NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (held in public)
Friday 3 August 2018, 9.00am – 11.15am
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2018-19 (20)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2018-19 (21)	Declarations of interest	Neil Franklin	N
9.10	2018-19 (22)	Questions from members of the public	Neil Franklin	N
9.15	2018-19 (23)	Patient's story: End of life care	Marcia Perry	N
9.30	2018-19 (24)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 25 May 2018 b. Actions' log c. Committees' assurance reports: i. Charitable Funds Committee: 22 June 2018 ii. Nominations and Remuneration Committee: 22 June 2018 iii. Audit Committee: 20 July 2018 iv. Quality Committee: 23 July 2018 v. Business Committee: 25 July 2018	 Neil Franklin Neil Franklin Brodie Clark Neil Franklin Jane Madeley Tony Dearden Brodie Clark	 Y Y Y Y Y Y Y
		Quality and delivery		
9.50	2018-19 (25)	Chief Executive's report	Thea Stein	Y
9.55	2018-19 (26)	Leeds Health and Care Academy - Partner Board briefing	Jenny Allen and Laura Smith	Y
10.00	2018-19 (27)	Performance brief and domain reports	Bryan Machin	Y
10.10	2018-19 (28)	Serious incidents report	Marcia Perry	Y
10.15	2018-19 (29)	Safe staffing report	Marcia Perry	Y
10.25	2018-19 (30)	Freedom to speak up annual report	Thea Stein	Y
10.30	2018-19 (31)	Guardian for safe working hours update report	Turlough Mills	Y
10.35	2018-19 (32)	Leases with Community Health Partnerships (CHP)	Bryan Machin	Y
		Strategy		
10.40	2018-19 (33)	Organisational development refresh update	Jenny Allen and Laura Smith	Y
10.45	2018-19 (34)	Research and development strategy: update	Ruth Burnett	Y
		Governance		
10.50	2018-19 (35)	Medical Director's report: medical revalidation	Ruth Burnett	Y
10.55	2018-19 (36)	Nurse and AHP revalidation	Marcia Perry	Y
11.00	2018-19 (37)	Mental Health Collaborative Committees in Common update	Thea Stein	N
11.05	2018-19 (38)	Significant risks and risk assurance report	Thea Stein	Y
11.10	2018-19 (39)	Board work plan	Thea Stein	Y
		Minutes		
11.10	2018-19 (40)	Approved minutes for noting: a. Audit Committee: 20 April and 23 May 2018 b. Quality Committee: 23 April, 21 May 2018 c. Business Committee: 25 April, 23 May 2018 d. Leeds Health and Wellbeing Board minutes: 19 February 2018	Neil Franklin	 Y Y Y Y
11.15	2018-19 (41)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 5 October 2018, 9.00am -12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PF

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

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

AGENDA ITEM 2018-19 (24a)

Friday 25 May 2018, 9.00am – 12.00noon

Present:	Brodie Clark	Trust Vice Chair, Non-Executive Director (deputising for the Trust Chair)
	Thea Stein	Chief Executive
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Phil Ayres	Interim Executive Medical Director
	Ann Hobson	Interim Director of Workforce
Apologies:	Neil Franklin	Trust Chair
In attendance:	Diane Allison	Interim Company Secretary
	Megan Rowlands	General Manager Adult Services
	Mandy Young	Senior Practitioner and Clinical Pathway Lead (for agenda item 4)
Minutes:	Liz Thornton	Board Administrator
Observers:	Suzanne Slater	Clinical Governance Manager
	Angela Gregson	Interim Clinical Lead – Specialist Services
Members of the public:	One member of the public was in attendance.	

Item	Discussion points	Action
2018-19 (1)	**Welcome and introductions** The Trust Board Vice Chair welcomed Board members, members of the public and observers attending the meeting. **Apologies** Apologies were noted from the Trust Chair. **Opening remarks** The Chair noted that the Interim Medical Director was attending his last meeting before his retirement and the Interim Director of Workforce was attending her last meeting before returning to her substantive role as Assistant Director of Workforce. On behalf of the Board he expressed his thanks to them both for their attendance and contribution at the Trust Board meetings and their work to support the	

	Executive Team and the Trust.	
2018-19 (2)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2018-19 (3)	**A patient's story** The Executive Director of Nursing introduced the patient's story item and welcomed the Clinical Pathway Lead from the Musculoskeletal Service (MSK) and a patient who had received care from the service. The patient introduced himself to the Board and began by explaining that in recent years he had suffered from wrist pain. He said that he had been invited to speak to the Board today about his experience of the musculoskeletal service (MSK) provided by the Trust. The patient spoke about his symptoms which had begun with a tingling feeling in his wrists and developed into pins and needles and a numbness which had affected both hands. Following a visit to his General Practitioner (GP) he had been referred to the MSK service for further assessment. After a physical examination by a physiotherapist and a series of test he had been diagnosed with carpel tunnel syndrome. His treatment plan had been agreed and included an exercise regime and a recommendation that he wear wrist splints. He said that he had not been good at following the exercise programme and he had neglected to wear the splints consistently. Following a further consultation with the MSK service he had be offered steroid injections into his wrists which had been very effective and resulted in a six month period where he had been pain free. Unfortunately the effect of the injections had worn off and he had been told that the MSK service could not offer any further injections. The Clinical Pathway Lead explained that the Trust's treatment pathway meant that only one set of injections could be offered to patients and then their GP would need to consider whether a referral to secondary care was appropriate. In response to a question from a Non-Executive Director (IL), the patient said that he thought that the exercise regime and wearing the splints would improve his condition fairly quickly and he was disappointed when this had not proved to be the case. The Executive Director of Operations suggested that there might be a need to review the information leaflets currently available for patients with a view to including clearer advice on the treatment pathways offered by the Trust and the outcomes expected from the agreed care plans and exercise regimes. The Chair thanked the patient on behalf of the Board for taking time to attend the meeting, speaking about his experience of the MSK service and highlighting some issues for the Trust to consider further.	
2018-19 (4)	**Questions from members of the public** There were no questions from the member public in attendance.	
2018-19 (5) **(5a)**	**Minutes of the previous meeting held on Thursday 29 March 2018 and matters arising** **Minutes of the previous meeting held on Thursday 29 March 2018** The minutes were reviewed for accuracy and agreed to be a correct record.	

(5b) **Items from the actions' log**

Item 2017-18 (97) Performance brief and domain report- responsive domain: This action referred to the possibility of forming an academic research partnership to improve the understanding of caseload complexity in relation to activity levels. The Executive Director of Nursing reported that meetings had taken place with colleagues at both local universities to discuss the potential for an academic partnership. It seemed positive and all parties were considering how this work could be taken forward.

The completed actions from previous meetings were noted.

(5c)

Assurance reports from sub-committees

Item 5c(i) – Quality Committee held 21 May 2018

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

- ***Service spotlight* –** the Committee had received a presentation from the End of Life Care Service, which had been integrated into the neighbourhood teams. The Committee had heard that the Trust was achieving the preferred date of death target of 85% and the presentation had provided the Committee with a positive story supported by a range of evidence.
- ***Performance brief April 2018 (safe domain)* –** the Committee was advised that there had been a 42.8% reduction in avoidable pressure ulcers during 2017-18. Managing avoidable pressure ulcers remained a key priority for the Trust, as the target for 2018-19 of 10 avoidable pressure ulcers was a challenging one.
- ***Quality Challenge* + –** the Committee heard that the Quality Challenge + programme had been well received by staff. Non-Executive Directors had been invited to participate in the 2018-19 programme.
- ***Outcome measures update* –** the Committee remained concerned about the lack of progress in relation to the outcome measures process and had asked for a further update report in September 2018.

Item 5c(ii) – Business Committee held 23 May 2018

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

- **Productivity Programme Group –** the Committee had received an update on the activities of the Productivity Programme Group. The Group had considered its remit which would include, cost improvement plans, a better perspective on benchmarking information and an understanding of data surrounding appointments.
- **Programme management approach –** the Committee received an update on the initial discussions at the recently constituted Change Board, including the benefits of considering major change projects as part of the wider change programme.
- **E-rostering business case –** the Committee had approved a recommendation to initiate the procurement of the Allocate system.
- ***Performance brief and domain report April 2018* –** The Committee had noted that the information within the report was limited as this was month one of 2018/19.
- ***Digital strategy update* –** the Committee had received a 6-monthly update on the Digital Strategy, including progress on the implementation plan. It was requested that the Board should consider the city-wide implications of digital priorities in a future Board workshop.

Item 5c(iii) – Audit Committee held 23 May 2018

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 2017-18 –*** The Committee had considered the draft annual report and annual accounts for 2017/18. All end of year processes had been achieved smoothly, on time and to a good standard. The Chief Executive had attended a meeting of the Committee on 25 May 2018 and spoken about the achievements and challenges in 2017-18. The external auditors had confirmed that in terms of value for money, the Trust was doing well against the rest of the sector. KPMG had previously raised an issue in April 2018 about the valuation of the Trust's estate. Work had since been completed and the overall conclusion was that the valuation of material land and buildings included in the financial statement represented a balanced valuation. No changes had been noted on the financial statement. The external auditors had thanked the Trust's finance team for their hard work and support to deliver the end of year accounts. Both the annual report and annual accounts had been recommended for adoption by the Board. • ***Internal audit –*** The 2017-18 audit programme had been concluded, with the Committee reviewing the remaining six completed audits along with the recommendations. These audits had been shared with the relevant Committees. The annual audit plan for 2018-19 was approved; all audits had been aligned with the board assurance framework and risk register and assigned to an executive lead and a committee. • **Urgent decisions: Cybersecurity submission -** The Committee had reviewed a submission to NHS Improvement (NHSI) to confirm that the Trust was complying with the national data and cybersecurity standards outlined in the 2017-18 Data Security Protection Requirements (DSPR). The Committee had agreed that it was an accurate reflection of the Trust's position and recommended that the Trust Chair and Chief Executive approve its submission under the emergency powers and urgent decisions section of the Trust's reservation and delegation of powers. **Outcome:** The Board noted the verbal update reports from the committee chairs and the matters highlighted.	
2018-19 (6)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • An update on the CQC visit to Hannah House • Developing a culture of quality improvement • Flu fighter champion's awards In response to a question from the Chair, the Executive Director of Finance and Resources said that he was confident that the Trust was on track to complete the actions in the General Data Protection Regulation (GDPR) action plan to ensure a satisfactory position by 25 May 2018 and that the outstanding actions and associated timescales would be regarded as sufficient by the Information Commissioner's Office (ICO). No further questions were raised on any items in the Chief Executive's report. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2018-19 (7a)	**Annual report and accounts 2017-18** ***Annual report*** The Executive Director of Finance and Resources introduced this item and began by referring to the Audit Committee meeting on Wednesday 23 May 2018 at which the Chief Executive had spoken about the achievements and challenges in 2017-18.	

	A Non-Executive Director (JM), in her capacity as Chair of the Audit Committee, said that the Committee had welcomed the Chief Executive's attendance at the meeting 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.	
2018-19 (7b,c &d)	***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 2017-18. At the Audit Committee meeting on Wednesday 23 May 2018, 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. He advised that there was one minor amendment to be made to the annual accounts before final submission to the Department of Health, which had been agreed by the Non-Executive Director (JM) in her capacity as Chair of the Audit Committee prior to this meeting. 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. 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. **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.	
2018-19 (8)	**Quality Account 2017-18** The Executive Director of Nursing introduced the Trust's Quality Account for 2017-18. She advised the Board that the account, in its draft format, had been scrutinised by the Quality Committee. The feedback received from key stakeholders; Healthwatch and the Commissioners (CCG) had been extremely positive. The CCG were very supportive of the 2018-19 quality priorities which they described as 'strong and strategic'. A Non-Executive Director (IL), in his capacity as Chair of the Quality Committee, reported that the Senior Management Team (SMT) and the Quality Committee had set a number of priorities for the coming year. Achievement of priorities would be monitored quarterly by SMT and overseen by the Quality Committee	

	throughout the year. He added that he felt that stakeholders had provided a good and well-balanced response. The Chair stated that he felt that the document was comprehensive and struck the correct balance between realistic expectations and aspirations. He noted his thanks to the team responsible for compilation of the document. **Outcome:** The Board : • received the report • noted the final position of the quality improvement priorities for 2017-18 • approved the final version of the quality account for 2017-18.	
2018-19 (9)	**Operational plan 2017-18: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 four corporate objectives, key actions and success measures. The Business Committee would be monitoring progress against the plan on a quarterly basis in 2018-19. This would allow more flexibility to review and amend targets in-year to reflect exceptional circumstances. Referring to the RAG rating of priorities, a Non-Executive Director (IL) said that in future, consideration should be given to presenting the overall assessment of progress and performance in a different format which reflected the Trust's significant achievements in more positive way. **Outcome:** The Board received and noted the year-end progress report in delivering the 2017-18 priorities and success measures.	
2018-19 (10a)	***Performance brief and domain reports April 2018*** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during April 2018. The Executive Director of Finance and Resources said that the report highlighted any current concerns relating to contracts held by the Trust, a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. The information within the performance brief was limited as it was month one of 2018-19. He highlighted the following: ***Safe*** The Board discussed the annual target for avoidable category 3 pressure ulcers which was to have no more than ten and noted that three had been reported in April 2018. The Executive Director of Nursing clarified that there had been three avoidable category 3 pressure ulcers reported in April 2018 but only two incidents as one patient had two pressure ulcers. A Non-Executive Director (IL) reported that the Quality Committee had received reasonable assurance that the development and delivery of the pressure ulcer action plan was being effective and the situation was improving due in part to earlier identification and therefore earlier healing. ***Caring*** The Trust had inpatient beds in both specialist and children's business units. The percentage of inpatient respondents recommending care had remained 100% for	

three months and was rated green. 95.6% of respondents would recommend care in the community. The adult business unit (90.1%) was rated red against a target of 95.0%. Both children's and specialist business units were rated green.

Effective domain
It was noted that the measures in this domain were reported quarterly so would first appear in the Performance Brief for June 2018.

Responsive
The Trust had performed well in respect of its indicators relating to waiting lists and all were rated green for April 2018.

Referring to the data on patient contacts, the Chair said that concerns remained about the variance from profile.

The Executive Director of Operations said that she was confident that the Trust was meeting patient need but the current measure i.e. contacts did not reflect this. Discussions were taking place with the Commissioners about the possibility of moving away from recording the data in terms of face to face contacts and focus more on outcomes.

Well-led
The Board noted that total sickness absence was below target at 5.4% and rated as green. Short term absence stood at 1.9% and long term absence at 3.5%. Both were rated as green for April 2018. Staff turnover and staff leaving the organisation within 12 months were both rated as green.

The Chair said that he was very keen to have a diversity measurement re-introduced in the performance targets.

The Chief Executive reported that the Trust was working hard to improve its inclusivity as an employer to ensure its workforce broadly reflected the community it served. She added that the Trust had recently appointed a BAME project officer who would be monitoring how representative the workforce was and how the Trust could further promote diversity at all levels of the organisation. It is expected that a key measure would be incorporated following the project officer's work.

The Interim Director of Workforce drew the Board's attention to the partnership with the Yorkshire and Humberside Improvement Academy and the work programme for 2018-19. She also highlighted the work underway to develop a 12 month retention plan supported by NHS Improvement.

In response to a question from a Non-Executive Director (JM), the Executive Director of Nursing reported that 25 newly qualified nurses had been offered post in the neighbourhood teams to start in September 2018 and there was an ongoing campaign to recruit 30 healthcare professionals (band 6 nurses/paramedics) for the custody suites; 26 post had been offered to date.

The Chief Executive highlighted the good work undertaken as part of the nursing preceptorship programme, which had resulted in a 12% increase in the retention of newly qualified nurses over the last 12 months.

Financial position
The Executive Director of Finance and Resources reported that at this early stage in the year the Trust's financial performance was in line with the plan.

The forecast outturn position demonstrated that there was some financial risks in delivering the control total set by NHS Improvement of £2.541 million for the year.

	Additional risks included the proposed pay award, mitigating the loss of £1.2 million of contract income from the CCG and the delivery of the planned cost savings. In a response to a question from a Non-Executive Director (JM), the Executive Director of Finance and Resources confirmed that the CCG was aware that the loss of contract income had added to the risk of the Trust not delivering the control total for the year. **Outcome:** The Board noted the Trust's performance for April 2018.	
2018-19 (11a)	**Serious incidents report** The Executive Director of Nursing introduced the report which provided an update on the outcomes, themes, actions and learning from serious incident investigations closed during the period January to March 2018. The Executive Director of Nursing reported that there had been a total of 22 serious incidents reported during the period January to March 2018 taking the total to date for the year 2017-18 to 92. This represented a 14.1% reduction overall in serious incidents compared to the same period last year. Nineteen of the serious incidents related to pressure ulcers; two were unexpected deaths, one other related to an invasive procedure undertaken in the sexual health service. The Chair observed that the reduction of avoidable pressure ulcers and the delivery of the pressure ulcer action plan remained a key priority for the Trust. A Non-Executive Director (TD) asked about the two 'de-logged' incidents from the Leeds CCG Strategic Executive Information System (StEIS) and how this inaccurate reporting could be avoided in future. The Board agreed that this was a matter which should be taken forward by the Quality Committee. **Action:** The Quality Committee to consider how inaccurate recording on the StEIS could be avoided in the future. The Executive Director of Nursing reported that a new lessons learned template had been developed to improve how learning from incidents was embedded across the Trust and she agreed to share this with Board members. **Action:** The Executive Director of Nursing to share the new lessons learnt from incidents template with Board members.	**Executive Director of Nursing** **Executive Director of Nursing**
2018-19 (11b)	**Annual patient experience, complaints and incident thematic report** The Executive Director of Nursing presented the report which provided the Board with an annual review on the themes from patient experience and incidents within the Trust during 2017-18. It identified themes arising from complaints, concerns, incidents and feedback; and offered assurance that actions were in place to address areas for improvement. In response to a question from Non-Executive Director (JM), the Executive Director of Nursing advised that no complaints had been received from patients in relation to difficulties in accessing services at other locations following the closure of Garforth Clinic. Referring to the data on the top ten complaints and concerns, a Non-Executive Director (JM) observed that the main subject of complaint was staff attitude and communication and she asked what was been done to address this.	

