. <u>E-rostering project</u> It was noted that the outcome of this project had deteriorated, originally from greens and amber to amber. The SMT were reviewing the progress to date and potential options in June 2017. A 'deep dive' was to be scheduled for June 2017 meeting. <u>Electronic patient record</u> The Executive Director of Operations confirmed that implementation was continuing as scheduled. Full implementation would be completed by February 2018.	

	Outcome: The Committee noted the contents of projects' flash reports.	
2017/18 **(18)**	**Governance** **18a - Non-clinical risk register 8+** The Company Secretary introduced the Trust's risk register summarising changes to the register since April 2017. She said that the report for this month was a more in depth report. Currently there were three extreme risks scoring 15 or above: audiology 6 weeks wait, sickness absence and recruitment and retention. There were two new 8+ risks escalation of sickle cell service and respiratory service referral. The Company Secretary drew the Committee's attention to the categorisation of risks for non-clinical risks and clinical risks for both the Business Committee and the Quality Committee. She proposed that all operational risks were received by both Committees. The Committee agreed to this proposal. **Outcome:** The Committee noted the revisions made to the risk register. **18b – Board assurance framework 2017/18 (BAF)** The Committee received the Board assurance framework (BAF) for 2017/18. This document provided assurance to the Trust Board that risks to the delivery of the strategic objectives were identified and controls put in place to manage the risks. Committees provided assurance to the Board on the management of these risk areas. The new BAF for 2017/18 was aligned with the operational plan for 2017/18 and the schedule of risks was part of the operational plan approved by the Board on 31 March 2017. There were a total of nine risks out of the seventeen risks assigned to the Business Committee's areas of responsibility. **Outcome:** The Committee noted the revised BAF 2017/18 and the strategic risks assigned to the Business Committee. **18c – Internal audit annual plan 2017/18** The Committee received the internal audit annual plan for 2017/18 and noted that completed audit reports would be advised to the Committee during the course of the year.	
2017/18 **(19)**	**Business Committee's work plan** **19a – Items from work plan not on agenda** - No items were noted. **19b – Future work plan** - The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(20)**	**Matters for the Board and other Committees** • Financial situation • Recruitment and retention • End of year procurement paper • OD strategy • Digital strategy	
2017/18 **(21)**	**Any other business** None recorded.	

Leeds Community Healthcare NHS Trust

MINUTES

Item 2017/18 (37ciii)

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 28 June 2017 (9.00 – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD
	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Janice Patterson	Service Manager MSK & SpineFit+ (for item 23 only)
	Nico Batinica	Head of Workforce Intelligence & HR Systems (for item 24a only)
Observer:	Tim Norris	Internal Audit Manager
Apologies:	Vanessa Manning	Company Secretary
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(22)**	The Chair welcomed the Internal Audit Manager to the meeting as an observer. The Chair commenced the meeting by asking the Committee members to respond to an email he sent around with his proposal regarding the Committee's focus and future programme. He said he would welcome any comments by the end of the week. **22a - Apologies**: Please see above. **22b - Declarations of Interest**: None recorded. **22c - Minutes of last meeting:** The public and private minutes of the meeting dated 24 May 2017 were approved by the Committee. **22d - Matters arising from the minutes and review of actions:** No further actions were noted; action log was updated.	
	Musculoskeletal (MSK) service presentation The MSK Service & Spinefit+ Manager was welcomed to the meeting. The Committee received a presentation on the achievements, challenges and development opportunities in the MSK service. An update was also provided on potential business around 'first contact practitioners', occupational health contracts and private clinics. The Service Manager said that a lot of the staff were long standing and were very committed to the MSK service. She said the service had undertaken a skill mix exercise to reduce band 7's and increase band 6's.	

	It was noted that some of the staff were reducing their working hours in the NHS after achieving their professional development qualifications and opting out for a rewarding clinical career working across sectors. In response to a Non-Executive Director (RG) asking whether there was a duplication of services with Leeds Teaching Hospitals Trust (LTHT) and other partners in the city, the Service Manager said that the Trust was still very much within the agreed pathways for the MSK services. She said the pathways conversations were very much about multidisciplinary clinics, working together from different organisations across the pathway to facilitate patient care. The Chief Executive added that there was a commitment to follow up work, most of which fitted into the 'new ways of working' framework. This was meeting the needs of General Practitioners (GPs) Five Year Forward View by looking at a different workforce in Primary Care. She said that re-modelling MSK service in partnership was part of the work streams around new models of care. The Chair invited the Executive Director of Finance & Resources to follow up on the business development potentials taking into account the Chief Executive's and a Non-Executive Director's (RG) comments. The Chair thanked the MSK Service & Spinefit+ Manager and said that it had left the Committee with a strong and positive impression of work in the service and that the forward thinking and development possibilities were impressive. **Outcome:** MSK presentation on the service area was well received by the Committee.	
	Project management **24a – E-rostering** Please see private minutes. **24b – projects' highlight reports** There was a discussion on the highlight reports presented which provided a summary of the progress of a number of significant projects. The Executive Director of Finance & Resources said that the work was continuing with the four projects; e-rostering, electronic patient record, estates rationalisation and patient administration. It was noted that the definition of "complete" in the status boxes was unclear. The Executive Director of Operations would make that more explicit in the next report. The Executive Director of Operations said that the next phase in the EPR project was Integrated services for Children with Additional Needs (ICAN) which was currently EPR light. She said there was a need to re-model the EPR system to mirror the new ways of working in that service. The Executive Director of Operations said that by the end of this financial year the neighbourhood teams would also be 'services as usual' from an informatics perspective. The Executive Director of Operations said that the roll out of the new demand and capacity tool was running behind schedule but had now been implemented. Members of the internal audit team had reviewed the progress to date and a report was expected in late July 2017. The audit work would be	

	repeated in quarter four to review whether the new ways of working had been embedded. It was agreed that of the projects which were still to be scoped, patient administration, was to be taken off the list. The Executive Director of Operations said that in the neighbourhood recovery plan there were three pieces of work; new ways of working, capacity and demand and contractual requirements. It was agreed that these items were no longer to be included in the projects update. The Chair said that the Committee was happy to receive the flash reports in terms of raising issues and concerns but he was looking for a programme oversight commentary from the Executive Director of Finance & Resources to come back. The Committee would still welcome some opportunity to look at the individual projects to note and in terms of the programme, how that interconnection was working effectively. **Outcome:** The highlight project reports were received by the Committee. Clarification was sought on reporting back on key projects and the assurance arrangements for the overall programme of developments; pending this, the report had provided limited assurance only.	
2017/18 **(25)**	**Triangulation issues between quality, staffing and finance** A paper was produced jointly by the Executive Director of Operations and the Executive Director of Nursing following a request by the Committee for assurance that the management of demand and capacity had not impacted adversely on the quality of service provided or on any other key performance indicators. The Executive Director of Operations said that more work was required to understand the demand of all elements of the system. In terms of capacity, she said it had been useful to fund the neighbourhood team budgets to the Trust's average sickness rate to ensure appropriate cover was secured. Finally, the Executive Director of Operations said that the neighbourhood team ended the financial year with budgets within tolerance. A Non-Executive Director (TD) said that the area which remained a challenge and continuous pressure was a risk around the necessary training potentially slipping and having an impact on capacity and delivery and concerns around deferred activities. The Executive Director of Operations said that in terms of deferred visits they were in line with a protocol which stated that a routine visit could be deferred depending on what was required, and only when it was clinically safe to do so. The Executive Director of Operations said that in the last month the service had reviewed the offer of activities for daily living (ADLs). The Director of Workforce added that the information about staffing the services was not just about filling gaps by agency and bank staff but also being paid overtime which needed to be factored into the financial assessment. The Chair welcomed some consideration towards looking to populate a balanced scorecard for each of the neighbourhood teams.	