	The Executive Director of Nursing advised the Board that every complaint and concern received by the Trust was thoroughly investigated and responses signed off by herself or the Chief Executive. Where areas for improvement were identified appropriate support and training was put into place quickly and reflective practice undertaken with a view to improving ways of working. The Chief Executive confirmed that individual staff members were made aware if a complaint had been made about them. The Chair welcomed the assurance provided by the report but noted that appointments remained a top theme for patients and carers across concerns and complaints. He stressed the need to demonstrate evidence that improvements were made over the coming year and he observed that the Business Committee would receive regular updates from the Productivity Programme Group on the work around improving waiting times for appointments. **Outcome:** The Board noted the themes identified and received assurance that action and learning was in progress to address the themes identified.	
2018-19 (12)	**Annual report of the Guardian for Safe Working Hours** The Non-Executive Director (IL) introduced the report as the Guardian was unable to attend the meeting. He advised that he was not in a position to take any questions in relation to its content. He explained that the role of guardian for safe working hours had been introduced as part of the 2016 junior doctors' contract as an assurance that the protections included in the contract regarding working hours and training would be honoured in practice. The Executive Medical Director provided a brief overview of the background and context to the report and drew Board members attention to the annual data summary. The Chair, on behalf of the Board, expressed support for this work across the Trust. **Outcome:** The report and activity to date was noted.	
2018-19 (12.5)	**Progress on CAMHS Tier4 development and approval of fees**	
	The Executive Director of Finance and Resources presented the report which sought approval from the Trust Board to commit an estimated £1.5 million of fees and associated development costs to take the CAMHS Tier 4 development to full business case. The Executive Director of Finance and Resources explained that if the scheme was approved and proceeds these costs would be met from the existing allocation of £13 million but if the scheme did not go ahead (for whatever reason) these costs may have to be met from the Trust's own revenue resources. The Chair noted that the financial assumptions and the indicative costs to take the project to phase one to the completion of the full business case total of £1.5 million had been considered in detail by the Business Committee and recommended to the Board for approval. **Outcome:** The Board approved that £1.5 million be committed to the fees and development costs to take CAMHS Tier 4 development to full business case.	

2018-19 (13)	**Significant risk and risk assurance report** The Interim 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 four risks with a current score of 15 or above relating to: • Reduced level of care due to prevalence of staff sickness in particular services and or across the Trust • Difficulties recruiting to and retaining staff within neighbourhood teams • New CAMHS Tier4 building • Risk of delays to new CAMHS Tier 4 service model The Board discussed the risk if the cost of the new CAMHS Tier 4 unit could not be contained within the existing allocation of £13 million and the Trust was required to identify other sources of funding. In response to a question from a Non-Executive Director (TD), the Executive Director of Finance and Resources said that he hoped that the risk score would be reduced once there was more clarity around the development of the scheme. He added that the Business Committee would be monitoring developments and receive an update report at each meeting. A further update report would be made available to the Board in August 2018. **Action:** An update on the risks associated with the new CAMHS Tier 4 building to be made available to the Board in August 2018. The Board noted that the quality issues associated with the new CAMHS Tier 4 service model would be considered by the Quality Committee when appropriate. **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	**Executive Director of Finance and Resources**
2018-19 (14)	**Corporate governance report** The Interim 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. ***Committees' annual reports 2017-18 –*** 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 and received annual reports from the Board sub-committees. The Trust's external auditors (KPMG) had confirmed the Trust's annual report contains all the relevant information. ***Committees' terms of reference –*** in March and April 2018, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. 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 provided an	

	assessment of the Trust's compliance with the provider licence. ***Changes to the standing orders, standing financial instructions and scheme of reservation and delegation powers*** – in April 2018, a review of the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers was completed and reported to the Audit Committee. The changes and amendments were agreed by the Committee. ***Details of the use of the Trust's corporate seal*** – In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. The report contained a copy of the register of sealings. **Outcome:** The Board: • Noted the outcome of the annual review of Board and committees' effectiveness. • Received the Audit Committee's annual report for 2017-18. • Approved the amendments to the terms of reference of Board sub-committees. • Received and noted the self-certification against required NHS provider licence conditions. • Approved the revisions to the standing orders and standing financial instructions. • Ratified the use of the corporate seal and noted the content of the sealings.	
2018-19 (15)	**West Yorkshire Mental Health Services Collaborative: committees in common memorandum of understanding** The Chief Executive introduced the report which provided the Board with a copy of the signed memorandum of understanding (MOU) for the committees in common, the governance mechanism to support the West Yorkshire Mental Health Services Collaborative (WYMHSC). **Outcome:** The Board received the signed WYMHSC MOU.	
2018-19 (16)	**Urgent decisions: Cybersecurity submission** The Executive Director of Finance and Resources advised that NHS Improvement (NHSI) required that all providers confirm that they were complying with the national data and cybersecurity standards outlined in the 2017-18 Data Security Protection Requirements (DSPR). At a meeting on 20 April 2018, the Audit Committee had reviewed the information and agreed it was an accurate reflection of the Trust's position. As the submission to NHSI was required in advance of this Trust Board meeting, it was agreed that the Committee, from its review and discussion, felt comfortable to recommend that the Trust Chair and Chief Executive approve its submission under the emergency powers and urgent decisions section of the Trust's reservation and delegation of powers. Confirmation of this action was reported to the Board. **Outcome:** The Board formally ratified the submission to NHS Improvement to confirm that the Trust was compliant with the national data and security standards.	
2018-19 (17)	**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.	
2018-19 (18)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Audit Committee: 16 March 2018 b. Business Committee: 16 March 2018 c. Quality Committee: 19 March 2018 d. Leeds Safeguarding Adult Board minutes: 14 November 2018	
2018-19 (19)	**Close of the public section of the Board** The Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 3 August 2018, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair:
Date: 3 August 2018

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AGENDA ITEM 2018-19 (24b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 3 August 2018

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting Friday 25 May 2018				
2018-19 (11a)	**Serious incidents report:** The Executive Director of Nursing to share the new lessons learnt from incidents template with Board members.	Executive Director of Nursing	June 2018	Completed
2018-19 (11a)	**Serious incidents report:** The Quality Committee to consider how inaccurate reporting on the Leeds CCG Strategic Executive Information System (StEIS) could be avoided in future.	Executive Director of Nursing	July 2018	Completed
2018-19 (13)	**Significant risks and risk assurance report :** An update on the risks associated with the new CAMHS Tier 4 building to be made available to the Board in August 2018.	Executive Director of Finance and Resources	August 2018	Completed

Key		
Total actions on action log	**3**	
Total actions on log completed since last Board meeting: 25 May 2018	**3**	
Total actions not due for completion before 3 August 2018; progressing to timescale		
Total actions not due for completion before 3 August 2018; agreed timescales and/or requirements are at risk or have been delayed		
Total actions outstanding as at 3 August 2018; not having met agreed timescales and/or requirements		

NHS
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AGENDA ITEM 2018-19 (24ci)

Report to: Trust Board 3 August 2018

Report title:
Charitable Funds Committee 22 June 2018: Committee Chair's assurance report

Responsible Director:
Chair of Charitable Funds Committee

Report author: Executive Director of Nursing

Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Charitable Funds Committee held on 22 June 2018, and indicates the level of assurance based on the evidence received by the Committee where applicable.

Overview and Context
The Chair noted progress in key areas such as the 'More Than A Welcome' and front of house work. The event with John Lewis was an important engagement opportunity with our staff. The Chair noted that it is important that focus is maintained on areas such as 'More Than A Welcome as mainstreamed. This led to a discussion in relation to buildings and the ability to influence change in multi occupied buildings which LCH does not own. It also makes it difficult to define a single agreed model of best practice as usage of buildings varies significantly in terms of services provided. The estates group now oversees the strategy and an assessment of current buildings is currently underway with the intention of identifying an improvement proposition. That work will be completed in 6 months with interim updates on progress.

The Director of Nursing updated on staffing issues and that it had been a challenging few months as the current post holder had taken up a secondment in the Trust and therefore the development group had not met. The post has been reviewed and is currently out to recruitment as a secondment opportunity. The grading of the post has been reviewed.

A discussion and debate followed in relation to the future direction of charity working in the Trust. It was agreed that there is a need for further discussion within SMT on this, and recommendations for the future direction of travel.

The Trust Chair updated on his meeting some time ago with the Chair of LTHT Charitable Funds Committee, and the potential areas for exploration for joint working. It was agreed that the Director of Nursing would now seek an early meeting with the newly appointed lead officer for LTHT Charitable Funds. The outcome of this conversation may potentially inform the future direction of travel.

Hannah House
The Committee received the application to develop the exterior areas of Hannah House. This would include work such as a redesigned activity area and sensory garden. The Committee had a lengthy discussion about the application and the criteria of the Charity. The Committee Chair noted that this could be a very useful area to develop interest and engage with local businesses. The Director of Nursing agreed that this was correct but reminded the Committee that capacity to undertake this sort of engagement work was not available at this time. The Committee agreed that the work and plans should

be developed and a more detailed plan return prior to agreeing the funding route.

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

Staff Lottery

The Committee considered the first paper in relation to the potential to develop a staff lottery. Committee members were pleased to note the work and benchmarking in terms of other local provider organisations. It was agreed that the next steps should be a further discussion at SMT. The Committee recommended that a piece of work be undertaken supported by the communications team to explore staff views and attitudes towards a staff lottery. This would also be a useful mechanism to determine such issues as a monthly contribution.

Evaluation of previous years projects

The Committee received the paper which provided an update on the projects that had been supported by charitable funds over the last year. The Committee noted that feedback was positive. The Director of Nursing presented an updated framework for applications and post application evaluation. This Committee reviewed and discussed the new forms and the proposal and agreed it was helpful to see the link to Trust outcomes.

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

Finance

The Committee received and accepted the updated finance report. There were no issues or exceptions to note. The Committee scrutinised and approved the annual report and accounts. It was noted that the Independent examination by Sedulo will be presented to the Audit Committee on the 20 July 2018.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (24cii)

Report to: Trust Board 3 August 2018
Report title: Nominations and Remuneration Committee 22 June 2018 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 22 June 2018, and indicates the level of assurance based on the evidence received by the Committee.

Chief Executive's and Directors' Appraisals and Performance:

The Chief Executive's and Directors' appraisals were reported and the Committee noted the outcomes of the appraisal processes undertaken.

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

Interim Medical Director and Deputy Medical Director Salaries and Contractual Arrangements:

The Committee approved decisions relating to the recruitment of an Interim Medical Director and Deputy Medical Director as well as the salary underpinning these appointments. The Committee expressed some concerns around the process associated with these appointments however, follow up work and further communication to the Committee provided the assurance required.

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

Leeds Community Healthcare NHS Trust

Agenda Item 2018-19 (24ciii)

Report to: Trust Board 3 August 2018
Report title: Audit Committee 20 July 2018: Committee's Chair assurance report
Responsible Director: Chair of Audit Committee **Report author:** Interim Company Secretary
Previously considered by: Not applicable

Summary
This paper identifies the key issues for the Board arising from the Audit Committee 20 July 2018.

Internal audit
The Committee noted completion of three audits as part of the 2018/19 internal audit plan. The audits covered: Data Quality – Audiology Services, IT Procurement, and Emergency Response Planning. The review of Emergency Response Planning had received a limited assurance opinion. The Committee chair was encouraged by the prompt response to address the recommendations. The Committee asked for SMT to review how and where testing of the major incident plan plus any resultant learning should be reported.

Charitable Funds
The Committee received the annual report and accounts for the Trust's charity. The independent examination had been undertaken by Sedulo (accountants). There were no concerns and the accountants had come across no other matters in connection with the examination to draw the Trust's attention to. The Committee recommended adoption of the annual reports and accounts by the Charitable Funds Committee at its next meeting (21 September 2018).

Counter Fraud annual update
The Committee received the annual report from the Local Counter Fraud Specialist; the report included an analysis of counter fraud activity for the year. The Committee noted that the self-assessment rating for 2017/18 was green across 22 standards, with only one rated as amber, due to the need for time to elapse before a new policy could be said to be embedded.

Security Management annual update
The Committee received the 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 decrease in the number of security incidents reported during 2017/18, compared with the previous year. The Committee was keen to learn about how the Trust compared with other similar Trusts in terms of reporting of incidents, and was advised that its reporting rates were lower in comparison with local mental health trusts. However there was no true benchmarking information available to compare the Trust with similar ones since NHS Protect no longer operated. The Committee was updated on the trial of safety alert devices for lone workers and the Trust's potential move towards purchasing a mobile phone App as a more effective alternative.

GDPR update
The newly appointed Head of Information Governance presented a progress report of the Trust's actions to ensure compliance with the GDPR Legislation, which came into effect on the 25th May 2018 along with the Data Protection Act 2018. The Committee was advised that the main

challenge she identified was having adequate resource in the Information Governance team to complete the work required to ensure the Trust was compliant, but that funding had been agreed for an interim post. The Committee requested that timescales should be firmed up for completion of essential work such as data mapping and asked that a further update should be provided at the October 2018 Audit Committee meeting.

Board Assurance Framework

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. The Committee reviewed the Strategic Risk Assessments in detail and requested further work to be done with SMT to ensure that there was a common approach to the risk scoring – initial, current and target – and that Directors should ensure that actions listed under gaps in controls or gaps in assurance should aim to be sufficient to achieve the target risk score.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (24iv)

Report to: Trust Board 3 August 2018
Report title: Quality Committee 23 July 2018: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Director of Nursing
Previously considered by: Not applicable

Purpose of the report

This paper identifies the key issues for the Board from the Quality Committee held on 23 July 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service spotlight:

The Committee received a presentation from the Health Case Management Team, which is a relatively new service, operating seven days a week, providing timely case management for patients who are eligible for NHS fast track and continuing healthcare funding. The Committee learned that the team are professionals with health or social care backgrounds. Their objective is to offer appropriate support to patients with complex health needs and to help them avoid unnecessary admission or discharge. The 37 staff manage between them an active caseload of 340 patients and an additional passive caseload of a similar size. The team have been actively seeking feedback and have received no complaints to date. The team leadership has been supporting staff through a period of change, implementing new systems and developing a staff competency framework. There has also been thought given to professional development and career development opportunities, including offering social work student placements. The team spoke of the challenges they face including increasing demand for the service for end of life case management activity.

Performance brief and domain reports

Safe

There were no pressure ulcers grade 3 or 4 reported during June 2018. A change in the reporting process for VTE assessments meant the percentage reported is inaccurate. The committee was assured that this was a recording issue, and not a patient safety issue.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Caring

Friends and family test responses amongst patients recommending care is slightly lower than previously, the staff response rate for recommending care is higher than the target set.

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Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Effective

Services are making good progress towards achieving compliance with NICE guidance. Clinical supervision is below target. Overall the Committee was reasonably assured.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Little Woodhouse Hall CQC visit (*Director of Nursing Report*)

The Committee was apprised of the CQC's unannounced Mental Health Act (MHA) inspection in June 2018. This inspection does not result in a rating, but does require an action plan to address any areas of improvement required. Issues identified by the inspectors include the need to repeat MHA rights to young people, the need to alleviate some young people's boredom, and issues concerning the ethics of 'blanket' restrictions of items e.g. hairdryers and mobile phone chargers. The issue of lines of sight also arose again. An action plan has been developed and the Committee was reasonably assured by the information the summary report provided.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Clinical Audit

The Committee received an update on the status of the 2017-18 clinical audit programme. The Committee had previously been concerned with the lack of progress being made. The Committee was advised that the clinical audit programme had been delivered and achieved by the end of quarter 4.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Quality Improvement Plan (QIP)

The Committee received a progress report on the outstanding 'must do' and 'should do' actions set out in the QIP plan. Issues that remained outstanding include compliance with training. The Committee heard that the Quality Challenge Plus visits were focussing attention on the QIP plan areas, when visiting relevant services and the Committee were reasonably assured that sufficient work had been completed to date to address issues. Further updates would be reported to the Committee, by exception in the Director of Nursing report.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (24cv)

Report to: Trust Board 3 August 2018
Report title: Business Committee 25 July 2018: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Director of Nursing
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Quality Committee held on 25 July 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Workplace Race Equality Standard (WRES) performance update
The Committee was provided with an update of the Trust's current WRES performance against the nine indicators. The report identified a number of WRES indicators where there has been deterioration year on year. The Committee was disappointed by the deterioration and that the Trust was in a poor position when compared to other community trusts. The Committee agreed that WRES indicator 1 should be included in the performance brief. The Committee offered its support in addressing the issues raised in the report and requested that a specific action plan should be presented at the September 2018 Business Committee meeting. The Committee noted that the report provided only limited assurance as there was as yet no agreed plan of action.

Assurance level							
Substantial		**Reasonable**		**Limited**	x	**No**	

Neighbourhood teams
The Committee had a helpful discussion on the work of the neighbourhood teams and what would be expected of the teams in the new world of collaborative business delivery. The Committee recognised the finite resource and the pressures of protecting and delivering core services against the need to transform and work more closely with partners such as the local care partnerships. The Committee believed this to be a particularly important area of work and will maintain a focus on this issue.

Podiatry Update
The Committee was provided with an update on the issues the Committee had previously raised with the service during the 'deep dive' presentation provided in January 2018. The Committee was advised of the progress made with the new foot protection service, staff training in health coaching to promote self-management, and the service's participation in a joint LCH/commissioner 'roadmap' review. The update provided the Committee was impressive and provided the Committee with reasonable assurance.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Operational Plan
An update report was received which provided an overview of progress towards achieving the Trust's priorities as of quarter one. The Committee appreciated the amended format to this report and agreed that it provided reasonable assurance that the Trust's priorities were, on the whole, on track.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

Board Assurance Framework (BAF)
The Committee reviewed the (BAF) strategic risks assigned to it. It recognised that there were some risks that required additional sources of assurance for the Committee to better evaluate the effectiveness of the controls. The Committee agreed that a smaller group should review these in greater detail outwith of the Committee meeting. The Committee was advised that the Audit Committee had recently scrutinised the BAF and had recommended SMT should review BAF risk scores to ensure there was a common approach to scoring the risks and to ensure that actions listed under gaps in controls were sufficient to mitigate the risks. The Committee agreed some further off-line work on scrutinising and updating the Business Committee responsibilities within the report.

Estates review
The Committee received an informative presentation on the Trust's estates strategy. There was clearly some good work happening, albeit not particularly in line with the previous planning aspirations. The Committee approved the approach to the change in the way the Trust utilises its estate. The Committee asked for a plan to be produced for its next meeting in September 2018. This was agreed.

Business development strategy
The Committee was apprised by the head of Business Development on the progress being made with the Business Development Strategy. This included information about current bids and anticipated tenders. The Committee also received information about the traded services project, which is going well. The Committee was very encouraged by this positive report, which provided substantial assurance.

Assurance level							
Substantial	x	**Reasonable**		**Limited**		**No**	

Workforce Quarterly Report
The report summarised the work undertaken to progress current priorities, including a refresh of its strategic and delivery priorities in alignment with the Trust's strategy and priorities. The Committee recognised the progress being made in key areas including retention and engagement and that there were renewed efforts to tackle sickness absence rates, with some positive and constructive external support.

Assurance level							
Substantial		**Reasonable**	x	**Limited**		**No**	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (**25**)

Meeting: Trust Board 3 August 2018	**Category of paper**	
Report title: Chief Executive's report	**For approval**	
Responsible director: Chief Executive **Report author:** Chief Executive	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

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

Main issues for consideration

The main features of the report are:

- Executive Medical Director and Deputy Medical Director
- Work on developing Integrated Nursing
- Insight programme – Non-Executive Director trainee
- Staff dress code
- Board to Board Meeting 19 July 2018
- Newton-Europe summit meeting

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

Recommendation

The Board is recommended to:

- Note the contents of this report

Chief Executive's report

1. Trust news

Queen's Nurses
In May 2018, two of our members of staff, Liz Keat and Steph Lawrence, became Queen's Nurses. The title of 'Queen's Nurse' is awarded by The Queen's Nursing Institute and is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. The title is not an award for past service, but indicates a commitment to high standards of patient care, learning and leadership. Nurses who hold the title benefit from developmental workshops, bursaries, networking opportunities, and a shared professional identity.

NHS 70 celebrations
On 4 July, the Trust joined in the celebrations for the 70th birthday of the NHS. LCH sites were decked with birthday displays and bunting. Our staff shared pictures from the early days of their careers, and they hosted birthday tea parties and held baking competitions. Some staff also attended the celebration event at Westminster Abbey and the NHS 70 Choral Celebration at York Minster.

The Trust also marked 70 years of the NHS by saying 'Thanks a Bunch' to a number of staff, by surprising them with special NHS 70 'Thanks a Bunch' awards. Thanks a Bunch' is an award presented to a team member for being a shining example of 'How We Work'.

As part of the Trust's NHS 70 celebration week, we proudly shared a staff story each day to showcase our exceptional colleagues and the lifetime of care we offer. This included one of the Primary Care Team Leaders based at Her Majesty's Young Offenders Institute, Wetherby, a Homeless Admissions Leeds Pathway Liaison Nurse, an Occupational Therapy Technical Instructor, a Palliative Care Lead, a Senior Mental Health Practitioner, a Children's Specialist Speech and Language Therapist, and a Respiratory Nurse Specialist.

Playing our part in the Leeds Primary Care Conference
The City of Leeds hosted its first primary care conference on 21 June 2018. The event celebrated successful collaboration, with sessions on partnership working, social prescribing and supporting self-care, and developing quality improvement. The Trust was very much involved in this event, with information stalls and presented a session on the 'Otley leg Club', which offers support to people who have a lower leg health condition. The service is delivered by nursing staff from Leeds Community Healthcare NHS Trust and Chevin and Westgate GP Surgeries, with support from Otley Action for Older People. The conference heard how the club is offering a new approach by treating lower leg conditions in a non-clinical, community-based setting and gives its members a chance to socialise with others experiencing similar health problems.

Executive Medical Director and Deputy Medical Director
We welcome Dr Ruth Burnett as interim Executive Medical Director and Dr Rob Arnold who has been appointed Deputy Medical Director (Quality and Adult Services). Ruth was previously the Regional Medical Director Health In Justice (North), CareUK. Rob who is a GP partner in Morley brings 25 years' experience.

Freedom to Speak Up – Trust Board self-assessment
In May 2018 NHS Improvement (NHSI) provided new guidance setting out expectations of NHS Trust Boards in relation to Freedom to Speak Up (FTSU). The guide is accompanied by a self-review tool, which is aligned with the good practice set out in the CQC well-led framework, The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. Completing the self-review tool and developing an improvement action plan will help trusts

to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is. NHS I regional teams will be seeking assurance that strategy, vision and action plans are being developed and implemented and that change is being measured. The completed tool will be shared with inspectors as part of the CQC's assessment framework for well-led. Our Trust is currently completing the self-assessment tool in order to identify any areas of development.

Freedom to Speak up Non-Executive (NED) Lead
The Chief Executive is the FTSU Executive Lead, John Walsh is the FTSU Guardian. The new Freedom to Speak Up guidance recommends that trusts have a NED lead on FTSU, and I am very pleased that Richard Gladman, Non-Executive Director has agreed to take on this important role.

Integrated Nursing
The work on developing Integrated Nursing is now developing in terms of action. The initial Local Care Partnership (LCP) footprint (Woodsley and Holt Park) has been agreed following a very successful engagement meeting. Partners have worked together to identify capacity from within existing resources to drive this work forward. An operation group at LCP level facilitated as agreed by the Director of Nursing (LCH) is meeting to develop and drive the work forward. Over August 2018 the work is focussing on

- Mapping current locations of activity across the footprint
- Skills Analysis of nursing workforce
- Engagement with teams
- Proactive shadowing
- Mapping current know activity

The aim of this work is to develop a set of draft priority action areas for the LCP to consider and agree in September.

Insight programme – Non-Executive Director trainee
The Insight Programme is a collaboration between GatenbySanderson, sponsoring NHS Trusts, a network of Non-Executive Directors (NEDs), and aspiring NED candidates (the participants) with the aim of encouraging more high quality candidates, including those from diverse backgrounds, to succeed in their applications to become NEDS. For potential non-executive candidates, the Insight Programme provides unprecedented access to Trust boards; the experience they gain is intended to support future applications for non-executive roles in the NHS. Once selected onto the Programme, participants are attached to two Trusts in succession, in each case under the sponsorship of the Trust Chair. We are pleased to support this programme and our Trust is currently evaluating candidates' applications with the aim of providing an opportunity to an aspiring NED candidate from September 2018.

Recycling
The Trust has a Sustainability Forum which meets regularly to review what the Trust do to improve its approach to sustainability. Following requests from members of staff, the Trust has purchased recycling bins for eleven of its sites. Together with our paper recycling/ confidential waste, our target is to have more recycled waste than general waste. The bins have replaced the normal under desk bins in office areas. The forum has also reviewed single use items for example coffee and milk sachets for visitors and discussed how to improve flexible working and use of teleconference options.

Relocating the Child Development Centre
From June to September 2017 the Trust asked for feedback on plans to relocate the Child Development Centre from St James Hospital Site to the Reginald Centre. All feedback has been carefully considered and work has taken place with clinical teams, the estates team, and health and social care partners to make sure the Trust provides services in the best facilities for patients and their families.

Two public information sessions were held in June 2018 to talk about the plans to move and for people to ask any questions. With this in mind, the decision is to relocate the Child Development Centre currently based at St James Hospital to the Reginald Centre by the end of August 2018. The Chair of Scrutiny at LCC is fully aware of the decision and the process undertaken.

Staff dress code
Following a consultation with staff groups including the 50 voices group, Staffside colleagues, and the Senior Team, it has been agreed that the Trust will no longer have a non-uniform dress code. This new approach has been welcomed by staff. The clinical uniform part of the policy remains the same as it is now however it is being reviewed in collaboration with all uniformed colleagues over the coming months.

Newton-Europe Summit Meeting
Newton-Europe was commissioned nationally to support fourteen health and social care economies including Leeds in improving flow. This work included a five week deep dive consisting a point of prevalence study of all patients in beds to identify the number who were medically optimised for discharge; a review of 80 patients who had been discharged from hospital analysing whether they had been discharged to the most ideal place after hospital and analysis of a questionnaire on the culture in the system from both a senior leadership and frontline staff perspective. A summit was held on 24 July where representatives from across the system heard the feedback and suggested recommendations. In the latter part of the session Chief Executives and Chief Operating Officers agreed the accountability for taking the recommendations forward. A verbal update will be given at the Board meeting.

Major Incident Plan
The Major Incident Plan, which is to be presented to the Board in private, aims to provide an agreed framework for the Trust to be able to respond to the impact of a major incident in its capacity as a provider of healthcare in Leeds. This plan is intended to be flexible enough to meet the demands of a range of circumstances regardless of the nature of the incident.

Board workshop – September 2018
The Board workshop in September 2018 will include an assessment of the well-led framework and a horizon scanning review of the Digital Strategy.

Leeds CAMHS young persons' interview panel involvement
Leeds MindMate SPA and CAMHS were delighted to have young people join their interview panel over two days in July, to assist in the recruitment of staff for MindMate Single Point of Access. The young people created and asked their own questions of the candidates and their opinions were held in high regard.
Involving young people in the interview process has ensured that they have a say in who is recruited and it also helps them develop new skills, build confidence and gain experience of the interview and recruitment process.

2. Local activity

Mental Health Services Collaborative Non-Executive Directors and Governors engagement event.

NEDS and Governors from the West Yorkshire Mental Health Services Collaborative were invited to an engagement event on 17 July 2018 to discuss progress with some of the programme's work streams including Child and Adolescent Mental Health Services (CAMHS), Eating Disorders, and Learning Disabilities. Key themes from the event will be provided to the Committees in Common.

Board to Board Meeting 19 July 2018.

A number of Executive and Non-Executive Directors attended the Health and Wellbeing Board: Board to Board Session on 19 July 2018. Members were challenged to think how their organisations and their staff would need to change to support the development of Local Care Partnerships. There was a session on strengthening the 'Team Leeds" approach to developing our workforces during which table discussions clearly identified opportunities for organisations to work closed together. Hannah Davies, the new Chief Executive of Healthwatch talked about strengthening the engagement of citizens in our planning. A significant presentation was given by Newton Europe on the emerging findings from their work. Summing up on this later, Tom Riordan (Chief Executive, Leeds City Council) thought that this work may prove a turning point in how we planned to improve patient care over the challenging winter months particularly.

West Yorkshire and Harrogate Health and Care Partnership (WYHHCP) Integrated care system update

The MOU for the WYHHCP is now in a very strong draft, and has benefited from discussions at Health and Wellbeing Boards, organisation boards and governing bodies over that period. Formal sign off sign-off by Partners will be sought at the beginning of September 2018.

In recognition that becoming an ICS requires access to greater levels of funding to support service transformation NHS England has now confirmed the overall package of financial support that will be available for the year 2018-19.

A Partnership Board will be established in 2018/19 to provide formal leadership. The Board will be responsible for setting strategic direction and have oversight of all Partnership business. The Board will be made up of the chairs and CEOs of all NHS organisations, chairs of Health and Wellbeing Boards, council CEOs and senior representatives from other partner organisations. The Board will have an independent chair and will meet at least four times each year in public. The System Leadership Executive (SLE) Group will continue to meet and will include representation from our partnership sectors. This group will be responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives. A new System Oversight and Assurance Group (SOAG) will be established in 2018/19 to provide a mechanism for partner organisations to take ownership of system performance and delivery. It will be chaired by our Partnership CEO Lead and include representation covering each sector / type of organisation.

Recommendation

The Board is recommended to:

- Note the contents of this report

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (26i)

Meeting: Trust Board meeting: 3 August 2018	**Category of paper**	
Report title: Leeds Health and Care Academy – Partner Board Briefing	**For approval**	
Responsible director: Director of Workforce **Report author:** Leeds Health and Care Academy	**For assurance**	
Previously considered by N/A	**For information**	✓

Purpose of the report

The Health and Care Academy's vision is:

'To create one Leeds workforce with the best skills, founded upon the best research and evidence, to care for and empower the people of Leeds.'

The following report provides the Board with an update directly from the Leeds Health and Care Academy on their form, progress and next steps, as the Academy approaches the conclusion of its Planning and Implementation stage.

The Board is advised that the Workforce Directorate and other LCH representatives are engaged with the Health and Care Academy both as stakeholders and Project Board members.

LCH's engagement also includes participation in the mapping exercise and conference described in paragraphs 4(b) and 4(e) of the update.

Discussions are ongoing regarding the proposed appointment of an Academy Director.

LCH continues to work with the Health and Care Academy and further updates will be provided to the Board as the Academy progresses into its Operational stage.

Recommendation

The Board is invited to note the content of this update.

Leeds Health and Care Academy - Partner Board Briefing June 2018

1. Introduction

This report has been produced by the Leeds Health and Care Academy (hereafter 'Academy') project and intended recipients are Boards/Executive Groups of Leeds Teaching Hospitals NHS Trust, Leeds Community Health Care Trust, Leeds & York Partnership Foundation Trust, The Leeds Clinical Commissioning Group Partnership and Leeds City Council, these being the bodies that have initially funded the project.

The last update was provided in March 2018 and that provided a background to the Academy, progress of the project and specific details of the approved workstreams that the Academy will deliver.

This is a new information giving report with the following aims:

a) Update the partner Board on the background to the Academy and the progress of the project to date

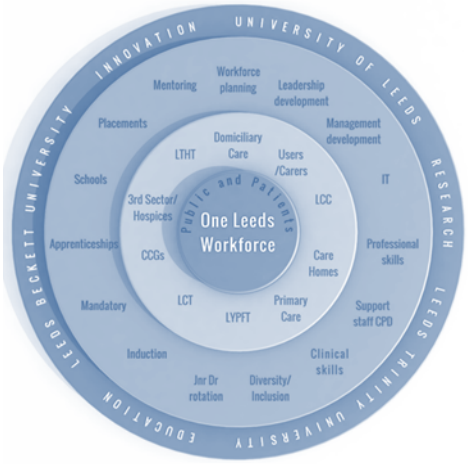
b) Specifically highlight the development of the Academy structure and form and the work on understanding the people and financial resources that exist in partner organisations against the Academy workstreams

c) Explain the next steps of the Academy project and how partner Boards will be engaged, both for information and on future decisions related to resourcing

2. Vision and Values

The project has developed and approved the following vision and is founded upon the vision and values for the Academy:

Vision



To create one Leeds workforce with the best skills, founded upon the best research and evidence, to care for and empower the people of Leeds

Ambitions:

- Improve system sustainability through collaboration on learning and development to deliver 'One workforce'
- Accelerate learning transfer from universities and research and innovation into care delivery
- Engage with citizens to expand career and employment opportunities and enhance social mobility

3. Workstreams

The workstreams, set out as 'delivery' and 'enabling' were approved at the Project Board on 5.2.18 and reported to LAHP Board 13.2.18.

4. Progress

Since March 2018 the Academy project has:

a) Made steady progress against all of the workstreams engaging people from across the system to have outputs ready for September 2018

b) Started the process of detailed mapping of the people and financial resources that exist within each partner organisation that is aligned to each of the workstreams for when the Academy goes live and in the longer term - this process has been initiated and is being completed as a collaboration between the project team and L&D departments in partner organisations

c) Started to develop the Academy structure/form - this was discussed in detail during the Project Board meeting held on 7.6.18 where the partners reinforced their commitment to the Academy and agreed that in readiness for becoming operational the Academy should appoint a new post of Academy Director - a further discussion on this is planned for the Partnership Executive Group (PEG) on 13.7.18. This will include consideration as to how this, (and on-going transition costs) could be resourced through existing Leeds Plan funds and fit with strategic workforce capacity across the city.

d) Gone live with an Academy website and approved the distinct branding for the Academy which reflects our position as a Leeds Academic Health Partnership (LAHP) project and links it with the Leeds Health and Wellbeing Strategy.

e) Marketed the Leeds Health and Care Academy Conference to be held on the 18.7.18 - this will engage colleagues in learning and development roles throughout the Leeds health and care system with the development of the Academy, along with providing a networking and CPD opportunity.

5. Next Steps

The project is entering a critical period as it comes towards the end of the Planning and Implementation stage - the next steps are:

a) Complete the detailed mapping of the people and financial resources that exist within each partner organisation - each organisation has been asked to have this signed off by the HR Director or another person with equivalent authority by the end of June 2018

b) Discuss the funding arrangements for the Academy Director at PEG on the 13.7.18 along with any transitional funding to move the Academy from the Planning and Implementation stage into the Operational stage of the project

c) Consider the Academy structure/form with partners and the relevant staffing and risk share arrangements around learning and development people and budgets with a target of having these approved by the Project Board on 24.7.18

d) Develop detailed proposals and assess impact with each partner organisation for individual partner Board approval and agree timescales.