	The Chair thanked the Executive Director of Operations and the Executive Director of Nursing for the paper. It gave good assurance on safety issues and measures and progress around maintaining quality of service. The Committee took strong assurance from the measures that were in place to maintain that effective balance between quality, staffing and finance. Further work was invited to highlight more sharply the measurable benefits arising from the key productivity improvements, and to come back to the Business Committee in three months' time, particularly in preparation for the winter period. In his summary, the Chair said that it was a very informative paper, a comprehensive piece of work. He noted the measures that were mitigating the pressures and they were well laid out. He was particularly interested in the reviews of caseloads and deferral of visits and to understand what impact the case reviews were having in terms of reduction in work or increase in productivity. **Action:** The Executive Director of Operations to report on measurable benefits from productivity improvements to Committee in October 2017. **Outcome:** The Committee noted from the quality indicators and processes that there had been no detrimental to quality of service provided. It was concluded that this provided substantial assurance.	SP
2017/18 **(26)**	**Business planning and commercial development** Please see private minutes.	
2017/18 **(27)**	**Organisational Development Strategy and implementation:** OD strategy: prioritisation and packaging of initiatives A revised plan was presented back to the Committee to demonstrate planning for 2017/18. It was a simplified revision with a stronger coherence to the developing of business requirements. A Non-Executive Director (RG) noted that the four objectives around building a foundation of the organisational structure and infrastructure systems did not appear to be in the list of priorities. The Director of Workforce had noted these in the objectives and next steps and would add to the list. **Action:** Progress against plan would be reported to Committee in July 2017 as part of the first quarterly workforce report. **Outcome:** It was agreed that progress against the plan would be presented back to the Business Committee on a quarterly basis starting in July 2017. The Business Committee will continue to seek assurance on the implementation of the OD plan.	SE
2017/18 **(28)**	**Performance management** **28a – Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports and said that it was worth reflecting that there were more greens than this time last year and where there were concerns last year the indicators had improved or were improving.	

	The Chair noted that the appraisal rate had decreased on last month's figure and the issue of better understand the reasons for leaving the Trust continued to be a concern, but he was pleased to see that the Trust had achieved all of its targets within the safe domain, especially the Duty of Candour incidents reported as 100%. The Director of Workforce said that the concerns were with ESR recording and not with exit questionnaires. It was noted that the friends and family test remained high. The target rate for this year was carried forward from last year which was the response rate at quarter four. A Non-Executive Director (RG) queried the increase in short term staff sickness absence in May 2017. It was noted that the sickness related to adult and corporate services and included South Leeds Independence Centre (SLIC) and Community Intermediate Care Unit (CICU). *Finance* It was reported that the Trust's financial performance was satisfactory in line with plan for the year to date. CIP delivery continued to be a concern and pay overspending had been mitigated by underspending on non-pay and release of reserves. Staffing levels were below funded levels, and had reduced again this month; temporary staffing was in place to mitigate service risks. A Non-Executive Director (RG) asked about the progress on cost improvement plans (CIPs) and asked whether that was recoverable. The Executive Director of Finance & Resources said that the financial position reflected in the report assumed savings of £800k to be recovered in the remaining months of the year. **Outcome:** The Committee noted areas of satisfactory performance and some areas of improvements across previous challenges. **28b – Neighbourhoods' report, dashboard and systems resilience report** The Committee received the updated report on neighbourhood services. No further comments were noted. **Outcome:** The report was noted. **28c – Operational and non-clinical risks register 8+** The risk register report provided the Business Committee with an overview of the Trust's clinical and operational risks currently scoring 8 or above after application of controls and mitigation measures. It was noted that there had been six new non-clinical risks added to the risk register since May 2017. Risks associated with e-rostering and new business development in terms of exposure will be recorded in the risk register. There were discussions regarding the high vacancy risk in school nursing service. The Executive Director of Operations said that a clear judgement was made not to recruit to particular posts whilst waiting for phased recruitment and a review of skill mix. She said that this was a short term risk. SMT had recently signed off a number of posts at lower banding.	

	The Executive Director of Operations confirmed that risk 868 relating to six-weeks waiting list breach risk in children's audiology due to reduced clinical staff capacity had been de-escalated. **Action:** The risk register would be refreshed to capture the two new risks. **Outcome:** The Committee noted the revisions made to the risk register. **28d – Internal audit reports** The Committee noted the audits completed as part of the approved 2016/17 plan. The Director of Workforce advised the Committee that the Audit Committee had asked her for an update in July 2017 on the audit recommendations related to statutory and mandatory training. **Action:** The Committee welcomed a copy of the report at its next meeting in July 2017. **Outcome:** The Committee noted the audit report.	BM SE
2017/18 **(29)**	**Business Committee's work plan** **29a – Items from work plan not on agenda** - No items were noted. **29b – Future work plan** - The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(30)**	**Matters for the Board and other Committees** • MSK presentation – a positive business potential • e-Rostering • Overview of projects • Triangulation of indicators – a recognition of assurance of quality, staffing and focus • CAMHS bid • Finance – limited assurance • Fire risk	
2017/18 **(31)**	**Any other business** *Fire Inspection* – The Trust was asked to submit a report to NHS Improvement relating to any issues with cladding on buildings. It was noted that the Trust had in place its own fire risk assessments or fire risk plan in accordance with the Trust's fire safety policy. The assessments had been sent off to NHS Improvement. The Executive Director of Finance & Resources said that, over the weekend of 24/25 June 2017, all NHS providers were asked to ask the fire service to inspect all their properties by close of play Sunday 25 June 2017. The Chief Executive's report for August 2017 would also include a paragraph on fire safety. **Outcome:** The Committee took substantial assurance from the update on fire risk across the Trust estate. A process of inspection was in place and a revised operating procedure was in production for future inspection arrangements.	

Leeds Safeguarding Adults Board

Minutes – 21st February 2017

Board Membership		
Name	**Organisation**	**Attended**
Richard Jones CBE	Independent Chair – Leeds Safeguarding Adults Board	✓
Cath Roff (Member)	Leeds City Council (LCC) - Director of Adult Social Services	✓
Shona McFarlane (Member)	Leeds City Council (LCC) - Adult Social Care	✓
Julie Bootle (Deputy)	Leeds City Council (LCC) – Adult Social Care	
Superintendent Sam Millar (Member)	West Yorkshire Police (in part)	✓
DCI Mark Griffin (Member & SAR Sub-group Chair)	West Yorkshire Police	
Maureen Kelly (Member and L&I Sub-group Chair)	Leeds South & East NHS Clinical Commissioning Group (CCG)	
Gill Marchant (Member)	Leeds NHS Clinical Commissioning Group (CCG)	✓
Suzanne Hinchliffe CBE (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Helen Christodoulides (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Karen Sykes (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Rachel Stanton (Deputy)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Anthony Deery (Member)	Leeds and York Partnership NHS Foundation Trust (LYPFT)	
Lindsay Britton-Robertson (Deputy)	Leeds and York Partnership NHS Foundation Trust (LYPFT)	✓
Marcia Perry (Member)	Leeds Community Healthcare NHS Trust (LCH)	✓
Steph Lawrence (Deputy)	Leeds Community Healthcare NHS Trust (LCH)	
Tanya Matilainen (Member and CE Sub-group chair)	Healthwatch Leeds	✓
Stuart Morrison (Deputy)	Healthwatch Leeds	
Lisa Toner (Member)	West Yorkshire Fire and Rescue Service	
Gary Borthwick (Deputy)	HMP Wealstun	
Max Lanfranchi (Member)	National Probation Service	
Rachel Garry (Deputy)	National Probation Service	✓
Sandra Chatters (Member)	Community Rehabilitation Company	
Peter Turner (Deputy)	Community Rehabilitation Company	
Sharna Duggan (Deputy)	Community Rehabilitation Company	✓
Mandy Sawyer (Member)	Leeds City Council: Housing Leeds	✓
Emma Stewart (Member)	Alliance of Service Experts	✓
Philip Bransom (Member)	Third Sector Leeds and Advonet	
Bridget Emery (Member)	Leeds City Council: Public Health	✓
Derek Sylvester (Member)	West Yorkshire Fire and Rescue Service	
Richard Hattersley	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Dan Harris	HMP Leeds	✓
Maureen Sirrell	HMP Leeds	✓
Dave Basker (Member)	Children's Services Leeds	✓

Board Membership		
Name	**Organisation**	**Attended**
Tony Westwood	Leeds City Council, Legal	✓
Gerry Gillen	Leeds Safeguarding Adults Board (LSAB) Legal Adviser	
Gillian Probyn (in attendance for item 2)	Leeds City Council (LCC) - Adult Social Care	✓
Emma Mortimer (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓
Kieron Smith (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓
Loraine Danby (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓

Item No.	Item	Action, Timescale and Person responsible
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 8th December 2016 and Matters arising**	
	The minutes were agreed as correct. Richard presented the actions from previous meetings requesting updates. **LSAB 8th December 2016** **Action:** Item 1) Revise and update October 2016 Savile Learning Pack • **Update:** Emma Mortimer Safeguarding Adults Partnership Support Unit had revised the learning pack, however some people have reported difficulties accessing the documents. Hence these will be reformatted and redistributed to members. **Action**: Item 3) Taking Forward the Learning. Use the learning from the October 25th Development Session to inform the next Board Development Session on 7th February 2017. • **Update**: It was noted that this matter was on the agenda for this meeting at Item 4. **Action**: Item 3) Proposal for LSAB learning from the three statutory safeguarding review processes in the City to be brought to the February 2017 Board.	Action: Updated learning pack to be placed on LSAB Website, and update members with what has been done By: 7th March 2017 Lead: E Mortimer

Item No.	Item	Action, Timescale and Person responsible
	• **Update**: Richard Jones informed the members this has been discussed within the three board managers' meeting and it is proposed that this will form part of the agenda for the Three Board's Development session planned for 24th May 2017. **Action**: Item 3) City-wide commissioning presentation to be deferred until after the Board Development Day on 7th February 2017 • **Update**: Action noted and to be scheduled. Richard Jones noted that this links with discussion at Item 4 about the the Board Development Day. This is essential to the Board being able to understand the wider commissioning picture in Leeds and its role in the context of the poor care / neglect. **Action**: Item 5) Meeting to take place between the three board chairs to discuss the key cross-cutting themes for a Joint Board development session between LSAB, LSCB and SLE. • **Update**: The Board development session is planned for the 24th May 2017, the meeting between Chairs is currently being arranged. **Action**: Item 5) Proposal to use a shared online assurance tool to be discussed with LSCB and reported back to a future Board. • **Update**: Early discussion with the LSCB, which holds the database have taken place. Updates to be provided in due course. **Action**: Item 6) SARs to be reported to the Executive Group • **Update:** process now established. **Action**: Item 7) LCH to report safeguarding related learning from its CQC Inspection at the Board meeting following publication of the inspection report. • **Update**: Marcia Perry informed the members that the CQC Inspection report is not expected before April 2017. **Action**: Electronic invitations for Board Meeting dates to be circulated to Board members • **Update**: Action complete	Action: LCH to provide learning from its CQC Inspection By: April 2017 Lead: M Perry
2.	**Safeguarding Adults Data for 2015-16:** **Comparing Leeds Performance with our 15 Comparator Cities**	
	Gillian Probyn, Principle Performance Officer, ASC presented a paper on the Safeguarding Adults Data for 2015-16 comparing Leeds performance with our 15 comparator cities. The report outlined the key issues relating to the Leeds Safeguarding Adults Return for 2015-16, in terms of comparing Leeds performance with its 15 comparator authorities.	

Item No.	Item	Action, Timescale and Person responsible
	The report incorporated finalised Safeguarding Adults Collection data to compare Leeds' data with its comparator cities; these are Bolton, Medway Town, Warrington, Bradford, Liverpool, Newcastle, Bristol, Dudley, Sheffield, Derby, Salford, Swindon, Kirklees, Wakefield and Coventry. These comparator Local Authorities have been grouped together in recognition of various similar aspects such as demographic profile, economic pressure, organisation structure etc. It was noted however that it can be difficult to compare exactly across areas, as each will have different processes and may capture data differently. Cath Roff spoke about the work of Yorkshire & Humber Performance Group and that it may take a couple of years to establish consistency of information produced by each authority in the region. Locally the information captured on CIS is improving. Cath Roff recommended that we need to have a good understanding of the equalities issues within the data produced in Leeds, and asked that the Quality Assurance and Performance Sub-group to provide an analysis of ethnicities of individuals within their quarterly reports. Gillian Probyn noted that the percentage of interventions where the risk was reduced or removed was good in Leeds. It was the second highest in the comparison report. Gillian Probyn invited LSAB members to get in touch with her should they require more information. Richard Jones thanked Gillian for her paper to the Board.	Action: Quality Assurance and Performance sub-group to provide an analysis of ethnicities of individuals subject to safeguarding adults process within its quarterly reports By: 19 April 2017 Led by: Shona McFarlane
3.	**LSAB Governance Arrangements**	
3(i)	Executive Group: Discussion Summaries Emma Mortimer presented a report providing the Board members with a summary of the discussions that took place in November 2016 and twice in January 2017. The role of the Executive Group is to shape and lead the agenda for the Board, it is not a decision making group. Members of the Board noted discussions. The Executive Group meets in-between the LSAB Board meetings. The Executive Group is Chaired by Richard Jones. Going forward there will also be an Executive Group: SAR Review Chaired by Maureen Kelly. The new Executive Group SAR panel will replace the previous SAR Sub-group. Richard Jones informed the members of the LSAB Board that he had written to the SAR sub-group and its chair thanking them for their contributions.	
3(ii)	LSAB Strategy Unit Review and Timescales for Completion Shona McFarlane provided an update on the restructure of the Safeguarding Adults Partnership Support Unit. The Board had received updates from Shona on this matter at each meeting. Shona informed members that the revised structure has	

Item No.	Item	Action, Timescale and Person responsible
	been approved by the local authority Delegated Decision Panel and would now be working to take this forward in line with the appropriate procedures.	
3(iii)	LSAB Annual Report Requirements 2016-17 Kieron Smith presented a paper on the LSAB Annual Report 2016-17. Kieron explained that since the introduction of the Care Act 2014 the Board has a statutory requirement to produce an Annual Report. The paper sets out the legal requirements of the Board in relation to the production of an Annual Report, and includes a request for member organisation contributions and an outline of timescales. Kieron Smith highlighted that there is not just a requirement for the LSAB Board to report what it has done in relation to its objective and its strategy; but also there is a need to report what each member has done during that year to implement the strategy. Board members were requested to note the contents of the report and provide a member organisation contribution to the Annual Report by 21st March 2017. Kieron Smith to send an electronic template for member organisation contributions by 22nd February 2017. Members to forward their contribution to Kieron Smith by 21st March 2017. Kieron Smith to present the Annual Report to the Board on the 19th April for consideration and potential approval.	Action: Template to be sent electronically to Board Members By: 22nd February 2017 Led by: Kieron Smith Action: Board Members to complete the template with their contribution to the LSAB Board Annual Plan By: 21st March 2017 Led by: LSAB members Action: Draft Annual Report to the 19th April meeting By: 19th April 2017 Led by: Kieron Smith
4.	**LSAB Development Session – 7th February 2017**	
4(i)	Board Member reflections Richard Jones led a reflection on the Board Development Session that took place on 7th February 2017. This day was held as part of a process of development. A wide consultation exercise was undertaken in September/October 2016 seeking feedback on safeguarding practice from a wide range of stakeholder groups, during which it was clear that there was a diversity of views as to what issues required a response within the Board's multi-agency policy and procedures. There was also a need for the Board to reflect the extent and breadth of its role beyond those individuals supported through this particular process. The Board Development Day was therefore devised to provide an opportunity to explore these issues. Gerry Gillen had given a presentation from a legal perspective on role and responsibilities of Safeguarding Adults Boards; and the local authority Section 42 Duty to make enquiries. A number of exercises followed to explore what issues would be addressed within the multi-agency procedures and to reflect on the Board's wider strategic interests. The Board Development Day confirmed that there was a diversity of views about when a safeguarding adults response was required, but it was also useful in exploring the Board's interests in relation to a range of issues such as sexual exploitation, scams, distraction burglary, prisoners, hate crime, forced marriage, domestic violence and abuse, poor quality care and radicalisation.	