6. Recommendations

The partner Board is recommended to:

a) Acknowledge progress made to date on the Leeds Health and Care Academy project

b) Note the decision in principle of the Project Board to appoint an Academy Director once funding is agreed

c) Await further information that specifies the financial and people resourcing with the objective of gaining partner Board sign off

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (27)

Meeting: Trust Board 3 August 2018	**Category of paper** *(please tick)*	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 18 July 2018 Quality Committee, 23 July 2018 Business Committee, 25 July 2018	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during June 2018.

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.
It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

More detailed narrative on each of the individual indicators will be available in the domain reports.

Main issues for consideration

The main issues are highlighted in Section 1 at the front of the Performance Brief

Recommendations
The Committee is recommended to:

- Note present levels of performance
- Determine levels of assurance on any specific points

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, June 2018

Senior Management Team – 18th July 2018
Quality Committee – 23rd July 2018
Business Committee – 25th July 2018

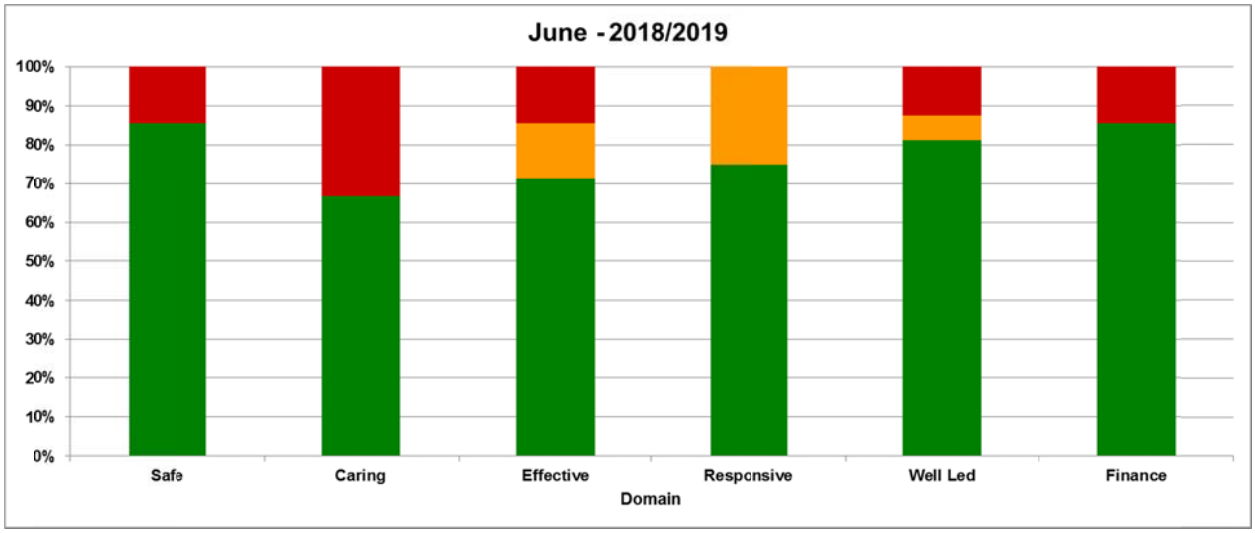
1. High Level Performance Summary

1.1 Summary of Performance Against High Level Indicators

Please note that the charts included below do not represent the CQC key lines of enquiry. They do reflect the Trust's high level indicators which are aligned to the CQC domains.

1.1.1 Getting to Good

A visualisation is provided of each domain to show progress to "Good", where Good is green and achievement of trust approved targets from monthly reporting. This replaces the donut visualisation in previous Performance Briefs.



The measures in the Effective domain are reported here for the first time this reporting year.

1.1.2 Safe Domain

The percentage of VTE risk assessments completed in June is reported as 50.0%. The figure is expected to increase when current data sheet is reviewed and will be further supported when a new recording system is implemented

There were no Category 3 or Category 4 pressure ulcers reported in June.

1.1.3 Caring Domain

LCH has inpatient beds in both the Specialist and Children's Business Units. The percentage of Inpatient respondents recommending care has dipped to 75.0% in June although this is based on only 8 resonses.

There was a small decrease in the percentage of respondents who would recommend care in the community. The Adult Business Unit (92.5%) remains rated red against a target of 95.0%. Both Children's and Specialist Business Units remain above target and are rated green.

The percentage of staff recommending care, taken from the Staff Friends and Family test, is reported for the first time at the end of Q1. This is 83.0% against a target of 73.0%

1.1.4 Effective Domain

The measures in this domain have been first reported this month for Q1.

Services are making good progress towards achieving compliance with NICE guidance.

Compliance with Clinical Supervision is reported at 75.0% and is below the target of 80.0%

1.1.5 Responsive Domain

The Trust has performed well in its indicators relating to waiting lists with all rated as green for June. A more in depth view of breaches can be found in section 1.2 of this document.

Patient Contacts are reported as -7.7% below profile in June and 8.4% below the position reported in June 2017.

No patients are waiting more than 6 weeks for a diagnostic test.

Both IAPT measures remain above the target of 75%

1.1.6 Well Led Domain

Staff turnover has increased this month from last and is now rated as amber. Turnover within Corpororate Services is higher than other areas at 24.7% in June. This can be explained by the smaller pool of staff in Corpororate Services but work is underway to understand this further. All other Business Units are below the target of 15.0%

The percentage of staff reported as having an appraisal continues to be below the target of 95% and is reported at 79.9% In June. This is an improving position from the low reported in December 2017 of 78.3% New reporting, which includes the Corporate Directorate, shows it to be reporting compliance of 64.8% The lowest level of compliance within the Trust although a slight increase on May's position. The Operations Directorate reports the highest compliance of 90.2% but every Business Unit is below target.

The percentage of staff reported as being compliant with the 6 statutory and mandatory training requirements is demnstrating a downward trend, reported as 89.6% in June but remains below the target of 95.0% and after 4 months of an improving position dips in May. New reporting, which includes the Corporate Directorate shows it to be reporting compliance of 92.3%

1.1.7 Finance Domain

At the end of quarter 1 the Trust is slightly underspent year to date, as a result of vacancies. Staffing levels are 149 wte below funded numbers; temporary staffing is in place to mitigate service risks. CIP delivery has been good for June.

The forecast outturn demonstrates there are some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will continue to be monitored closely as the year progresses.

1.2 Statutory Breaches

Leeds Community Healthcare NHS Trust is currently performing within all nationally set targets.

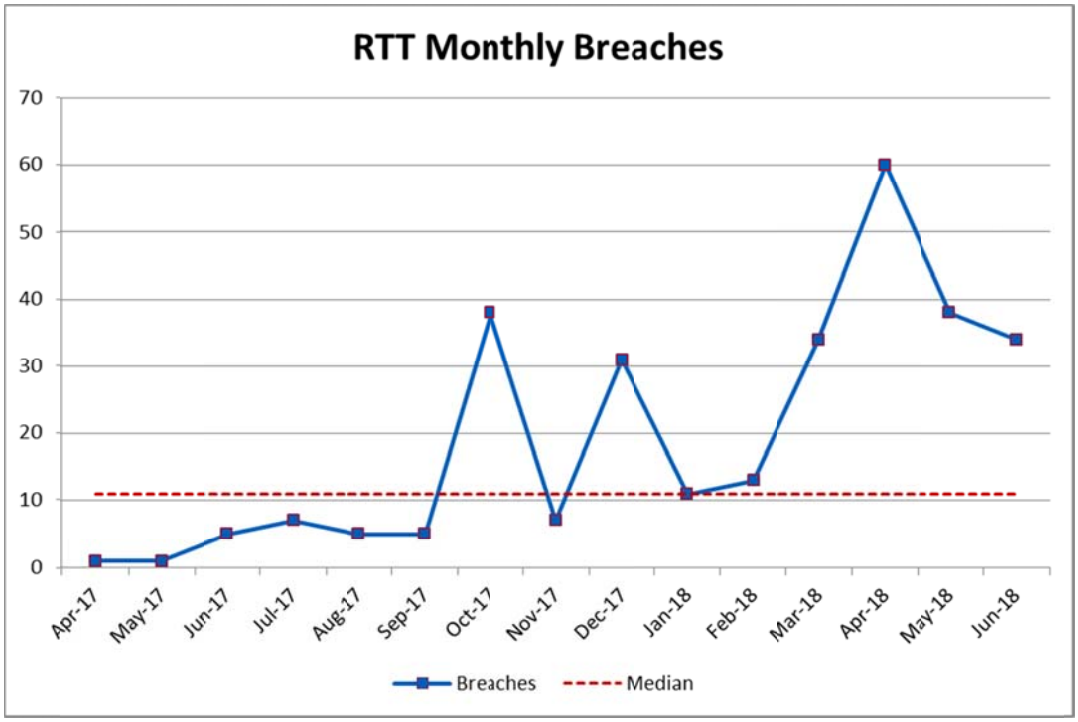
At the end of June 2018, 34 patients were waiting more than 18 weeks for treatment in consultant-led services. This is a decrease of 4 from the previous month. In the 2018-2019 Financial Year there have been 132 breaches compared with 158 for FY 2017-2018.

There were 22 waiters within the Children's Development Centre (CDC) service. 21 have been given appointments or have been seen with one patient awaiting an appointment. 20 patients have all either received an appointment or have now been seen.

There were 7 waiters within the Child Protection Medical Service (CPC) service. 6 patients have all either received an appointment or have now been seen.

There were 7 waiters in the Paediatric Neuro Disability (PND) service. 6 patients have all either received an appointment or have now been seen.

The graph below shows a 12 month position for RTT Breaches. There is a gradual increasing trend. Comparing June 2017 (5) to June 2018 (34) there has been a marked increase and a suggestion of factors outside of the normal process affecting the number of breaches.



2. Contract Related Performance Highlights

No contract related performance issues this month

Leeds Community Healthcare NHS Trust

Director of Nursing Report

Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		Target	YTD	Apr	May	Jun	Q1	Forecast	Rolling 12 Month Trend
Overall Safe Staffing Fill Rate - Inpatients	2018/19	>=97%	-	99.7%	101.0%			●	
	2017/18		-	97.0%	100.5%	95.9%	97.7%		
Patient Safety Incidents Reported in Month Reported as Harmful	2018/19	0.56 to 1.1	0.87	0.91	0.83	0.87	0.87	●	
	2017/18			0.79	1.03	0.92	0.92		
Potential Under Reporting of Patient Safety Incidents	2018/19	1.22 to 2.71	1.86	1.98	1.78	1.83	1.86	●	
	2017/18			2.01	2.48	2.15	2.22		
Serious Incident Rate	2018/19	0 to 0.63	0.04	0.05	0.03	0.05	0.04	●	
	2017/18			0.05	0.06	0.06	0.05		
Percentage VTE Risk Assessment Completed*	2018/19	>=95%	100.0%	100.0%	87.5%	50.0%	79.2%	●	
	2017/18			-	-	-	-		
20% Reduction in Avoidable Category 3 Pressure Ulcers	2018/19	10	1	1	0	0	1	●	
	2017/18			1	0	1	2		
0 Avoidable Category 4 Pressure Ulcers	2018/19	0	0	0	0	0	0	●	
	2017/18		12	0	0	0	0		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2018/19	100%	100.0%	100.0%	100.0%	100%	100.0%	●	
	2017/18		100.0%	100%	100%	100%	100%		

Caring - staff involve and treat people with compassion, kindness, dignity and respect		Target	YTD	April	May	June	Q1	Forecast	Rolling 12 Month Trend
Percentage of Staff Recommending Care (Staff FFT)	2018/19	>=73%	-	83.0%			83.0%	●	
	2017/18		-	81.0%			81.0%		
Percentage of Respondents Recommending Inpatient Care (FFT)	2018/19	>=95%	-	100.0%	100.0%	75.0%	91.7%	●	
	2017/18		-	100.0%	100.0%	100.0%	100.0%		
Percentage of Respondents Recommending Community Care (FFT)	2018/19	>=95%	-	95.6%	96.5%	95.5%	95.9%	●	
	2017/18		-	95.9%	95.8%	95.3%	95.3%		
Written Complaints - Received	2018/19	<211		14	17	13	44	●	
	2017/18			18	20	12	50		

Due to a change in personnel in the Workforce Intelligence Team there are some measures not available in this month's Performance Brief. Overall Safe Staffing Fill Rates – inpatients is one. Data will be backfilled as it arrives.

1. Patient Safety Incidents (LCH only)

1.1 Patient safety incident data has been captured from Datix for incidents reported within the month of June 2018. There were a total of 239 LCH PSIs reported in June 2018. (The 260 incidents reported in May 2018 has reduced to 242 – due to ongoing incident investigations and amendments to original records), this is due to duplicates found in the system where multiple staff report the same incident. Some of these incidents are reported incorrectly as PSI or attributable to LCH. These records are still available in Datix under the correct categories and available for audit.

Breakdown by degree of harm is consistent with previous months and there do not appear to be any exceptions in this area.

Figures by business unit show that the ABU reporting figures are lower than last month (this rise was identified as coinciding with new safety huddles and new ways of working in some teams), however the figure is consistent with other earlier months.

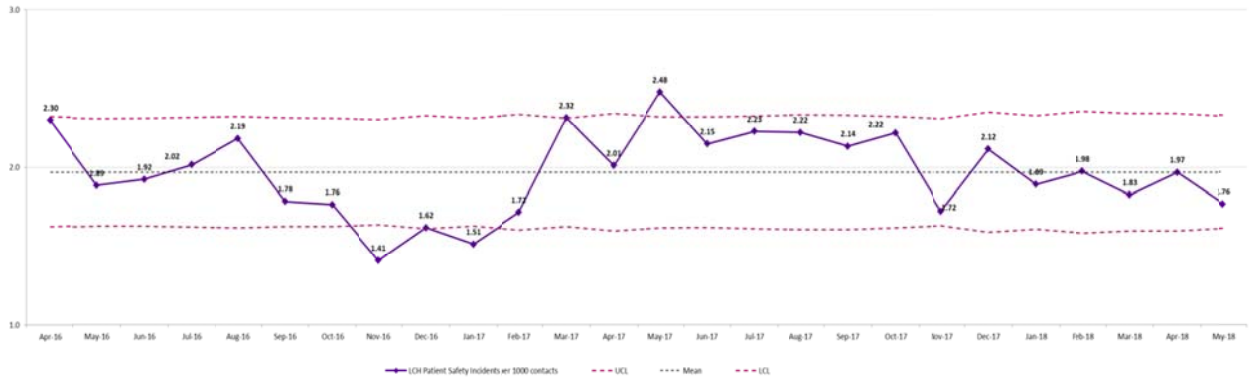
The reduction in reporting in May for Children's and Specialist business units has returned to a level more consistent with earlier months

1.2 The LCH Patient Safety incidents per 1000 contacts show that the increase above mean in April has now reduced. This is due to incident investigations and changes made to records. Causes for these changes can include duplicate incident reports being identified and merged; records incorrectly reported as patient safety and incident reports that are concerns or complaints. When these incidents are identified, the department creates a feedback record and shared with business units for action

The figure for May has dipped below the mean but remains within control.

There is only a difference of 5 incidents between April and May, however a combination of an increase in contacts of over 11,700 and an minimal decrease in incident reports has resulted in this drop.

**data available to May 2018 only*

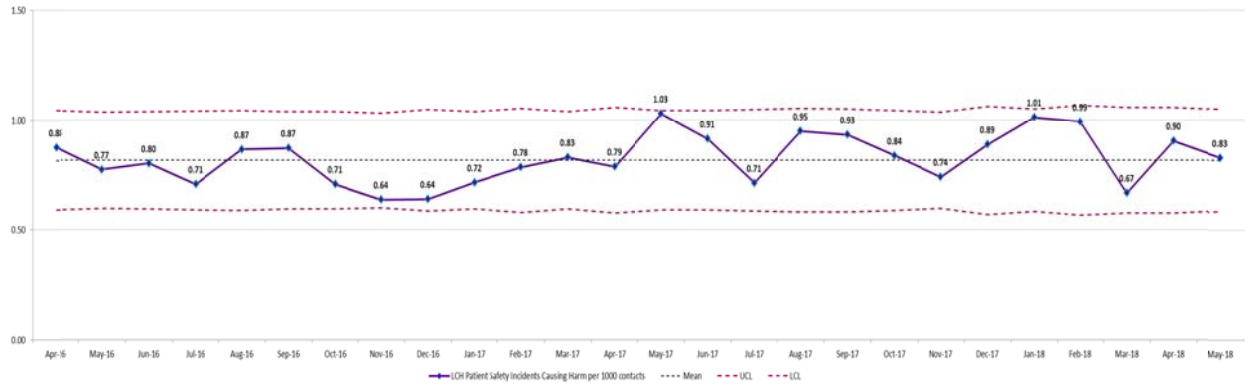


2. Incidents causing harm (LCH only)

2.1 No exceptions in levels of harm have been seen in June.

There were 113 (47.0%) LCH PSI incidents reported as causing harm during June. Although figures are slightly lower than May, there has been no change in percentages.

2.2 The chart below shows LCH incidents causing harm up to May 2018. Although percentage figures for harm are the same as the previous month, there is a drop towards the mean in the chart. This is attributable to the increase in patient contacts in May



2.3 SPC charts broken down by Business unit are not available as 25 points of data are required to produce a meaningful chart. Currently only 19 points exist; therefore expected date for production of SPCs by business unit will be January 2019.