Item No.	Item	Action, Timescale and Person responsible
	Members of the Board felt that this session had provided a helpful insight into practice in Leeds it is proposed that the Executive Group develop a plan for how the Board could take forward such an approach.	Action: Executive Group to develop a plan for how the Board could take forward proposals By: 31 March 2017 Led by: LSAB Executive Group
5.	**Leeds Safeguarding Adults Board, Strategic Plan 2016-17**	
5(i)	**Sub-group Chairs' updates** Shona McFarlane – Chair of the Quality Assurance and Performance Sub-group. • Shona updated the Board on the work of the groups as set out in the sub-group chairs report. The work is challenging and progressing. Tanya Matilainen – Chair of the Citizens Engagement Sub-group. • Tanya Matilainen noted that there had not been a meeting in the previous period. The sub-group recognises however the importance of working in partnership with other Boards to promote awareness of safeguarding services. Tanya Matilainen spoke of the importance of gathering people's views on the safeguarding process. Richard Jones reflected on the need to commission arrangements to gather and learn from people's lived experiences. Maureen Kelly – Chair of the Learning and Improvement Sub-Group. • Richard Jones stated that in Maureen's absence there was nothing additional to highlight to the Board at this stage. There had been no meeting in the previous period. Cath Roff reflected that as a Board we need to do more to support the work of the sub-groups. Cath felt sub-groups should be able to draw upon collectively expertise of the partnership, and should not be solely dependent on the Partnership Support Unit. Richard Jones spoke of the need to have the right resources and best contribution from member organisations in order for the Board to own and deliver its agenda.	
6.	**Board Member Updates**	
6(i)	West Yorkshire Police Operational Safeguarding Arrangements Supt. Millar offered to provide Board members with an outline of the Leeds District Safeguarding Unit at a future meeting.	Action: Supt. Millar to provide Board members with an outline of the Leeds District Safeguarding Unit By: 19 April 2017

Item No.	Item	Action, Timescale and Person responsible
		Led by: Supt. Millar
6(ii)	LTHT Safeguarding Operational Arrangements Karen Sykes, Head of Safeguarding advised that Leeds Teaching Hospitals NHS Trust has recently reconfigured its safeguarding team and this has included a significant increase in resources. These new posts are currently being recruited that will assist the Trust to achieve its ambition to provide a high standard of safeguarding adults and children.	
6(iii)	Public Health Commissioning: Update Bridget Emery explained that there are newly commissioned services which will be operational in Leeds from July 2017 and contributes to improving outcomes for some of the most vulnerable people in the city. Bridget Emery provided an update of Housing Related Intensive and Dispersed Accommodation Services. A six month mobilisation period is underway from 1st January 2017 and during this time they look forward to working with Beacon to finalise arrangements for service delivery. Beacon has been commissioned to provide a new city wide Housing Related Support (HRS) accommodation service for vulnerable adults, couples and families to prevent homelessness, and to address housing need. Beacon will be delivered by a consortium made up of Leeds Housing Concern, Touchstone and Foundation. The Service will provide accommodation and support and enable individuals to have choice and control through a personalised, responsive and flexible service promoting independence whilst improving and sustaining individuals' long term wellbeing and independent living. The service will work in partnership with a wide range of other agencies to help all clients, particularly those people who have multiple or complex needs to tailor their own personal 'recovery journey'. Accommodation will be delivered through a mixture of intensive supported accommodation with access to staff 24 hours a day, 7 days a week and community dispersed properties with visiting support. Delivery will be focused upon the following themes: Prevention of homelessness and early intervention, sustainment and a person's ability to live in safe and suitable accommodation and integration - supporting people to participate and access the services and social/recreational opportunities available to them. Peer support, befriending and volunteering is an integral part of the service and part of a range of options available to clients. The service will ensure that all clients have the opportunity to access this as part of their support package. In addition a number of accommodation based housing related support services have been retained as part of the wider model. These services include the; Overnight Centre and Hub, Regents Terrace, Carr Beck, Kirkstall Lodge and RD Willis Properties. These services are strategically important to the city working with some of the most	

Item No.	Item	Action, Timescale and Person responsible
	vulnerable people with multiple support needs who are at risk whilst being street homeless, rough sleeping and vulnerably housed. The services will proactively engage with, and be accessible to individuals from a diverse range of ethnic, religious and cultural backgrounds.	
6(iv)	All other members Cath Roff informed the members there is a National / Regional Reports on Making Safeguarding Personal (MSP) which members may be worth considering at a future meeting.	
7.	**Any Other Business and Reflection**	
7(i) 7(ii) 7(iii) 7(iv)	Richard Jones outlined to members that there was currently a tragic case relating to the death of an individual in Leeds. Potentially this was a case with which each safeguarding Board in Leeds may need to have involvement. Richard explained a briefing has been prepared to provide Leeds Safeguarding Adults Board Executive Group SAR Panel, the Leeds Safeguarding Children Board Executive Board SCR Panel and the Safer Leeds Executive Chair and DHR sub-group chair with information concerning the case. There is an criminal investigation process being led by West Yorkshire Police Homicide and Major Enquiry Team (HMET). Richard asked members to be aware of its high level of sensitivity. Cath Roff spoke of diversity issues and suggested that future meetings could include a safeguarding insight from an equalities perspective and suggesting linking with the work of the equalities hub to inform the Board's thinking and forward planning. Karen Sykes raised the subject of children's gender and the transition into adulthood. Shona McFarlane explained that Max Naismith and Shona attend a Panel based meeting held twice yearly on sexual exploitation and transition and this could be explored further through that meeting. Richard Jones on behalf of the Board members thanked Bridget Emery for her contribution to the work of the Board and wished her well for the future. Richard Jones thanked members of the Board for their contributions.	Action: Explore the possibility of using feedback form the Equalities Hubs within the Safeguarding Reflections item By: September 2017 Led by: Executive Group
8.	**Date of Next meeting**	
	19 April 2017 The Rose Bowl, Leeds Beckett University, Portland Crescent, Leeds LS1 3HB http://www.leedsbeckett.ac.uk/conferencing/our-venues/rose-bowl/	Action: Electronic invitations to be circulated to Board Members. By: 8 March 2017 Led by: J Ogier

Leeds Safeguarding Adults Board

Actions from 21st February 2017

Item No.	Action	Person / organisation responsible	Target date
Item 1.ii	LSAB 13th October 2016: Item 2 i.) – LSAB learning 2 i.) Savile *Learning pack to be updated as discussed and redistributed.* Updated learning pack to be placed on LSAB Website, and update members with what has been done.	E Mortimer	7th March 2017
Item 1.ii	LCH to provide learning from its CQC Inspection	M Perry	19 April 2017
Item 2	LSAB 21st February 2017 - Safeguarding Adults Data for 2015-16: Comparing Leeds Performance with our 15 Comparator Cities Quality Assurance and Performance Sub-group to provide an analysis of ethnicities of individuals subject to safeguarding adults process within their quarterly sub-group reports.	S McFarlane	Future quarterly reports
Item 3.iii	LSAB 21st February 2017 - LSAB Governance Arrangements Annual Report Template to be sent electronically to Board Members Board Members to complete the template with their contribution to the LSAB Board Annual Report Draft Annual Report to the 19th April meeting	K Smith Board Members K Smith	22nd February 2017 21st March 2017 19th April 2017
Item 4.i	LSAB 21st February 2017 - LSAB Development Session – 7th February 2017 Executive Group to develop a plan for how the Board could take forward proposals	Exec Group	31 March 2017
Item 6.i	LSAB 21st February 2017 - Board Member Updates Supt. Millar to provide Board members with an outline of the Leeds District Safeguarding Unit	Supt. Millar	19 April 2017
Item 7. 7.iv)	LSAB 21st February 2017 - Any Other Business and Reflection Explore the possibility of using feedback form the Equalities Hubs within the Safeguarding Reflections item, to inform the Board's thinking and forward planning.	Executive Group	September 2017
Item 8	LSAB 21st February 2017 - Date of Next meeting Electronic invitations to be circulated to Board Members.	J Ogier	8 March 2017

Leeds Safeguarding Adults Board

Continuing Actions from Previous Board Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
December 2015	Item 7	LSAB Strategy and Annual Plan Vice Chair of the Board to be appointed by April 2017.	LSAB	1st April 2017	Richard Jones, Independent Chair to discuss with Cath Roff, DASS after April 2017
13th October 2016	Item 2 ii.)	LSAB Learning Mazars The final report into the findings is currently being awaited from the Department of Health. To be brought back to a future Board meeting	Emma Mortimer Safeguarding Adults Partnership Support Unit	To a future Board	
		Safeguarding Unit to undertake a review of good practice in learning from untoward deaths, reviewing good practice both locally and nationally, mapping terminology, definitions and legal duties.	Emma Mortimer Safeguarding Adults Partnership Support Unit	To a future Board	Not an immediate priority. Needs to be undertaken with partner Boards.
13th October 2016	Item 3	Board Member Updates Domestic Violence and Abuse Routine Enquiry Pilot and Film to be brought to December Board for review and discussion.	Gill Marchant	Deferred to the Board meeting that considers the	