2.4 6 incidents were submitted to the CCG via STEIS in June 2018, one has since been de-logged, because on review it didn't meet the SI criteria for Pus, therefore 5 incidents are undergoing a full Serious Incident investigation.

3. Moderate & Major Harm Incidents

3.1 The ratio of moderate/major incidents to minimal/no harm incidents for LCH Patient Safety Incidents was 1:4.4 during June. This figure is consistent with previous months.

The rise seen in May is now back within usual expectations. We are now review data from the previous month as standard procedure following work with the business intelligent unit.

LCH Patient Safety Incidents by Degree of Harm

	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
No injury sustained	202	174	198	163	151	186	140	140	119	113	133	126	116	110
Minimal Harm	95	89	70	81	79	62	73	66	82	62	45	66	75	72
Moderate Harm	47	37	23	39	39	48	36	36	51	45	32	43	33	36
Major Harm	4	4	5	5	6	8	4	5	4	9	7	5	6	5
Death	4	2	11	5	9	9	10	7	0	2	13	8	12	16
Total	352	306	307	293	284	313	263	254	256	231	230	248	242	239
Ratio: (moderate/major incidents : minimal/no harm incidents for LCH Patient Safety Incidents)	1:5.8	1:6.4	1:9.6	1:5.5	1:5.1	1:4.4	1:5.3	1:5	1:3.7	1:3.2	1:4.6	1:4	1:4.9	1:4.4

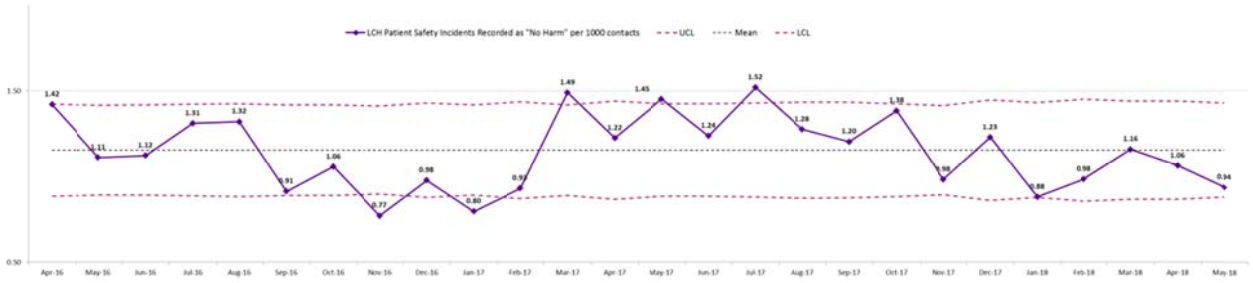
4. No Harm incidents

4.1 52 teams/services reported no harm patient safety incidents in June which is an increase in service/team reporting from the previous month.

4.2 10 of the reporting teams or services saw an increase above their average reporting figures for no harm LCH PSIs. There were three teams where reporting of these incidents had risen more than 2.5 points above their previous year's average. These services were Childrens Continuing Care (4.5); Armley NHT (4.5) Podiatry Service (2.9)

4.3 The number of LCH **patient safety incidents causing no harm per 1000 contacts has** dropped again this month, this is due to the increased number of contacts within the month and a small reduction in incidents reported (-5).

**data available to May 2018 only*



5. Overdue Incidents

5.1 There are 433 live incidents in Datix as of 05/07/2018. Of these, 51 are LCH Patient safety incidents and have breached the 15 or 30 day investigation time. A breakdown of the Business units and who the incident affected is below.

Overdue Incident Reports	Adult Services	Children's Services	Specialist Services	Operational Support Services	Corporate & HQ functions	Total
LCH Patient Incident	53	5	6	2	0	66
(of which) Patient Safety	46	2	3	0	0	51
Patient Incident - other	33	2	1	0	1	37
Incidents affecting the staff	9	1	0	0	1	11
Incidents affecting the Trust	4	1	1	1	10	17
Total	92	6	5	1	12	116

The number of incidents assigned to 'patient flow services' has reduced from 37 to 25 and these are mainly awaiting investigations from the Discharge Facilitators, which in turn, is reliant on feedback from the wards in LTHT so outside of LCH control

Weekly reminder spreadsheets with all overdue incident information is now being sent to all Business Unit Clinical Leads. This is in addition to the automatic weekly reminders that are sent to incident handlers and incident investigators.

The oldest overdue records are those linked to the Integrated Discharge Service (LiDS).

6. Never Events

There have been no Never Events reported in May/June 2018.

7. Safety Alerts (CAS)

There were 8 Safety alerts issued which were due to be closed in June 2018. One response was a day late, but still responded to within June.

Although no alert has yet been issued, and in response to widespread news which focused on Graseby syringe drivers; work has been undertaken throughout the Trust in June to identify any of these devices that may still be existence in Trust properties. Initial findings are that no such drivers are either in use or stored in cupboards in our estate. A large piece

of work was undertaken in 2010 in response to another alert and all Graseby drivers were thought to have been removed and replaced at that time.

8. Duty of Candour

At the end of June 2018 there were 2 incidents closed where the duty of candour was applicable (verified as actual moderate + harm attributable to LCH)

Both patients have received an apology in the form as requested by the patient.

LCH are therefore 100% compliant.

9. Infection Prevention Control (IPC)

9.1 MRSA bacteraemia and C difficile Infection
During June there were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to LCH.

9.2 Other contractual issues and outbreaks
There have been no other reported outbreaks reported during June.

9.3 Sharps injuries continue to be seen across the Trust, once again some of these are in relation to staff using patients own products.

Work is underway to highlight the key messages to all teams and students on safe use of sharps. Student competency is also being highlighted to ensure they are aware and trained on all relevant devices before use.

9.4 Some issue were seen and managed with cleaning in the children's outpatient development unit at St James, this was addressed and ongoing review.

9.5 FFP mask fit testing is taking place across the Trust and at present work in Middleton, Horsforth and dental is well underway.

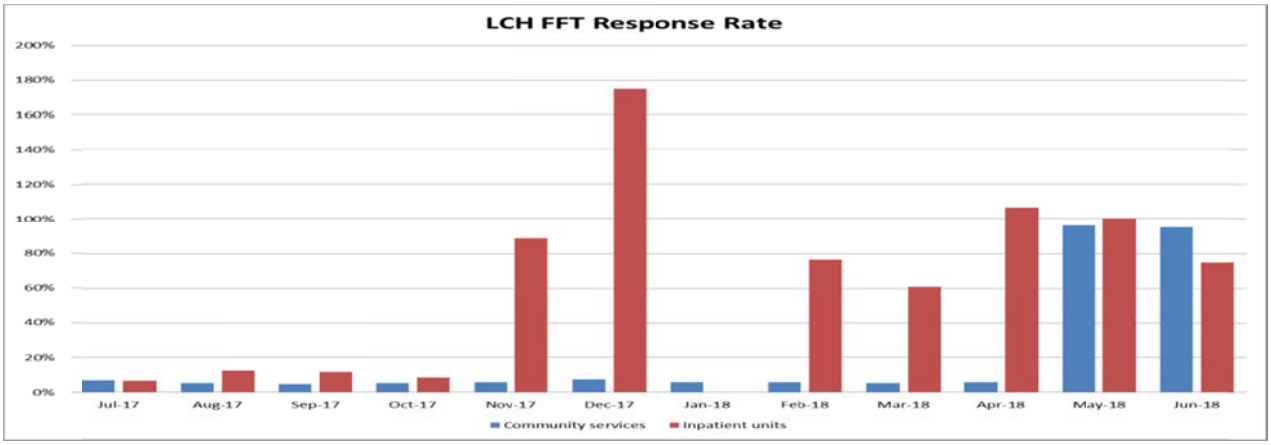
10. Patient Experience

Friends and Family Test (FFT)

10.1 FFT performance Dashboards

10.1.1 Response rates (community and inpatient)

The number of completed FFT surveys fluctuates on a monthly basis due to variation in when surveys are received in the month by the Clinical Governance Team. Overall 95.42% of Community patients and 75% of Inpatients for May would recommend LCH services.



10.1.2 Performance by Business Unit

Jun-18	% recommended	Response rate	Comments
ABU services	92.5%	9.0%	189
CBU services	95.7%	15.7%	1436
CBU inpatients	71%	350%	No data
SBU services	96.1%	9.2%	891
SBU inpatients	100%	6.3%	No data

11. Complaints, Concerns, PALS and Claims

Item	June 2018 Received	Comments
Complaints – see table below	**13**	No exceptions to report
Concerns	**21**	7 concerns are about the Sexual Health service (significant reduction on previous month)
PALS Enquiries	**10**	No exceptions to report
PALS Signposting	**7**	No exceptions to report
Clinical Claims	**0**	No exceptions to report
Non-clinical Claims	**0**	No exceptions to report

Key Performance Indicators and Developments - Complaints	Status
Acknowledged within 3 days	**100%** Compliance
Responded to within 180 days	**100%** Compliance (closed complaints)
Contacts from External Agencies	**1** CCG **1** NHS England **3** LTHT
Active PET Caseload	**44** open complaints **14** open concerns
PHSO requests	**0**

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		Target	YTD	April	May	June	Q1	Forecast
Compliance with Technology Appraisals Within 3 Months	2018/19	100%	-	non relevant to LCH				●
	2017/18		-	-			-	
Compliance with Other NICE Guidance Within 2016	2018/19	32						●
	Full Compliance		5	5			5	
	Action Plan		4	4			4	
	Under Review		23	23			23	
Number of Mandatory Audits	Due to start in Q	All audits started		48			48	●
	Started in Q			48			48	
Number of LCH Generated Audits Started	2018/19	>=80%	-	100.0%			100.0%	●
	2017/18		-					
Compliance with Clinical Supervision	2018/19	>=80%	-	75.0%			75.0%	●
	2017/18		-	80.0%			80.0%	
Number of Unexpected Deaths in Bed Bases	2018/19	No Target		0			0	
	2017/18		-	0			0	
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2018/19	No Target		5			5	
	2017/18		-	1			1	
Percentage of services rated good or outstanding following the Quality Challenge Peer Review	2018/19	>=70%		100.0%			100.0%	●
	2017/18		-	-			-	
Percentage of services rating themselves as good/outstanding through the Quality Challenge Self Assessment	2018/19	>=80%		82.0%			82.0%	●
	2017/18		-	-			-	

Technology appraisal published January – March 2018

- None of the 23 Technology Appraisals published by NICE between January and March 2018 were relevant to LCH

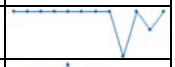
Other NICE guidance published April to June 2016 (exception report)

- NG 43 Transition from children's to adults services for young people using health or social care services
    - Published in February 2016. Applies to three service areas: CAMHS; Healthy Child Services; Complex Child Pathways Services
    - LCH is heavily involved in the city-wide transition group, looking at implementation of this guidance across health & social care to deliver this complex, comprehensive system-wide guideline. A transition conference is planned to take place with partners across the city in October 2018.

- NG 13 Workplace health – management practices
    - First published in June 2015 and updated in March 2016, this guideline covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers. The workforce team have a plan in place to update LCH policies, guidelines and protocols in line with planned review dates, to ensure all relevant aspects of the guideline are embedded into practice; as well as reviewing and implementing recommendations around training packages and job design.

Leeds Community Healthcare NHS Trust

Responsive Domain Report

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		Target	YTD	April	May	June	Q1	Forecast	Rolling 12 Month Trend
Patient Contacts - Variance from Profile*	2018/19	0 to ± 5%	-8.1%	-10.5%	-6.0%	-7.7%	-8.1%	●	
	2017/18			-12.1%	-4.5%	-1.2%	-5.9%		
Patient Contacts - Variance from 2017/2018	2018/19	-	-	-0.5%	-3.6%	-8.4%	-4.3%	●	
	2018/19		-	125,191	136,667	130,328	392,186		
	2017/18		-	125,763	141,835	142,260	409,858		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2018/19	>=92%	-	96.1%	97.2%	97.5%	97.0%	●	
	2017/18		-	99.9%	99.7%	99.6%	99.6%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2018/19	0		0	0	0	0	●	
	2017/18		0	0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2018/19	>=99%	-	100.0%	99.1%	100.0%	99.7%	●	
	2017/18		-	96.1%	99.1%	99.5%	99.5%		
% Patients waiting under 18 weeks (non reportable)	2018/19	>=95%	-	98.9%	98.9%	98.8%	98.9%	●	
	2017/18		-	98.7%	99.0%	99.0%	98.8%		
IAPT - Percentage of people treated within 18 weeks of referral	2018/19	>=95%	-	99.2%	99.2%	99.6%	98.9%	●	
	2017/18		-	99.6%	100.0%	100.0%	100.0%		
IAPT - Percentage of people treated within 6 weeks of referral	2018/19	>=75%	-	92.2%	91.4%	89.2%	98.9%	●	
	2017/18		-	96.5%	95.7%	96.1%	96.1%		

Leeds Community Healthcare NHS Trust

Well Led Domain Report

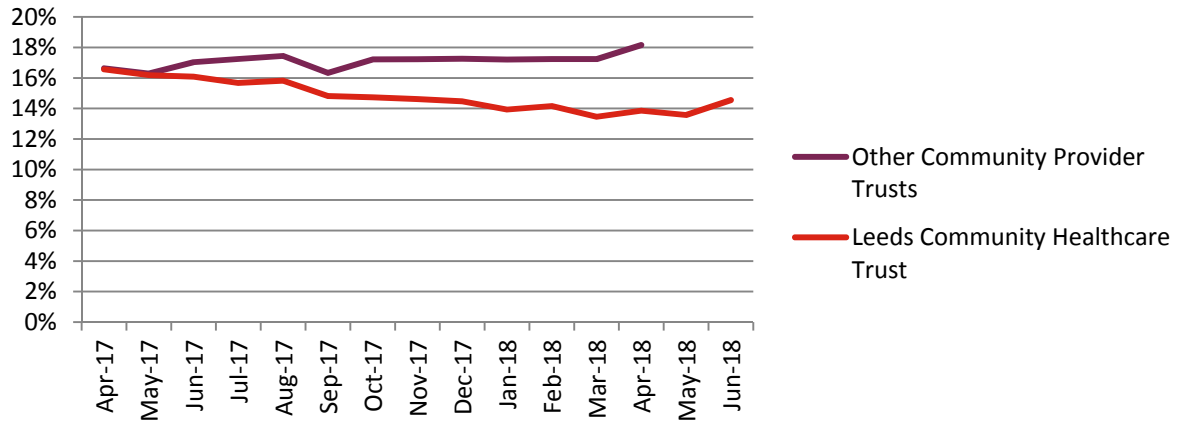
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		Target	YTD	April	May	June	Q1	Forecast
Staff Turnover	2018/19	<=15.0%	-	13.9%	13.6%	14.6%	14.0%	●
	2017/18		-	15.6%	15.3%	15.2%	15.2%	
Reduce the number of staff leaving the organisation within 12 months	2018/19	<=20.0%	-	13.0%	13.0%	13.2%	13.1%	●
	2017/18		-	19.4%	16.2%	16.3%	16.3%	
Executive Team Turnover	2018/19	<=14.5%	-	0.0%	0.0%	0.0%	0.0%	●
	2017/18		-	0.0%	0.0%	0.0%	0.0%	
Stability Index	2018/19	>=85%	-	85.6%	85.2%	85.6%	85.5%	●
	2017/18		-	83.1%	83.5%	83.8%	83.8%	
Short term sickness absence rate (%)	2018/19	<2.2%	-	1.9%	1.6%	2.2%	1.9%	●
	2017/18		-	1.6%	2.1%	1.8%	1.8%	
Long term sickness absence rate (%)	2018/19	<3.6%	-	3.5%	3.5%	3.3%	3.5%	●
	2017/18		-	3.8%	3.4%	3.5%	3.5%	
Total sickness absence rate (%)	2018/19	<5.8%	-	5.4%	5.1%	5.5%	5.3%	●
	2017/18		-	5.4%	5.5%	5.2%	5.2%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2018/19	>=95%	-	81.9%	80.2%	79.9%	80.7%	●
	2017/18		-	87.3%	89.3%	88.8%	86.6%	
Medical staff appraisal rate (%)	2018/19	100%	-	100.0%			100.0%	●
	2017/18		-	100.0%			100.0%	
6 universal Statutory and Mandatory training requirements	2018/19	>=95%	-	91.4%	89.9%	89.6%	90.3%	●
	2017/18		-	90.5%	90.6%	91.0%	91.0%	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2018/19	>52.0%	-	63.0%			63.0%	●
	2017/18		-	54.0%			54.0%	
Percentage of staff who are satisfied with the support they received from their immediate line manager	2018/19	>52.0%	-	64.0%			64.0%	●
	2017/18		-	62.0%			62.0%	
Response Rate for Staff FFT	2018/19	>22.0%	-	24.0%			24.0%	●
	2017/18		-	22.2%			22.2%	
Response Rate for Inpatient FFT	2018/19	23.1%	-	27.7%	44.4%	44.4%	38.9%	●
	2017/18		-	11.0%	15.6%	15.4%	15.4%	
Response Rate for Community FFT	2018/19	6.8%	-	5.8%	4.8%	11.5%	7.4%	●
	2017/18		-	4.6%	5.1%	6.9%	6.9%	
Total agency cap	2018/19	£534k	£1,403k	£438k	£417k	£549k	£1,403k	●
	2017/18		£6,089	£563k	£474k	£507k	£1,544k	
Percentage Spend on Temporary Staff	2018/19		7.8%	7.1%	7.5%	8.8%	7.8%	
	2017/18		8.0%	8.6%	7.4%	8.3%	8.1%	

12. Retention

The overall trend in this area is a positive one, with turnover and stability rates several percentage points better than the same period in 2017.