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
				A 17 SAR.	
13th October 2016	Item 4 i.)	Sub-group chairs' updates Learning and Improvement Strategy and Quality Assurance Framework to be reported to December Board.	Learning and Improvement Sub-group	Deferred. Date to be confirmed	
4th August 2016	Item 4	Local Government Association – Peer Challenge: Review Adult Social Care, Public Health and Clinical Commissioning Groups to jointly present an overview of commissioning responsibilities in Leeds to the LSAB.	Adult Social Care, Public Health and Clinical Commissioning Groups	To a future Board meeting in 2017-18.	
December 2016	Item 3	Board Development Session 25th October 2016 – Taking Forward the Learning Proposal for LSAB learning from the three statutory safeguarding review processes in the City to be brought to February 2017 LSAB. City-wide commissioning presentation to be deferred until after the Board Development Day on 7th February 2017.	E Mortimer and K Smith Richard Jones CBE	Deferred. Date to be confirmed Date to be confirmed	
December 2016	Item 5	Leeds Safeguarding Partnerships – A proposal for enhanced collaborative working Meeting to take place between the three board chairs to discuss the key cross-cutting themes and proposals for progression. Joint Board development session between LSAB, LSCB and	Richard Jones CBE K Smith and E	1st April 2017 – new target date June 2017 1st June 2017	Agreement at February 2017 Board meeting that this would form part of the Three Board Development day on 24 May 2017

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
		SLE to be convened. Proposal to use a shared online assurance tool, to be discussed with LSCB and reported back to a future Board.	Mortimer K Smith and E Mortimer	 TBC	

Leeds Safeguarding Adults Board

Minutes – 19th April 2017

Board Membership		
Name	**Organisation**	**Attended**
Richard Jones CBE	Independent Chair – Leeds Safeguarding Adults Board	✓
Cath Roff (Member)	Leeds City Council (LCC) - Director of Adult Social Services	
Shona McFarlane (Member)	Leeds City Council (LCC) - Adult Social Care	✓
Nigel Parr (Deputy)	Leeds City Council (LCC) – Adult Social Care	
Superintendent Sam Millar (Member)	West Yorkshire Police (in part)	✓
Detective Chief Inspector Dave Cowley (Deputy)	West Yorkshire Police	
Maureen Kelly (Member and L&I Sub-group Chair)	Leeds South & East NHS Clinical Commissioning Group (CCG)	
Gill Marchant (Member)	Leeds NHS Clinical Commissioning Group (CCG)	✓
Suzanne Hinchliffe CBE (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Helen Christodoulides (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Karen Sykes (Member)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Rachel Stanton (Deputy)	Leeds Teaching Hospitals NHS Trust (LTHT)	
Anthony Deery (Member)	Leeds and York Partnership NHS Foundation Trust (LYPFT)	
Lindsay Britton-Robertson (Deputy)	Leeds and York Partnership NHS Foundation Trust (LYPFT)	✓
Marcia Perry (Member)	Leeds Community Healthcare NHS Trust (LCH)	✓
Steph Lawrence (Deputy)	Leeds Community Healthcare NHS Trust (LCH)	
Tanya Matilainen (Member and CE Sub-group chair)	Healthwatch Leeds	
Stuart Morrison (Deputy)	Healthwatch Leeds	
Gary Borthwick (Deputy)	HMP Wealstun	
Max Lanfranchi (Member)	National Probation Service	
Rachel Garry (Deputy)	National Probation Service	
Sandra Chatters (Member)	Community Rehabilitation Company	
Peter Turner (Deputy)	Community Rehabilitation Company	
Sharna Duggan	Community Rehabilitation Company	
Mandy Sawyer (Member)	Leeds City Council: Housing Leeds	✓
Emma Stewart (Member)	Alliance of Service Experts	✓
Philip Bransom (Member)	Third Sector Leeds and Advonet	
Emma Howson (Member)	Leeds City Council: Public Health	✓
Derek Sylvester	West Yorkshire Fire and Rescue Service	
Richard Hattersley	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Zoe Hiner	HMP Leeds	✓
Maureen Sirrell	HMP Leeds	
Dave Basker	Children's Services Leeds	

Board Membership		
Name	**Organisation**	**Attended**
Tony Westwood	Leeds City Council, Legal	
Gerry Gillen	Leeds Safeguarding Adults Board (LSAB) Legal Adviser	
Emma Mortimer (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓
Kieron Smith (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓
Amanda Loftus (Ex officio)	Leeds Safeguarding Adults Partnership Support Unit	✓
Belinda Sharratt (Observer)	Leeds South & East NHS Clinical Commissioning Group (CCG)	✓

Item No.	Item	Action, Timescale and Person responsible
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 21st February 2017 and Matters arising**	
	1.i) The minutes were agreed as correct. Richard presented the actions from previous meetings requesting updates. **LSAB 21st February 2017** **Action:** Item 1.ii) Revise and update October 2016 Savile Learning Pack • **Update**: Complete. It was noted that the updated learning pack is now on the LSAB website. **Action**: Item 1.ii) LCH to report safeguarding – related learning from its CQC Inspection at the subsequent Board meeting following publication of the inspection report. • **Update**: It was noted that LCH are still awaiting the CQC report. **Action**: Item 2) Quality Assurance and Performance sub-group to provide an analysis of ethnicities of individuals subject to safeguarding adult's process within its quarterly reports. • **Update**: It was noted that this work is being taken forward within the sub-group.	

Item No.	Item	Action, Timescale and Person responsible
	Action: Item 3) Taking Forward the Learning from the Board Development Sessions. • **Update**: It was noted that this matter was on the agenda for this meeting at Item 4. **Action**: Item 6) Supt. Millar to provide Board members with an outline of the Leeds District Safeguarding Unit. • **Update**: It was agreed that in DCI Dave Cowley's absence this will be brought to the June Board. Richard noted that an outstanding action was the recruitment of a Deputy-Chair. He stated that if any Board members were interested in taking on this important role then to speak to him in the first instance.	Action: To be added to a future Board Agenda By: June Board Lead: Kieron Smith/Emma Mortimer
2	**Safeguarding Insights**	
	In response to an action from the February 2017 Board meeting, to explore the possibility of using feedback from the Equalities Hubs within the Safeguarding Reflections item. Howard Beck, Consultation & Involvement Officer had planned to attend today's meeting to offer a perspective from the deaf community, but was unable to do so due to being unable to access a BSL interpreter.	Action: To be invited to a future Board By: June Board Lead: Kieron Smith/Emma Mortimer
3	**Annual Report 2016/17**	
	Kieron explained that it is a statutory requirement for the Board to produce an Annual Report. This year the Annual Report is based around the Board's four ambitions that were set at the beginning of the year. The report also seeks to link the work of Member's Organisations to each of these ambitions. Kieron thanked members for their contributions. It was noted that not all member organisation had as of yet submitted their contributions. It was agreed that any outstanding contributions should be submitted by the end of next week if possible. Kieron explained that once the report is agreed an easy read version will be developed. Richard commented that Kieron Smith had done an excellent job and he felt that the format and feel of the report worked well. Richard encouraged those members that had not already made submissions to do so and asked for feedback. Marcia Perry stated that she really liked it and felt that it was very readable and felt very much a partnership document. The narratives were helpful as they link across agencies and show how the jigsaw links together across the city. Marcia added that she was looking forward to the final version. Richard agreed with Marcia's comments and stated that he would endorse how the report reads, in that it is reflective of a partnership approach.	Action: Any outstanding submissions to be sent to Kieron Smith By: 28th April 2017