The Trust's turnover rate continues to benchmark favourably against its Community Trust peers, consistently ranking in the upper quartile (Fig. 1).

Fig. 1: Staff Turnover Rate comparison with the average across other Community Health Trusts
(Data source: NHS Digital iView)



In June 2018, turnover was 14.6%, slightly above the 2018/19 outturn target of 14.5% and an increase on May 2018's 13.6% turnover figure.

Further analysis is being undertaken into the 33% of June 2018 leavers (9 individuals) whose reason for departure is described as "Voluntary Resignation – Work / Life Balance", to identify any opportunities for improvement.

The stability index in June was 85.6%. Whilst slightly above the Trust target of 85%, this remains within tolerance.

The incidence of staff leaving the Trust within the first 12 months of employment remains lower than overall turnover, at 13.20% at June 2018.

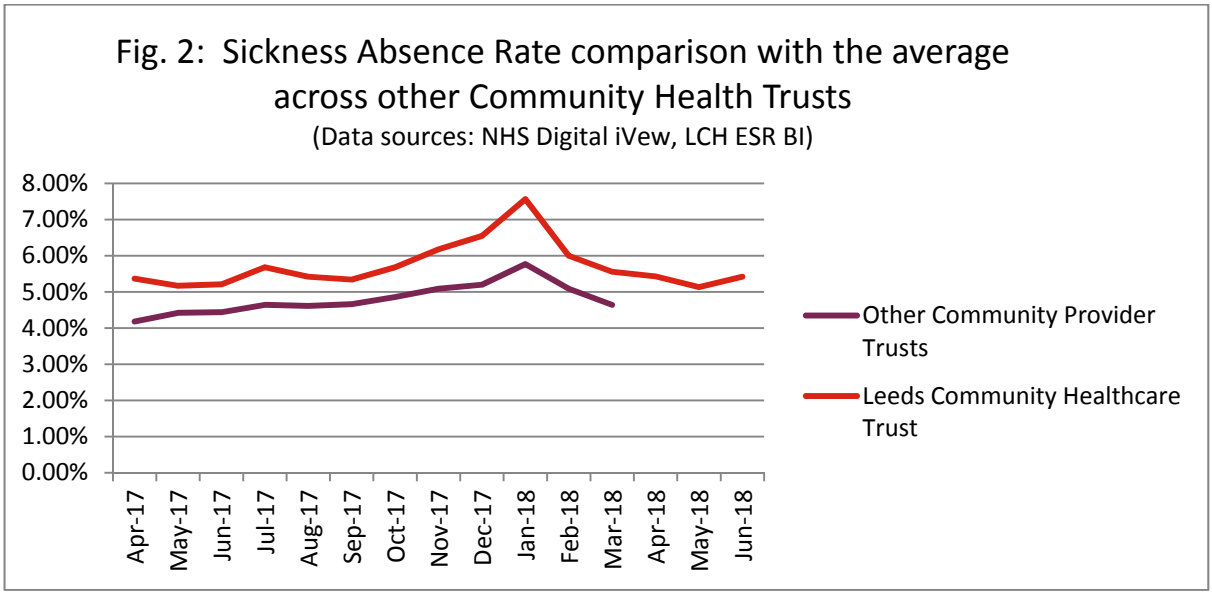
The number and distribution of leavers across the Trust's Business Units and professional groups in June 2018 remain consistent with the month-on-month pattern seen throughout Quarter 1.

With a set of retention initiatives in place, it is anticipated that both the stability index and turnover levels will improve against target during 2018/19.

Background detail associated with retention is at **Appendix 1**.

13. Sickness absence

Sickness absence is consistently rated as a significant risk for the Trust, and the Trust's overall sickness absence rate continues to benchmark unfavourably compared to its peer Community Trusts (Fig. 2).



Whilst the overall sickness absence rate of 5.42% for June 2018 is below the outturn 2018/19 target of 5.8%, it has increased from 5.13% in May 2018, and is higher than at the same time last year.

This month's increase is linked to an overall rise in long term sickness absence, from 3.5% in May 2018 to 3.87% in June 2018. The rise appears to be consistent across the organisation, with the exception of the Specialist Business Unit and Operations (Fig. 3). Further analysis is underway to identify patterns or potential causes of the rise.

Short term sickness has decreased slightly to 1.55% in June 2018, from 1.6% in May 2018.

Fig.3

Business Unit	June 2018 absence rate
Adult	6.68%↑(from 5.91%)
Children	4.30%↑(from 3.97%)
Specialist	5.63%↓(from 5.94)
Corporate	3.77%↑(from 3.16%)
Operations	5.61%↓(from 6.08%)

The Trust continues to work with NHSI as part of its Health & Wellbeing Programme, accessing their support and expertise to identify interventions and actions to deliver the greatest possible impact. The Health & Wellbeing Programme is one of the Trust's 4 main Quality Improvement programmes for 2018/19.

In addition, the Trust has volunteered to join an in-depth evaluation exercise offered by NHSI, which is expected to assess a range of factors including population health determinants to help identify any underlying factors contributing to sickness absence.

A Task and Finish Group for the Trust will lead the Health & Wellbeing Programme, chaired by the Assistant Director of Workforce. The group is expected to meet for the first time in August 2018.

Organisational initiatives focused on improving engagement, leadership and culture are expected to have a positive correlative impact on sickness absence figures in the long term; including the programmes of work underway to deliver local Staff Survey action plans and a revised programme of Leadership & Management development.

14. Appraisal

At the end of June 2018, 79.9% of available staff were registered as having had an appraisal within the last 12 months. This is a slight fall compared with May 2018's 80.2% figure; and below the trust target of 95%.

Compliance rates for the business units are as follows:

- 80.83% - Adults *down from 82% in May*
- 83.57% - Children's *down from 84.9% in May*
- 64.76% - Corporate *up from 57.4% in May*
- 90.24% - Operations *down from 90.8% in May*
- 76.65% - Specialist *down from 77.1% in May*

The figures suggest that fewer appraisals took place in June, except in the Corporate Directorates where ongoing focus on appraisal compliance is seeing an upturn in appraisal rates.

Appraisal rates are regularly reviewed and analysed at the performance panels for Adults, Children's and Specialist Business Units, and these figures will be brought to those panels' attention. An SMT discussion on 11 July has agreed that there will be a concerted effort over the summer months to improve compliance rates. Workforce Information will circulate weekly update reports to senior managers to support improvement of compliance rates.

Compliance rates for medical staff are 84.62% at June 2018.

15. Statutory and Mandatory training

The overall level of compliance for the universal statutory and mandatory training requirements currently stands at 89.6%. This remains below the target of 95%.

Fig. 4 shows the Quarter 1 compliance rates by month for each of the Business Units.

Fig.4

Area	Apr-18	May-18	Jun-18
Overall	91.4%	89.9%	89.6%
Adult Business unit	89.4%	87.9%	88.8%
Children's Business Unit	93.4%	92.6%	92.2%
Corporate Directorate	86.1%	92.6%	92.3%
Operations	82.9%	87.0%	84.2%
Specialist Business Unit	92.7%	90.3%	89.2%

A further SMT discussion on 11 July has agreed that there will be a concerted effort over the summer months to improve compliance rates. Workforce Information will circulate weekly update reports to senior managers to support improvement of compliance rates.

16. Staff Friends and Family Test (FFT)

Engagement levels as tested by the quarterly FFT have shown a marked positive rise in 2018/19 Q1.

A significant increase in responses has been recorded: 701 responses this quarter compared with 571 in the previous quarter, supported by a 24% response rate and the submission of 399 comments.

Responses for Q1 show 5 out of 8 indicators improving and 3 out of 8 remaining static. None of the indicators has shown a decline this quarter. The most significant improvement has been in “Staff likeliness to recommend LCH as a place to work”, which has seen an increase of 6% in Q1, having already seen an increase of 4% in Q4 of 2017/18.

Overall, the increased response rate and comments combined with slightly more positive scores suggests an improved sense of engagement across the Trust.

The Q1 2018 FFT results, including a comparison with previous quarters’ results, are summarised at **Appendix 2.**

FFT results have been cascaded to the organisation via General Managers and other colleagues.

Leeds Community Healthcare NHS Trust

Finance Report

Finance		Target	YTD	April	May	June	Q1	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2018/19	£0.1m	£0.3m	£0.2m	£0.3m	£0.3m	£0.3m	●
	2017/18		-£3.3m	-£0.2m	-£0.7m	-£0.9m	-£0.9m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2018/19	£2.5m	£2.5m	£2.5m	£2.5m	£2.5m	£2.5m	●
	2017/18		-£3.3m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	
Forecast underlying surplus	2018/19	£1.4m	n/a	n/a	n/a	n/a	n/a	●
	2017/18		-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	
Capital expenditure in comparison to plan (£k) - YTD	2018/19	£29k	£67k	£21k	£46k	£236k	£303k	●
	2017/18		£1.4k	£0.1m	£0.2m	£0.2m	£0.2m	
Capital expenditure in comparison to plan (£m) - Forecast	2018/19	£3.2m	£3.2m	£3.2m	£3.2m	£3.2m	£3.2m	●
	2017/18		£1.4m	£1.8m	£1.8m	£1.8m	£1.8m	
CIP delivery (£m) - YTD	2018/19	£0.3m	£1.0m	£0.3m	£0.3m	£0.3m	£1.0m	●
	2017/18		£2.8m	£0.2m	£0.4m	£0.6m	£0.6m	
CIP delivery (£m) - Forecast	2018/19	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m	●
	2017/18		£2.8m	£3.4m	£3.4m	£3.4m	£3.4m	
Use of Resources Risk Rating (from Oct 2016)	2018/19	2	1	1	1	1	1	●
	2017/18		1	1	1	1	1	

1. Summary & KPIs

The Trust is £0.1m underspent at the end of June. Pay costs are higher than last month mostly as a result of additional agency staff. There are 149 wte vacancies for the month; temporary staffing is in place to mitigate the impact on service delivery. The Trust remains within the agency cap for the year to date however the run rate for expenditure has increased see section 2.2 and 9. Cost savings plans continue to be 4.5% below expected levels however savings in procurement occur as the year progresses. Cash is running £0.2m more than planned. The use of resources risk rating is 1.

The major risks at this time are the uncertainty around the impact of the proposed pay- award, the £1.2m unidentified savings in respect of the CCG decommissioning plan and any shortfall in the delivery of planned cost savings.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	£0.3m	£0.1m	£2.5m	G
Remain with EFL of (£3.708m)			-£3.7m	G
Remain within CRL of £2.039m	£0.3m	£0.2m	£3.2m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	99%	4%	95%	G
BPPC Non NHS Invoices Number 95%	97%	2%	95%	G
BPPC Non NHS Invoices Value 95%	98%	3%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.2m recurrent in year	£0.8m	-6%	£3.2m	R
CIP Savings £1.5m planned non recurrent in year	£0.2m	-	£1.5m	G

2. Income & Expenditure

The Trust continues to run marginally ahead of plan at June. Expenditure is £0.1m underspent on pay as a result of the level of vacancies which are 149 wte (159 wte May), 5.6% of establishment after the planned vacancy factor reduction. Temporary staffing costs are £773k for the month. All un-committed reserves have been released into the position.

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			(34.4)	(34.4)	0.0	(137.2)	(137.1)	0.1	(0.0)
Other Income			(2.4)	(2.3)	0.0	(9.4)	(9.3)	0.1	0.2
Total Income			***(36.8)***	***(36.7)***	***0.1***	***(146.6)***	***(146.4)***	***0.2***	***0.2***
Expenditure									
Pay	2,659.4	2,510.7	26.0	25.9	(0.1)	102.6	103.2	0.7	0.2
Non pay			9.2	9.2	0.1	35.9	35.6	(0.4)	(0.6)
Reserves & Non Recurrent			0.9	0.7	(0.2)	3.1	2.6	(0.5)	0.1
Total Expenditure	***2,659.4***	***2,510.7***	***36.0***	***35.8***	***(0.2)***	***141.6***	***141.4***	***(0.2)***	***(0.2)***
EBITDA	**2,659.4**	**2,510.7**	**(0.8)**	**(0.9)**	**(0.1)**	**(5.0)**	**(5.0)**	**(0.0)**	**(0.0)**
Depreciation			0.5	0.5	(0.0)	1.9	1.9	0.0	0.0
Public Dividend Capital			0.2	0.2	0.0	0.7	0.7	0.0	0.0
Interest Received			(0.0)	(0.0)	0.0	(0.1)	(0.1)	0.0	0.0
Retained Net Surplus	**2,659.4**	**2,510.7**	**(0.2)**	**(0.3)**	**(0.1)**	**(2.5)**	**(2.5)**	**0.0**	**(0.0)**
	Variance =	**(148.7)**							

2.1 Income

Contract income is running slightly behind plan due to £33k of penalties in respect of the police custody contract. Non contract income is marginally less than expected this is spread across all business units and will be monitored as the year progresses. The CQUIN income has been accrued as it is paid in arrears. Income assumes the allocated STF monies for 2018/19.

2.2 Pay

Table 3 below illustrates the total pay costs by category. The underspending on substantive staff in post continues in June.

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	25,575	23,614	(1,960)	(1,573)	
Seconded staff costs	217	248	31	(6)	
Vacancy Factor	(1,788)		1,788	1,192	
Sub-total Direct Pay	**24,004**	**23,862**	**(141)**	**(387)**	
Bank Staff	377	618	241	379	
Agency Staff	1,601	1,403	(198)	(212)	
Total Pay Costs	**25,981**	**25,883**	**(98)**	**(219)**	**659**

The 149 wte vacancies are driving the underspending.

Agency costs have increased by £140k this month which means the Trust has spent more than planned on agency staff in month. This is the first time this has happened since the agency cap was introduced. If this continues there is a risk the agency cap will be breached. This will also impact on the use of resources risk rating. Costs have increased in corporate services, dietetics, CAMHS and Paediatric Medical satff, the community care beds service and police custody.

Monthly pay cost run rates are in table 4.

Table 4 Month on Month Pay Costs by Category	April £k	May £k	June £k	YTD Actuals £k
Directly employed staff	7,886	7,829	7,898	23,614
Seconded staff costs	88	51	109	248
Bank staff	176	218	224	618
Agency staff	438	417	549	1,403
Total Pay Costs	**8,588**	**8,515**	**8,781**	**25,883**

2.3 Non Pay

Non pay expenditure continues to run slightly more than planned.

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	200	199	(2)	(9)	
Clinical Supplies & Services	2,394	2,305	(88)	(83)	
General Supplies & Services	1,357	1,349	(8)	(15)	
Establishment Expenses	1,660	1,584	(76)	(37)	
Premises	3,133	3,258	125	143	
Other non pay	423	547	123	75	
Total Non Pay Costs	**9,168**	**9,242**	**74**	**74**	**(390)**

Premises costs includes £24k overspending on reactive maintenance which fluctuates throughout the year and £55k on IT; non pay expenditure is not smooth throughout the year and the early

expenditure on maintenance and IT has led to the overspendign for the year to date, as the year progresses this is forecast to recover. The overspending on other non pay includes the as yet unidentified CIPs of £500k in respect of the CCG decommissioning.

3. Reserves & Non Recurrent

The Trust has £3.1m in reserve at the end of June; all un-committed reserves have been released into the forecast outturn position including the £0.3m contingency.

4. Service Line & Contract Performance

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m	YTD Plan Activity	YTD Actual Activity	YTD Variance Activity	Corr-elation
Specialist Services	37.4	662.9	626.2	(36.8)	9.3	9.0	(0.4)	120,093	110,936	(9,157)	•••
Childrens Services	27.7	688.6	680.6	(8.0)	7.0	7.2	0.2	89,101	89,353	252	•••
Adults Services	40.2	886.9	837.0	(49.9)	10.4	10.3	(0.1)	217,368	191,897	(25,471)	•••
Ops Management & Equipment	1.4	48.2	50.4	2.3	0.4	0.4	0.0				••
Service Line Totals	**106.8**	**2,286.6**	**2,194.2**	**(92.4)**	**27.1**	**26.9**	**(0.2)**	**426,561**	**392,186**	**(34,376)**	•••
Corporate Support & Estates	26.2	372.8	316.5	(56.3)	6.6	6.8	0.2				••
Total All Services	**133.0**	**2,659.4**	**2,510.7**	**(148.7)**	**33.7**	**33.7**	**(0.0)**	**426,561**	**392,186**	**(34,376)**	•••

This month operational services have 92 wte less in post than planned. The clinical services are a net £0.2m underspent for June.

The overall activity is 8.1% behind plan, Specialist and Adult's BUs have not achieved their planned activity levels for the year to date; Children's is marginally ahead of plan. There is a recording lag and the position will be updated in the next few weeks before the freeze position.

5. Cost Improvement Plans

Table 7 has the Trust's performance against the cost savings plan for 2018/19. Overall the plan is £45k or 4.5% behind at this early point in the year. Corporate support savings have not been identified however overall corporate pay is underspent at the end of June so these savings are being made. The Finance team will work with Directors to identify the specific budgets to be removed recurrently. Procurement savings are delivered in year as opportunities arise. It is anticipated actions will be taken to recover the shortfall and this is reflected in the forecast outturn.