Item No.	Item	Action, Timescale and Person responsible
4	**Taking Forward the learning from the Board Development Sessions**	
	Richard explained that this had been discussed earlier at the Executive Group. Richard said that it was clear in the Board Development Session in February that there was a range of understanding around what safeguarding means, and around when the safeguarding procedures should be used. There was also a useful discussion about the statutory and operational responsibilities of the Board, as well as the Board's strategic interests. The challenge now was to put a set of proposals into action. Kieron explained that the proposed approach set out in the paper reflects the thinking from the Board Development Session. There was a general agreement that the Board should have a wider perspective. The proposal is to identify particular issues that are important to the Board, and take a holistic view to understand the full range of systems in place to support people to be safe in the city. Kieron gave an example of quality of care being a possible theme for the Board to discuss. A suggestion could be that the Board holds a session to understand the situation of people in care homes, looking at the safety of people using an holistic approach, for example what we know from the safeguarding adults process, what commissioning arrangements are in place to keep people safe, what is the learning from responsible regulatory bodies such as the Care Quality Commission. The responsibility of the Board would be to look at what arrangements are in place to protect people from abuse, to have an oversight of prevention work, and an understanding of what systems are in place to support this. The Board could pick a range of different topics with the focus being on understanding how we can be assured that people in these situations are safe, not just those people who have been through safeguarding adult's procedures. It would mean that the discussion would be more relevant to all members of the Board, reflecting the wider partnership approach. Kieron summarised that this was a proposal only and member's views were very welcome. The aim is to help the Board to take a broader approach, to be more proactive and to gain a real understanding of people's situations. Richard thanked Kieron for his contribution and asked for the views of members. Marcia stated that she liked the suggestion and the idea of working this way but the question is how we get the information and crucially the evidence to say what those issues are. The question is how we get agreement around what we look at. We are talking about a 'deep dive' of understanding. Richard was in agreement with Marcia and stated that it is about what we expect for the citizens of Leeds, as a Board we need to ask how we are making a contribution – how we influence others and raise the profile of safeguarding across the city. Helen Christodoulides added that she also thought it was a good idea and would welcome having a go at it, but that there would need to be clear guidance around the facilitation of the event and the preparation for it. Helen stated that as a Board we wouldn't want to be left with a range of issues that we are unable to deal with or do not have the authority to influence. However, the principle of being pro-active and	

Item No.	Item	Action, Timescale and Person responsible
	looking at the issues in a strategic way was welcome. Gill Marchant added that she would see that the role of the Board would be to identify and have awareness of any gaps. Emma Stewart stated that we should respond to identified gaps, by considering how we can influence change for example around commissioning. She was of the opinion that it would be good to have a more interactive conversation. Richard summarised that there appears to be really good support for such an approach. It is now about how we develop and deliver the process and get involvement from individuals and agencies. We need to get to a place where we feel we are delivering effective leadership. Clearly this is not without risk and we could just play it safe and run 5 business meetings per year – which could leave people thinking why are we here, we could be more passive and in a less active space but we need to ensure that we are not going backwards. We are working in a complex environment so this is a concept that needs working through. Richard stated that it felt to him as if it is a risk worth taking. It is good to hear advice and think through how we facilitate this and progress as an action. Richard asked the group for feedback in relation to the decision making process around what the issues to be looked at should be. He added that it had been discussed at the Executive group and Gill had commented on the need to be careful not to be overwhelmed, and perhaps undertake two of these sessions per year, rather than three. Richard made the suggestion of possibly using one of the development days to undertake a thematic sessions. Discussion took place and Gill made the suggestion of perhaps holding just one per year. Mandy Sawyer was of the opinion that the Board should be more ambitious, and she was not sure that one was enough, considering the number of client groups across the city; she added that if we are only holding one a year it is going to take a very long time. Mandy was of the opinion that priorities need to be identified based on risk – there has been lots of discussion around emerging risk and there are lots of identified risks with these groups, the key is to be ambitious but not overly ambitious. Richard suggested holding two per year, using one of the Board Development Sessions and one Board to do this. Sam Millar referred to the Three-Board Development Session and suggested that this could be a topic of discussion for the three Boards as some of the themes are universal. We could have a joint conversation around the themes that are emerging and what we are going to do. It is not about making more work it is something about saying how this Board contributes to a range of processes and agencies, for example mental health is thematic across all three Boards so that could an ideal topic to be discussed at the three Boards Joint Development Day which is scheduled to take place in May. Emma Mortimer added that in preparation for the three Board Development Session the three Board Chairs and the Business Unit Managers have been meeting, and discussion has taken place in relation to the Breakthrough Project, Community Cohesion being an a potential theme that could be explored within that event.	Action: to be added to the Agenda for the June Board. Lead Kieron Smith/Emma Mortimer

Item No.	Item	Action, Timescale and Person responsible
	Richard suggested that if anyone had any thoughts around what the other key-themes may be, then to let Emma or Kieron know. Richard said that if members are in agreement, we will come back to the June Board with ideas of how to frame and respond to questions around how to make this work. Richard reflected back, that we are saying yes to doing two per year, and yes to reflection from the three Board event being brought back to the June Board. Richard asked that if anyone is aware of any of this type of thematic work being undertaken previously by other organisations/Boards, could members please share the learning with Emma and/or Kieron.	
5	**Strategic Plan 2016-19 and Annual Plan 2017/2018:** Consultation draft	
	Kieron explained that this was a refresh of the current plan comprising of the four ambitions, which had been updated with actions emerging from the consultation events and Board Development Session that have taken place during this period. The plan also recognises the change of approach from the Board around multi-agency working and forging closer links with LSCB and SLE. Richard asked members for their initial reactions. Shona McFarlane stated that she felt that it was clear and nicely set out, and the only comment that she would have is the need for a more explicit reference 'to making safeguarding personal', just so that it is in line with the national drive around this. This is what would be expected by external people looking in at us as a Board. Emma Stewart commented that she felt that it was quite clear and she liked the concepts being around making sure someone feels safe, and felt that this is a question that is not asked enough, so it's good that it is included. Emma was of the opinion that many people do not understand what safeguarding means but they do understand 'safe' and feeling safe. Helen added that she was impressed by the action planning elements and liked the measures but queried what is the impact of the actions going to be – is it going to make a difference? Sam added that for her personally, previously, it had not felt as if the Safeguarding Adults Board was as relevant as the Safeguarding Children's Board, but reading a plan like this it is clear that things have changed. However she was not sure that the right level of ambition was there. Sam stated that her work is all around risk and vulnerability and previously the Board was very process driven. Sam was now of the opinion that the Board had moved on massively from where it was, but her instinct is for the ambitions to be more ground-breaking and 'vulnerability' should be wrapped around everything. Sam stated that she was very uncomfortable with thinking of vulnerable people in terms of whether they met or did not meet a threshold. Overall she felt that the document was easy to read but she wants it to mean something more to people working on the ground. Emma Howson added that she was in agreement with Sam in relation to vulnerability especially around those people that are difficult to engage with.	Action: to bring back to the June Board: Lead Kieron Smith

Item No.	Item	Action, Timescale and Person responsible
	Sam referred to the vulnerability of sex-workers in the city and the risk levels of vulnerability not being on anybody's radar in relation to safeguarding. At present, these are very vulnerable people, mainly women, the question is does the plan address their needs? Sam referred to the Board Development Sessions and stated that the issues discussed had been amazing, it was such a big difference to how it was previously, in my job within the police the words care and support needs are not key, but obviously for those in Adult Social Care this is important. What we need to be doing as a Board however is wrapping vulnerability around everything that we do. Shona referred to ASC social care teams in South Leeds that receive referrals in respect of sex-workers with care and support needs, noting that her staff tend to look at the issues in relation to risk rather than within the statutory safeguarding framework. Richard said for him, there were three key priorities that he wanted the Board to achieve this year. Firstly, to become a Board that has a continuing role around issues/situations of vulnerability in the city, changing the way we operate and influence. Secondly, to revise the multi-agency policies and procedures this year in Leeds, including an approach that builds on the experiences of people at the front end. He commented that we need to set out how we work in Leeds, asking what are our standards? what does good look like ? how do we are ensure we are person centred? The process needs to be about getting alongside people to help them feel safe and support them in understanding risk and in accessing support. What good looks like in Leeds needs to be based on our learning. Thirdly, we need to understand the lived experiences of safeguarding and vulnerability in the city.. Richard also stated that it is a given that we need to work more closely with the two other statutory Boards. Naturally, there are lots of other things as well that need to be achieved, but, Richard said, if we don't do those three things there would be a missed opportunity. Lindsay Britton-Robertson referred to finding out 'what good looks like' and that to have clarity on this would be helpful in terms of shared outcomes and measures.	
6	**Executive Group – Safeguarding Adults Board** Discussion summary and actions 22nd March 2017	
	Richard provided an overview of discussions from the Executive Group on 22nd March and 19th April 2017. It was noted that the Executive Group is not a decision making group but is more around shaping and thinking through ideas which the Board will then make decisions on.	