Table 7 Savings Scheme	2018/19 YTD Plan £k	2018/19 YTD Actual £k	2018/19 YTD Variance £k	2018/19 Annual Plan £k	2018/19 Forecast Outturn £k	2018/19 Forecast Variance £k	2018/19 Forecast Variance %
Estates	175	175	0	700	700	0	0%
Admin Review	63	63	0	250	250	0	0%
Corporate Support	75	75	0	300	300	0	0%
Procurement	45	0	(45)	180	180	0	0%
Non Pay Inflation	110	110	0	440	440	0	0%
CQUIN	113	113	0	452	452	0	0%
Contribution to overheads / fixed costs	208	208	0	831	831	0	0%
Release of Reserves	19	19	0	75	75	0	0%
IT Kit	75	75	0	300	300	0	0%
Discretionary spending	125	125	0	500	500	0	0%
Decommissioning cost reduction	0	0	0	700	700	0	0%
Total Efficiency Savings Delivery	**1,007**	**962**	**(45)**	**4,728**	**4,728**	**0**	**0%**

6. Capital Expenditure

NHS Improvement has notified the Trust of its capital resource limit for 2018/19. The Trust has planned for capital expenditure of £3.2m as below. The year to date position is an overspending of £0.2m in respect of IT expenditure. This is a timing matter and will resolve as the year progresses.

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	0.0	0.0	0.7	0.7	0.0
Equipment/IT	0.0	0.2	0.2	0.5	0.5	0.0
Electronic Patient Records	0.1	0.1	(0.0)	0.5	0.5	0.0
CAMHS Tier 4	0.0	0.0	0.0	1.5	1.5	0.0
Totals	**0.1**	**0.3**	**0.2**	**3.2**	**3.2**	**0.0**

7. Statement of Financial Position

The Trust's statement of financial position at the end of June is ahead of plan by £0.1m reflecting the income and expenditure position. Trade and other receivables are £3.1m more than planned and trade and other payables, including provisions, £3.3m more than plan.

Trade and other receivables total £10m at the end of June material items include:

- The largest debtor is Leeds City Council which owes £1.6m.
- Accrued income totals £5.3m, made up of:
    - £0.3m for CQUIN income,
    - £0.2m for NHS England/CCG non-contract income
    - £1m for NHS England/CCG contract income
    - Non-NHS contract income is £0.3m
    - Non-NHS non-contract income of £0.2m
    - STF accruals for 2017/18 total £1.8m as well as £0.2m for 2018/19; the STF income for 2017/18 was received early July.

Trade payables total £13.1m at the end of June as follows:

- Accrued expenditure totals £7.1m, and comprises:
    - £2.9m for property charges and
    - various other smaller accruals.

As a result of the above the cash position is £0.2m more than planned, with cash and cash equivalents totalling £24.1m.

There is no concern about overall Statement of Financial Positon or the detail within it.

Table 9 Statement of Financial Position	Plan 30/06/2018 £m	Actual 30/06/2018 £m	Variance 30/06/2018 £m	*Opening 01/04/17 £m*	Planned Outturn 31/03/19 £m	Forecast Outturn 31/03/19 £m	Forecast Variance 31/03/19 £m
Property, Plant and Equipment	28.9	29.1	0.2	*29.3*	30.7	30.7	0.0
Intangible Assets	0.0	0.0	0.0	*0.1*	0.0	0.0	0.0
Total Non Current Assets	**29.0**	**29.2**	**0.2**	*29.4*	**30.7**	**30.7**	**0.0**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	7.0	10.0	3.1	*8.8*	7.9	7.9	0.0
Cash and Cash Equivalents	23.9	24.1	0.2	*23.2*	27.3	27.3	0.0
Total Current Assets	**30.8**	**34.1**	**3.3**	*32.1*	**35.2**	**35.2**	**0.0**
TOTAL ASSETS	**59.8**	**63.3**	**3.5**	*61.5*	**65.8**	**65.8**	**0.0**
Current Liabilities							
Trade and Other Payables	(10.8)	(13.1)	(2.4)	*(12.1)*	(13.4)	(13.4)	0.0
Provisions	(0.4)	(1.4)	(1.0)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(11.2)**	**(14.5)**	**(3.3)**	*(13.4)*	**(13.8)**	**(13.8)**	**0.0**
Net Current Assets/(Liabilities)	**19.7**	**19.6**	**(0.1)**	*18.7*	**21.4**	**21.4**	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**48.7**	**48.8**	**0.1**	*48.0*	**52.1**	**52.1**	**0.0**
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	**48.7**	**48.8**	**0.1**	48.0	**52.1**	**52.1**	**0.0**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	1.8	1.8	0.0
Retained Earnings Reserve	17.8	18.0	0.1	*17.2*	19.7	19.7	0.0
General Fund	18.5	18.5	(0.0)	*18.5*	18.5	18.5	0.0
Revaluation Reserve	12.0	12.0	(0.0)	*12.0*	12.0	12.0	0.0
TOTAL EQUITY	**48.7**	**48.8**	**0.1**	48.0	**52.1**	**52.1**	**0.0**

8. Working Capital

The Trust's cash position is strong at £24.1m which is £0.2m more than planned. Table 10 demonstrates the Trust's performance in respect of the Better Payment Practice Code.

Table 10 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	99%	95%	G
Non NHS Invoices			
By Number	97%	95%	G
By Value	98%	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 is 1, which is the lowest risk.

Agency expenditure has increased this month and the performance has moved from being 20% below the cap at May to 12% below cap at June. As this measure is cumulative should June's performance continue there is a risk the performance for this metric will impact on the rating.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	50	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	8.2	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	-12%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

10. Conclusion on Financial Performance

At the end of quarter 1 the Trust is slightly underspent year to date, as a result of vacancies. Staffing levels are 149 wte below funded numbers; temporary staffing is in place to mitigate service risks. CIP delivery has been good for June.

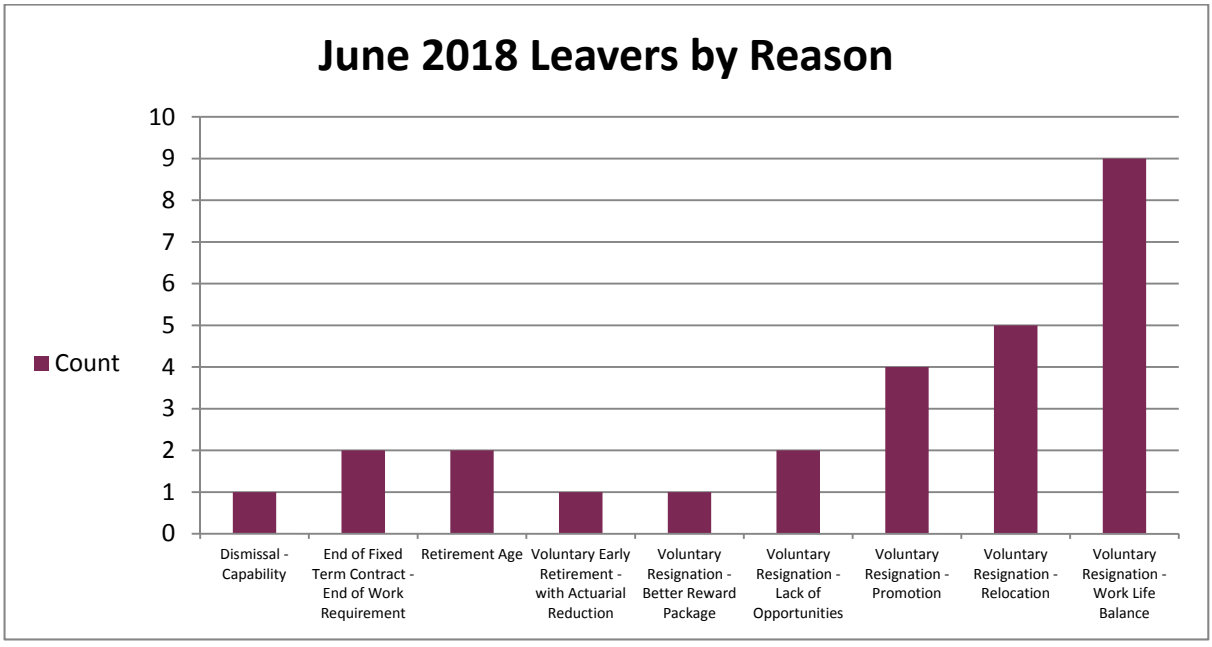
The forecast outturn demonstrates there are some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will continue to be monitored closely as the year progresses.

Appendix 1: Retention Background Data

In June 2018 there were 27 leavers across the Trust. Their distribution by Business Unit, staff group and reason for leaving is set out below:

Business Unit	June 18 Leavers
Adult Business unit	13
Children's Business Unit	7
Corporate / Operations	5
Specialist Business Unit	2
Grand Total	**27**

Staff Group	June 18 Leavers
Clinical Services and Scientific/medical	7
Administrative and Clerical	8
Allied Health Professionals	3
Nursing and Midwifery Registered	9
Grand Total	**27**



A summary of the initiatives contributing to the Trust's strategic Retention and Recruitment priorities are set out below:

- **Redesign of the leadership & management offer** – a focus on what it means to be a leader at LCH, core leadership & management essentials, communication essentials and Manager as Coach. The revised offer will be in place towards the end of 2018.
- **Enabling staff to contribute to improvement and change** – the 4 Quality Improvement learning projects are in the process of being established; training is being planned over the summer and autumn for project teams and other staff groups, with a focus on enabling staff to contribute to local, small scale improvements. This is being designated as an "obsession" within the Specialist Business unit, the leaders of which are participating in training during August 2018.

- **Creating positive team cultures:** ongoing work emerging from Staff Survey feedback discussions – across business units and corporate teams
- **Apprenticeships:** A working group has been established and meetings scheduled over the summer to identify the number of nursing and therapy apprenticeship posts each Business Unit can support on an annual basis. This work will inform the apprenticeship steering group/SMT in developing this important agenda.
- **NHSI retention plan:** Work continues to progress the 12 month retention plan which is being supported by NHS Improvement. Initiatives that will have the biggest impact are being prioritised for agreement with the trust and NHS Improvement. Our initial focus in on enabling our staff to discuss their career options by requesting an 'itchy feet' conversation and developing our processes to support internal transfers. A working group has now been established to progress this work.
- **Hard to recruit posts**. A particular focus will be given to hard to recruit posts ie: band 5 and 6 adult nurses, introduction of newly qualified band 5 nurses in Children's Community Nursing and Healthcare Professionals working in Police Custody.
- **Review of recruitment and selection process**, systems and methodologies
- **Pro-active work** with services currently experiencing recruitment difficulties
- **Further development** of the Trust's 'Work for us' web page/target advertising using social media/other promotional literature
- **Design and delivery** of assessment centres for identified posts
- **Continued standing interview panels** for high volume recruitment
- **Development of stronger links** to partner organisations and higher education, colleges and schools
- **Development of appropriate metrics** to monitor progress against plans
- **Strengthening of workforce planning capability** to identify talent supply against business requirements.

Appendix 2: Staff Friends & Family Test results

A comparison of the results from 2018/19 Q1 with 2017/18 is summarised below

Family Friends Tests – Results from Q1 2017 to Q1 2018

2017	Q1	Q2	Q4	2018 Q1
Staff likeliness to recommend LCH as a place for care/treatment	3% ↑	6% ↓	6% ↑	1% ↑
Staff likeliness to recommend LCH as a place to work	2% ↑	2% ↓	4% ↑	6% ↑
Other Questions				
I am able to make suggestions to improve the work of my team/department	1% ↓	1% ↑	1% ↑	0% -
I am able to make improvements that happen in my area of work	1% ↓	1% ↑	3% ↑	0% -
I am involved in deciding on changes introduced that affect my work area/team/department	2% ↑	3% ↑	1% ↓	2% ↑
I am satisfied with the support I get from my immediate line manager	1% ↑	2% ↓	3% ↑	1% ↑
My immediate manager gives me clear feedback on my work	2% ↑	1% ↓	1% ↑	2% ↑
My immediate manager asks for my opinion before making decisions that affect my work	3% ↑	1% ↓	1% ↑	0% -

A breakdown by business unit of core results from Q1 2018/19 is shown below

2018 Q1 Whole Trust

Percentage of Staff that would recommend LCH as a place of work	63%
Percentage of staff who are satisfied with the support they received from their immediate line manager	64%
Response Rate for Staff	24%
Percentage of Staff Recommending Care	82%

Children's Business Unit

Percentage of Staff that would recommend LCH as a place of work	55%
Percentage of staff who are satisfied with the support they received from their immediate line manager	62%
Response Rate for Staff	22%
Percentage of Staff Recommending Care	79%

Adult Business Unit

Percentage of Staff that would recommend LCH as a place of work	67%
Percentage of staff who are satisfied with the support they received from their immediate line manager	67%
Response Rate for Staff	21%
Percentage of Staff Recommending Care	86%

Specialist Business Unit

Percentage of Staff that would recommend LCH as a place of work	62%

Percentage of staff who are satisfied with the support they received from their immediate line manager	57%
Response Rate for Staff	25%
Percentage of Staff Recommending Care	79%

Corporate Directorate

Percentage of Staff that would recommend LCH as a place of work	70%
Percentage of staff who are satisfied with the support they received from their immediate line manager	67%
Response Rate for Staff	41%
Percentage of Staff Recommending Care	86%

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (28)

Meeting Trust Board 3 August 2018	**Category of paper** *(please tick)*	
Report title Serious Incident Summary Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident and Assurance Manager	**For assurance**	√
Previously considered by: N/A	**For information**	

Purpose of the report

This report provides the Board with an update and assurance in relation to the management of Serious Incidents (SIs). It summarises the outcomes, themes, actions and learning from SI investigations closed within the organisation during 1 April to 30 June 2018; as well as progress against action plans.

Main issues for consideration

A total of 16 Serious Incidents were reported and verified in April through to June 2018 Fourteen (87.5%) of the SI's in this reporting period related to pressure ulcers; with two 'other' one related to External feed error in SILC .

Outcomes of serious incident investigations completed in this reporting period are included in the report along with any themes identified through investigations. The themes remain consistent with previous reports and generally fall into three overarching categories: documentation, communication and processes.

There have been one record 'de-logged' from StEIS. This indicates there is still some learning to be done concerning identifying and categorising comprehensive SI's. This will also be balanced with the direction from the CCG Quality Review Meeting that they wish incidents to be logged at the earliest point and that incidents are de-logged if necessary, as investigation progresses. All moderate and above incidents are reviewed by the Incident and Assurance Manager and an independent review is undertaken by the Clinical Governance Manager to ensure that further investigations are undertaken where appropriate.

Recommendations

The Board is recommended to:

- receive this report and note the current position with regards action plans and learning
- receive assurance regarding the management of Serious Incidents and handling of inquests

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 April – 30 June 2018.

1.2 The report provides a summary of the outcomes, themes, learning and actions from completed serious incident investigations. An update of service improvements and actions taken to prevent recurrence of the incident is also included in the report.

1.3 The report provides an overview of Coroner's Inquests held in relation to Serious Incidents, along with the outcomes and any recommendations made.

2.0 Background

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

2.2 Serious Incidents (SIs) are reported on StEIS within 2 working days of the incident being confirmed as a Serious Incident. They are allocated to the relevant commissioner via the StEIS report.

2.3 A SI occurring in services with additional commissioning arrangements (for example HMP Wetherby YOI, Policy Custody, Leeds IAPT) is also reported to the relevant body, such as NHS England.

2.4 A monthly summary of SIs and any exceptions is included within the monthly Clinical Governance Exception report; part of the Trust's Executive Director of Nursing's Report. This is submitted to the Quality Committee.

3.0 New Serious Incidents in Quarter 1

3.1 Sixteen SI's were reported to the commissioners via STEIS between April and June 2018. Two have been reviewed and identified as not meeting the SI criteria and de-log requests have been submitted to the CCG. Details of the findings of the initial or full investigations have been provided to the CCG.

The table below provides a summary of the SI's recorded this quarter and their categories.

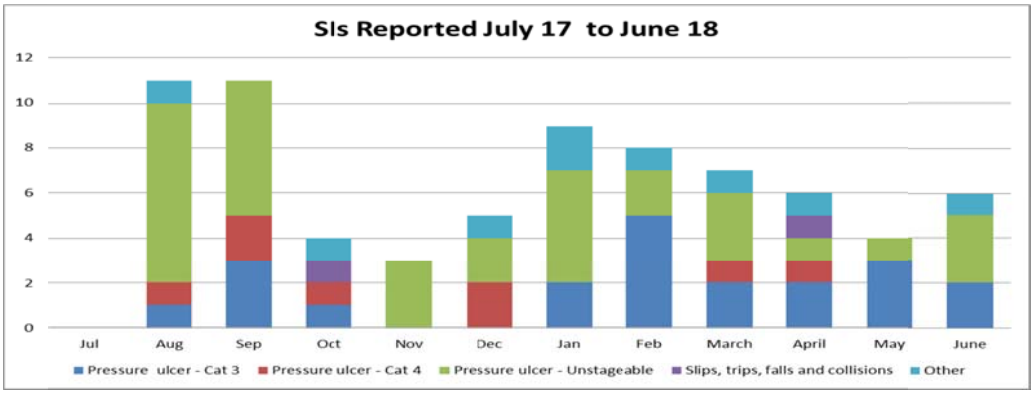
2018/19 Quarter 1	Apr 2018	May 2018	Jun 2018	Total
Pressure Ulcer - Unstageable	1	1	3	5
Pressurel Ulcer - Cat 3	2	3	2	7
Pressure ulcer - Cat 4	1	0	0	1
Slips, trips, falls and collisions	1	0	0	1
Other	1	0	1	2
Total	6	4	6	16
Request for De-Logs	1	0	1	2

The 2 'other' SI's relates to;

I. External feed error (ID: 49584) which was later delogged after the panel review

II. Paediatric Neuro Referral failure (50597); this is booked into panel in the coming weeks

3.2 Total SI's taken forward for investigations for the year are in the table below:



*Please note there were no SI's reported in July 2017.