Item No.	Item	Action, Timescale and Person responsible
7	**Safeguarding Partnership Support Unit** Restructure Update	
	Shona provided members with an update in relation to the Unit restructure. She explained that there were some HR matters that were causing some delay, but noted that once these were addressed it would be possible to begin recruiting to the new posts that had been established.	
8	**Governance Arrangements** LSAB Strategy Unit	
	Richard provided a brief overview in relation to governance arrangements and explained that previously the Business Support Unit had undertaken a range of functions which were both strategic and operational. The changes that have occurred now provide clarity around the role of the Support Unit in that it is to support the Board. The staff that are currently in post along with those that are yet to be recruited will be resourced by the three statutory partners, and the work that they do will be entirely strategic in support of the Board. The governance arrangements have therefore been set out to provide clarity around this going forward. The Local Authority will continue to be the employing agency, but this is a new model, in relation to how we operate. It is significantly different and there is now real clarity that the unit is a Board resource, accountable to the Board for what it delivers, and this is what the governance document sets out. Richard asked if anyone had any questions in relation to this – he added that we are now in a very different place with the full support of the Adult Social Care senior management team. Sam stated that when she compares the support that Emma and Kieron have to that provided to the LSCB Board Managers then there is a lot less in place for them. Sam explained that she provides support to the LSCB managers in her role as Vice-Chair and felt that this was a vital and very important role that needs filling to provide independent support to the team. Richard was in agreement that a deputy-Chair that is locally based was needed to provide support to the Support Unit Manager's. He asked that any members who would be interested in taking on this role speak to him in the first instance. Gill referred to page 4 of the Governance Document and asked if there was Service Specification in place as this would be helpful to see. Shona reported that there was not one in place as of yet and that it was for the Executive Group to develop one. Shona explained that there were service specifications for other units that may be useful starting point. Emma Mortimer was aware of one that Shona had suggested previously, and agreed to forward this to Shona / Sam.	<u>Action</u>**:** If any members are interested in taking on the role of deputy-chair to contact Richard <u>Action</u>: Develop a service specification for the Unit. <u>By</u>: TBC <u>Lead</u>: Executive Group

Item No.	Item	Action, Timescale and Person responsible
9.	**LSAB Budget Statements**	
	Richard thanked Shona and the team in Adult Social Care for the preparation of the budget statements. He provided an outline of what was included in the statements. Richard explained that there was an underspend for this financial year and it has been agreed that this will be carried forward to the new financial year. Richard stated now that the Board has clarity around budgets we are in a position to fund or commission work around the lived experiences of people in Leeds, through for example, third sector organisations. Any such proposal would come to the Board for approval. Shona further clarified that the budget is the Board's but is held on their behalf by the Local Authority and the finance reports etc. are provided by ASC. It is for the Board to ensure that the budget is managed within spending limits. Richard suggested that a further budget statement be brought back to the Board mid-year to provide an update of where we are at.	Action: Budget Statements to be brought to a future Board for update. By: September 2017 Lead: Executive Group
10	Mental Capacity Act Local Implementation Network Proposal to become a sub-group of the Board	
	Shona explained that Executive Group in March had been supportive of the MCA LIN becoming a sub-group of the Board. The purpose of the group was outlined and Shona explained that it is inextricably linked to safeguarding and covers issues relating to how to deal with people who do not have capacity in relation to particular decisions. The MCA LIN will be able to provide the Board with legal updates and support around complex mental capacity issues, and so will be a useful addition. Richard outlined the proposal – to link the MCA LIN to the Board and explained that there is no resource requirement from the support unit. Richard asked if there were any questions. None were noted. The proposal was agreed. Shona added that Max Naismith will be in attendance at the June Board and will provide a presentation to on current mental capacity / deprivation of liberty safeguard issues.	Action: Provide a presentation MCA / DoLS issues. By: June Board Lead: Max Naismith
11	LSAB Executive: SAR Group Governance Overview of reviews	
	It was noted that Maureen Kelly, Chair of the LSAB Executive SAR Group had sent her apologies for today's meeting. Sam provided an overview. She explained that discussion had been taking place around how the SAR process was managed and governed, looking at how the LSCB undertakes SCR's. A suggestion was made that this role be undertaken as part of the Executive Group in the same way that SCR's are managed and governed by the LSCB to ensure good practice across the	

Item No.	Item	Action, Timescale and Person responsible
	city. Sam reported that today was the first time that the group had met and it was a good example of how important the process is. Sam outlined the discussions that had taken place. There was discussion around two current SAR's and how these are progressing and there was opportunity for all agencies to agree a way forward. An overview of all the other potential reviews was provided to the group as an update and these were discussed in relation to how best to move forward with these. As core agencies the discussions were useful in being able to ensure that any reviews undertaken are relevant and timely in the way that they are done. Sam summarised that the first meeting went well and Gill who also attends the Executive Group was in agreement. Sam was of the opinion that there is a clear sense of change and of moving away from being process driven which is good news. It was noted that information and updates around SAR's will continue to be brought to the Board.	
12	Sub-groups chairs updates	
	• Citizen's engagement – Tanya Matilainen (Member and CE Sub-group chair) was not in attendance today so further update was provided. • Quality Assurance and Performance – Shona reported that the group had not met since the last Board. • Learning and Improvement – This group is in the process of being redeveloped and has not met since the last Board.	
13	Board Member Updates	
	(i) Yorkshire and Humber ADASS – Making Safeguarding Personal Temperature Check Shona summarised the work of the ADASS group in looking across the work in the region on Making Safeguarding Personal. The findings from which are captured within this report. Shona also outlined the developments with social work services in developing strengths based approaches to practice. (ii) Leeds Community Healthcare Trust – It was noted that the CQC report has not yet been received. LCH to report safeguarding – related learning from its CQC Inspection at the Board meeting following publication of the inspection report. (iv) (iii) Leeds District Safeguarding Unit – Overview –It was agreed that in DCI Dave Cowley's absence this will be brought to the June Board. (v) Other members' updates – none noted.	

Item No.	Item	Action, Timescale and Person responsible
14	Reflection	
	(i) Leeds Safeguarding Adults Board Marcia stated that it is good to see the Board moving in a positive direction and going forward it feels very positive. Gill added that it now feels like the Board is discussing the key issues, around what safeguarding is, vulnerability, protection, early intervention etc. Gill noted that some citizens don't understand what safeguarding is, but we do all know what 'safe' is, so it now feels like we have a wider perspective on the role of the Board. (ii) Messages for linked strategic partnerships – none noted.	
15	Proposed dates of future meetings	
	15th June 2017 The Rose Bowl, Leeds Beckett University, Portland Crescent, Leeds LS1 3HB http://www.leedsbeckett.ac.uk/conferencing/our-venues/rose-bowl/	**Action:** Electronic invitations to be circulated to Board Members. By: 15 May 2017 Jayne Ogier

Leeds Safeguarding Adults Board

Actions from 19th April 2017

Item No.	Action	Person / organisation responsible	Target date
1)	Item 2) It was noted that Howard Beck was unable to attend today's meeting due to being unable to access a BSL interpreter. To be invited to a future Board.	Kieron Smith/Emma Mortimer	June 2017
2)	Item 3) Annual Report - Any outstanding submissions to be sent to Kieron Smith.	All members who have not yet made submissions	28/04/2017
3)	Item 4) Learning from 3 Board Development session to be added to the Agenda for the June Board.	Kieron Smith/Emma Mortimer	June 2017
4)	Item 5) Strategic Plan: to bring back to the June Board:	Kieron Smith	June 2017
5)	Item 8) If any members are interested in taking on the role of deputy-chair to contact Richard.	All Members	June 2017
6)	Item 8) Funding Partners to work together to develop a service specification for the new Strategy Unit.	Executive Group	TBC
8)	Item 9) Budget Statements to be brought to a future Board for update.	Executive Group	September 2017
9)	Item 15) Details – Agenda, Venue etc. for the 3 Board Development Day to be sent to all members.	Emma Mortimer/Kieron Smith	TBC

Leeds Safeguarding Adults Board

Continuing Actions from Previous Board Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
December 2015	Item 7	LSAB Strategy and Annual Plan Deputy-Chair of the Board to be appointed.	LSAB	1st April 2017	Richard Jones, Independent Chair to discuss with Cath Roff, DASS after April 2017
13th October 2016	Item 2 ii.)	LSAB Learning Mazars The final report into the findings is currently being awaited from the Department of Health. To be brought back to a future Board meeting	Emma Mortimer Safeguarding Adults Partnership Support Unit	To a future Board date	
		Safeguarding Unit to undertake a review of good practice in learning from untoward deaths, reviewing good practice both locally and nationally, mapping terminology, definitions and legal duties.	Emma Mortimer Safeguarding Adults Partnership Support Unit	To a future Board date	Initial meeting being arranged.
13th October 2016	Item 3	Board Member Updates Domestic Violence and Abuse Routine Enquiry Pilot and Film to be brought to December Board for review and discussion.	Gill Marchant	Deferred to the Board meeting that considers the A 17 SAR.	

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
13th October 2016	Item 4 i.)	Sub-group chairs' updates Learning and Improvement Strategy and Quality Assurance Framework to be reported to December Board.	Learning and Improvement Sub-group	To a future Board meeting	
4th August 2016	Item 4	Local Government Association – Peer Challenge: Review Adult Social Care, Public Health and Clinical Commissioning Groups to jointly present an overview of commissioning responsibilities in Leeds to the LSAB.	Adult Social Care, Public Health and Clinical Commissioning Groups	To a future Board meeting in 2017-18.	
December 2016	Item 3	Board Development Session 25th October 2016 – Taking Forward the Learning Proposal for LSAB learning from the three statutory safeguarding review processes in the City to be brought to February 2017 LSAB. City-wide commissioning presentation to be deferred until after the Board Development Day on 7th February 2017.	E Mortimer and K Smith Richard Jones CBE	February 2017 LSAB 31st January 2017	
December 2016	Item 5	Leeds Safeguarding Partnerships – A proposal for enhanced collaborative working Meeting to take place between the three board chairs to discuss the key cross-cutting themes and proposals for progression. Joint Board development session between LSAB, LSCB and SLE to be convened.	Richard Jones CBE K Smith and E Mortimer	1st April 2017 – new target date June 2017 1st June 2017	Agreement at February 2017 Board meeting that this would form part of the Joint Board Development Session. This was due on the 24 May 2017, but had to be cancelled and so is in the process of being rearranged.

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
		Proposal to use a shared online assurance tool, to be discussed with LSCB and reported back to a future Board.	K Smith and E Mortimer	TBC	
21st February 2017	Item 6.i	Supt Millar to provide Board Members with an outline of the Leeds District Safeguarding unit.	Sam Millar/Dave Cowley	June 2017	
21st February 2017	Item 7 7.iv	Explore the possibility of using feedback from the Equalities Hub within the Safeguarding Reflections item, to inform the Board's thinking and forward planning.	Kieron Smith/Emma Mortimer	June 2017	This is currently being explored.
21st February 2017	Item 2	Quality Assurance and Performance sub-group to provide an analysis of ethnicities of individuals subject to safeguarding adult's process within its quarterly reports. It was noted that this work is on-going.	Shona McFarlane	TBC	This work has been undertaken within the sub-group. This will form part of future quarterly trend data reports.
21st February 2017	Item 1.ii	It was noted that LCH are 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	

HEALTH AND WELLBEING BOARD

THURSDAY, 20TH APRIL, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillors S Golton, G Latty and L Mulherin

Representatives of Clinical Commissioning Groups

Dr Jason Broch	NHS Leeds North CCG
Sue Robins	NHS Leeds West CCG
Dr Alistair Walling	NHS Leeds South & East CCG
Nigel Gray	NHS Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adult Social Services
Steve Walker – Director of Children's Services

Representative of NHS (England)
Gillian Laurence - NHS England

Third Sector Representative
Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Phil Ayres - Leeds Teaching Hospitals NHS Trust
Bryan Machin - Leeds Community Healthcare NHS Trust

Tony Cooke – Chief Officer Health Partnerships
Ann Akers – Interim Head of Communications, Engagement, Equality and Diversity, NHS Leeds CCGs

Paul Bollom – Chief Officer, Leeds Plan

55 Welcome and introductions
The Chair welcomed all present and brief introductions were made.

The Chair also welcomed Doctor Alistair Walling – Clinical Director of Primary Care, Leeds South and East CCG who had taken over from Andrew Harris.

56 Appeals against refusal of inspection of documents
There were no appeals against refusal of inspection of documents.

57 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

58 Late Items
No formal late items of business were added to the agenda.

59 Declarations of Disclosable Pecuniary Interests
There were no declarations of disclosable pecuniary interest.

60 Apologies for Absence
Apologies for absence were received from Councillor D Coupar; Dr Gordon Sinclair; Phil Corrigan; Julian Hartley; Moira Dumma; Thea Stein and Councillor E Taylor. Sue Robins; Phil Ayres; Brian Hughes; Gillian Laurence and Bryan Machin were welcomed as substitute members.

61 Open Forum
No matters were raised by members of the public under the Open Forum.

62 Minutes
RESOLVED – The minutes of the meeting held 20th February 2017 were approved as a correct record.

63 Draft NHS Leeds Clinical Commissioning Groups (CCGs) Annual Reports 2016-2017
The Interim Head of Communications, Engagement, Equality & Diversity for NHS Leeds South & East Clinical Commissioning Group (CCG) submitted a report on behalf of all three Leeds CCGs which highlighted the relevant sections from the draft Annual Reports of all 3 CCGs, seeking comments on the extent of their input into the Leeds Health and Wellbeing Strategy 2016-21.

Anne Akers presented the report along with Sue Robins and Nigel Gray highlighting the partnership working undertaken between the 3 Leeds CCGs and the Leeds Health & Wellbeing Board and wider partners to help deliver the Leeds Health and Wellbeing Strategy 2016-21.

Excerpts from the Draft Annual Reports were attached to the report as Appendix 1 NHS Leeds South & East CCG; Appendix 2 NHS Leeds West and Appendix 3 NHS Leeds North.

The report highlighted the timescale for submission of the Annual Reports to NHS England by 21st April 2017, which had curtailed longer consultation with the Board, however next year, with the move to the One Voice approach working together as three CCGS, an earlier discussion with members was anticipated to help shape the content and consider the wider context of alignment with the Leeds Health & Wellbeing Strategy 2016-2021

The Board discussed the draft reports and made the following comments:

- The need for a report which was user friendly.
- To produce a one city report rather than separate reports.

- The challenges of rolling out the strategies and engagement schemes across a city as diverse as Leeds.
- The work of the Board in progressing the Health and Wellbeing Strategy 2016-2021 and the need to capture this in the report.
- The need to capture the work of the third sector including the work of palliative care teams.
- To engage with communities to assess the pressures on the services. and to check how the service is making a difference.
- The need to have more input from communities.
- The approach to integrated NHS services in other core cities.
- That CCGs use their Annual General Meetings as an opportunity to engage and tell 'our city' story. This could be used along with feedback in the annual report.

Members were informed that it was a statutory duty to produce a report for NHS England which required a number of mandatory fields to be completed.

The Board welcomed a suggestion that a magazine rather than 3 reports could be produced which would be able to focus on the work undertaken across the city of integrated services and show the positives of partnership working.

It was noted for action that the Chair asked for a timetable to be provided to enable the Board to contribute to future annual reports. The Chair also requested timescales from the CCGs in relation to next year's report along with proposals for involving the Board in its development and agreement.

The Chair was grateful that the report had been presented to the Board but expressed her regret that the report had not been brought sooner to enable the Board to contribute.

RESOLVED

a) To note the contents of the report and the comments made during discussions.
b) That, having reviewed the information contained within the Appendices; the Board noted the comments made in respect of the extent of the NHS Leeds CCG's input in the Leeds Health and Wellbeing Strategy 2016-2902.
c) To acknowledge the extent to which the NHS Leeds CCGs have contributed to the delivery of the Leeds Health & Wellbeing Strategy 2016-2021.
d) To agree to the formal recording of this acknowledgement in the LHS Leeds CCGs annual reports according to statutory requirements.

Cllr. L Mulherin joined the meeting during this item.

64 Date and Time of Next Meeting

RESOLVED - To note the proposed date and time of the next Board meeting as 20th June 2017 at 2.00 pm (with a pre-meeting for board members at 1.30pm)

Cllr. S Golton joined the meeting during this item.