4.0 Completed Investigations

4.1 21 SI's were included in the Quarter 1 pressure ulcer report to the CCG. All were submitted within the quarter, 15 of these were before the date due. Extensions were agreed with the CCG for any SI reports that were identified as requiring extra time to complete.

4.2 Of the 21 reports, 3 were sent directly to the CCG for review, the remaining 18 related to category 3 and unstageable pressure and a quarterly thematic report and review is sent to commissioners
There was one category 4 pressure ulcers closed in quarter 4 which was found to be unavoidable following full investigation.

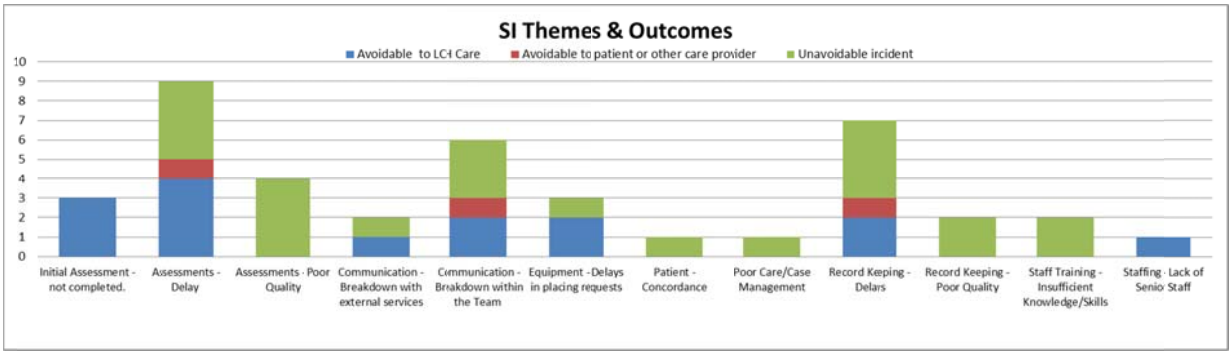
A synopsis of the 3 individual submissions sent directly to the CCG is provided below:

Ref	Type	Status	Root Cause(s)
48611	Cat 4 pressure ulcer	Unavoidable	Patient and his wife declined assessment and review from the neighbourhood teams so team were unable to establish any change/deterioration in the wound and to take appropriate preventative measures.
48975	Treatment/ Procedure *(Depo Injection affecting sciatic nerve)*	Unavoidable	No error or omission or other factor has been identified as a cause of the symptoms described by patient. There is a possibility of irritation by the drug and this could be a reason for symptoms.
48577	SUDIC	*N/A*	Ongoing coroner/inquest.

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

5.0 Outcomes and Themes

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



5.2 Themes are reflective of those identified in previous reports. However, even when a SI has been identified as avoidable to the patient or other carer (red areas), there have still been themes identified relating to LCH care regarding delays in record keeping/assessments and communication. The relevant teams have all created action plans around these incidents.

5.3 All of the above themes have an interrelated nature and so the trust is in the process of reviewing the existing education programme to include themes arising from investigations and to reiterate new key messages. For example although documentation remains a theme, the particular aspect found relating to documentation has changed, whereby the same ulcer has been described as being on the sacrum, coccyx and buttock. The wound prevention team has issued guidance for teams to help with this and will also be shared on the learning from incidents portal.

5.4 All SI reports require an action plan to be developed alongside completion of the investigation. Action plans are reviewed at a review panel to ensure they are SMART and fully address the recommendations.

5.5 A Lessons Learned template (for shared learning has been available to use by all staff since April 2018, and was initially a pilot for 3 months. However submissions to QPD/Clinical Governance for this knowledge base have been slow, with 6 'Lessons Learned' documents uploaded to date.

5.6 Clinical Governance and the Quality Leads are looking at further ways to encourage staff to populate this feature, including articles in Community Talk and Risky Business. The pilot is to be extended a further 6 months and will be reviewed at the end of December 2018.

6.0 CCG response

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

6.2 The CCG have not requested any further assurance in relation to SI reports in quarter 1.

6.3 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.

7.0 Inquests

7.1 Two potential inquests were registered with LCH as an interested party in quarter 1**.**

7.2 Two inquests were held and closed in the quarter with no recommendations for the organisation.

	Synopsis	**Inquest Date**	**Outcome**	**Recommendations**
1	Death of a patient recently released from a North Yorkshire Custody Suite	7th June 2018	Suicide	There were no coroner recommendations for LCH
2	Unexpected Death at South Leeds Recovery Hub	26th April 2018 (coroner review date)	Natural Causes	Coroner reviewed available evidence /statements and concluded no inquest required

NB: There will be other inquests held for LCH patients. Those listed are for inquests where LCH is officially registered with the Coroner's office as a Properly Interested Party (PIP) and/or where LCH witnesses are required to provide information/evidence.

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

8.0 Impact

8.1 Quality

8.1.1 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.

8.1.2 These priorities are addressed by ensuring the continuation of good governance of the Serious Incident process; identifying feedback from Commissioning bodies; and ensuring the opportunity for continuous improvement is embedded the SI management process.

8.2 *Risk and assurance*

8.2.1 Alongside the dissemination of learning and monthly SI training, themes are identified and triangulated against other information sources such as complaints feedback and involvement to provide assurance to the trust's patient safety and experience governance group (PSEGG).

8.2.2 Outcomes and experience from the management of SIs will be shared with other organisations at the regional SI network meeting in July 2018. This network will be used to develop benchmarking and identify areas for improving how learning is embedded.

8.2.3 SPC charts have recently been updated by the business intelligence team. They have changed the methodology of calculating the control limits for the SPC charts which they believe is more appropriate in representing the data.

9 Next steps – monitoring & improvements

9.1 A policy review group have been set by the clinical governance manager to review the current incident and Serious Incidents policy which is due for renewal.

9.2 The clinical governance manager and the Incident & Assurance Manager are looking at creating a multi-discipline standing panel to review all moderate incident which stands outside PU's, falls and comprehensive SIs. A 72 hour review template will be designed for these standalone incidents.

9.3 A quarterly report will continue to be presented to PSEGG. This will scrutinise the full range of quality data and information in relation to safe, caring, effective, and responsive and well led patient care and services.

10 Recommendations

10.1 The Trust Board is recommended to:

- Receive this report and note the current position with regards to action plans and learning.
- Receive assurance regarding the management of Serious Incidents and handling of inquests.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (29)

Meeting Trust Board 3 August 2018	**Category of paper**	
Report title Safe Staffing	**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. There are current pressures in a number of the neighbourhood teams during the gap waiting for the newly qualified nurses. The paper sets out the mitigation in place

The 0-19 service is awaiting the outcome of the tendering exercise

RECOMMENDATIONS

The Board is recommended to:

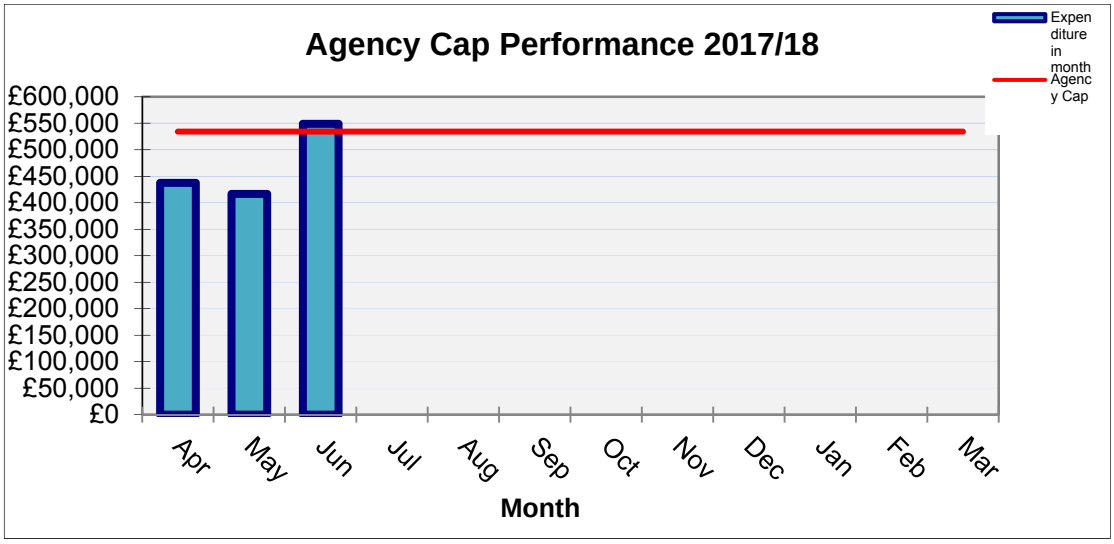
- Continue the recruitment drive and work to support new staff
- Continue to meet the national monthly collection and publication of staffing data as recommended in “Hard Truths”
- Keep staffing levels under constant review to maintain and ensure they are safe
- Note the contents of the report and the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

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.

2.0 Agency spend and cap

2.1 Agency costs have increased by £140k in June which means the Trust has spent more than planned on agency staff in month. This is the first time this has happened since the agency cap was introduced. If this continues there is a risk the agency cap will be breached. This will also impact on the use of resources risk rating. This additional spsend is related to some necessary spend in relation to medical cover in paedicatrics and CAMHs and whilst waiting for permanent medical staff to take up post. Risk and Quality Impact assessments are being completed.



3.0 Safe staffing

3.1 We continue to use a set of principles as set in appendix1 below to monitor safe staffing in our in-patient beds and wider teams in the absence of a national definition of community safe staffing. This is also underpinned by the national Quality Board good characteristics (appendix2). 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 reviewed in this bi-annual report.to board.

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. The focus remains on The National Quality Board framework of 9 characteristics of good quality care in District Nursing (appendix 3). This builds on the three expectations which were published in 2016 (Right Staff, Right Skills, Right Place and Time)

5.0 The local picture on staffing

5.1 LCH has complied with NQB recommendation that monthly planned and actual staffing data is uploaded to Unify.

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 and use of the agency framework in place
- The Trust continues to invest in nurse recruitment of the new cohort currently about to qualify
- Second programme of nursing associate pilot (Sept 18) and first cohort nursing degree apprenticeships (Sept 18)
- Participation in wave 2 NHSI recruitment and retention programme and currently reviewing and refreshing action plan

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.

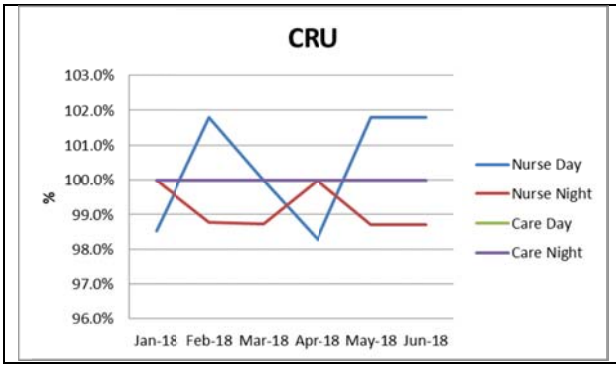
6.2 The trust is continuing the work to procure an e rostering system.

7.0 Current position

7.1 The Board receives information on a monthly basis for inpatient units as part of the integrated performance report.

8.0 Community Neurological Rehabilitation Unit

8.1 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 as set out below:

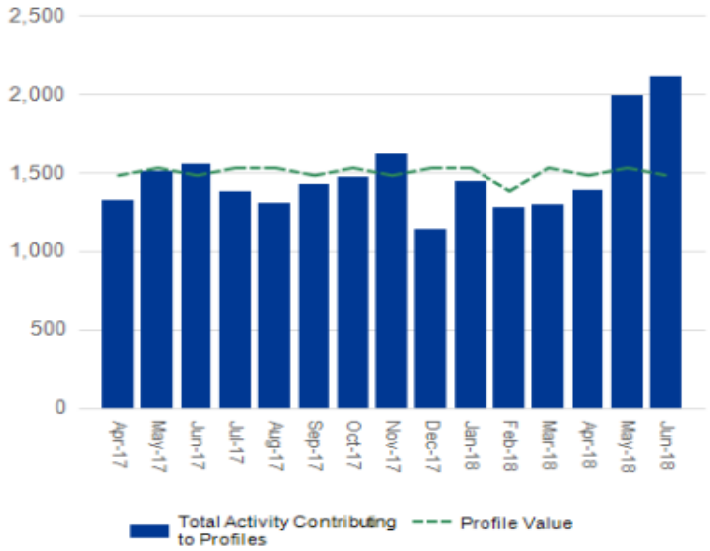


CRU				
Date	Nurse Day	Nurse Night	Care Day	Care Night
Jan-18	98.5%	100.0%	100.0%	100.0%
Feb-18	101.8%	98.8%	100.0%	100.0%
Mar-18	100.0%	98.7%	100.0%	100.0%
Apr-18	98.3%	100.0%	100.0%	100.0%
May-18	101.8%	98.7%	100.0%	100.0%
Jun-18	101.8%	98.7%	100.0%	100.0%

8.2 Activity:
The unit continues to operate under the revised model of five inpatient beds and providing day case and community services. Activity level to the end of June 2018 is included in the table below:

Community Neurological Rehabilitation Service Detailed Activity Report

Performance Against Activity Profile



8.3 The unit provides safe care as set out in the table below and tools such as Quality Challenge+. The service uses a quality board. Patients care plans are reviewed at the weekly multi-disciplinary team meeting.

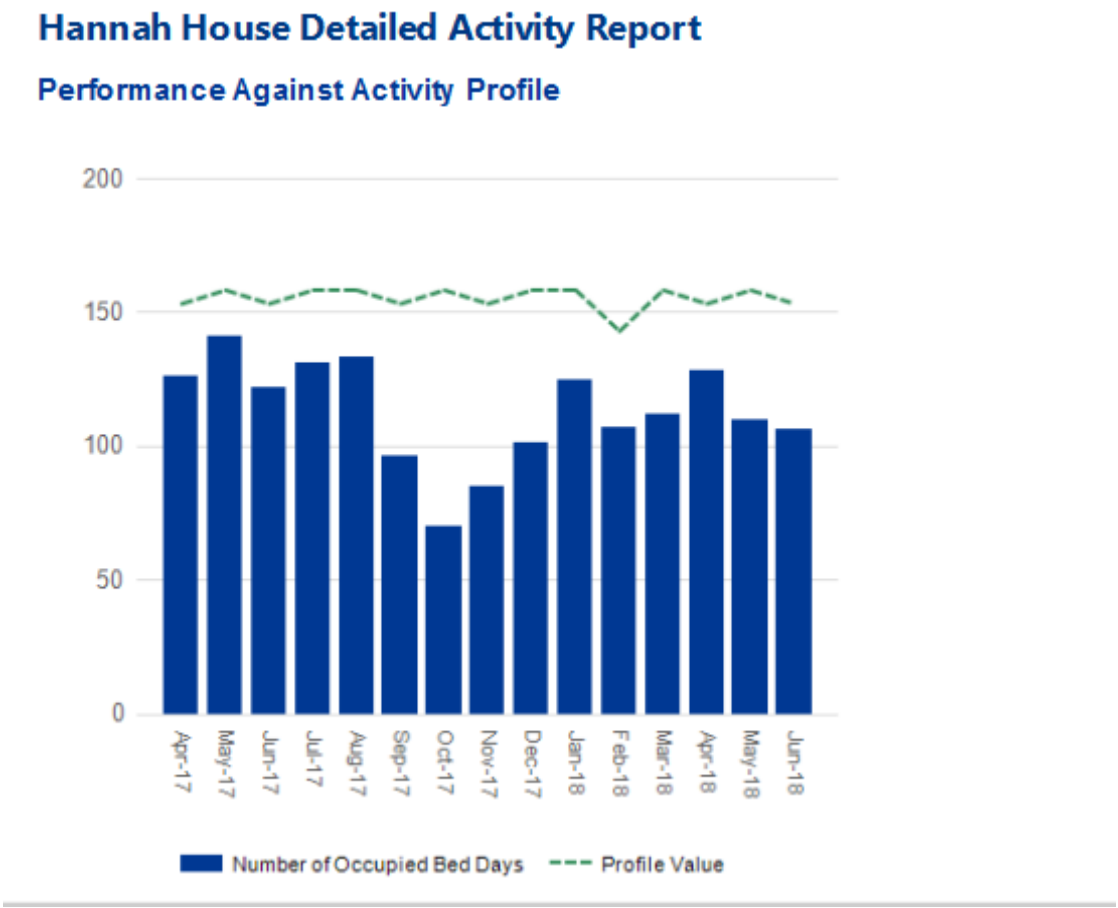
Community Neurology Inpatient (CRU)

Indicator	Jan	Feb	Mar	Apr	May	June
FFT	No Data	100%	100%	100%	100%	100%
Complaints Concerns PALS	1	0	1	0	1	0
Incidents	3	11	2	5	8	5
Serious Incidents	0	0	0	0	0	0

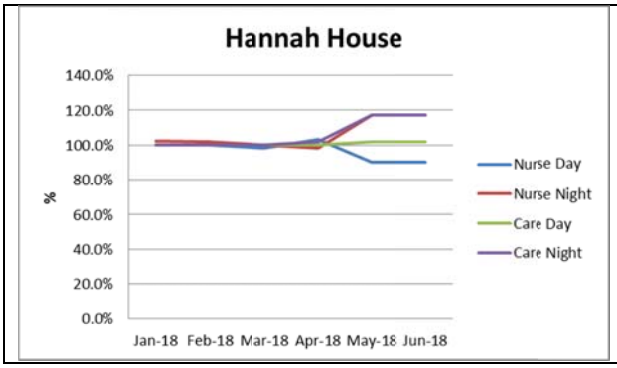
9.0 Hannah House

9.1 The specialist unit provides short breaks for children with complex disabilities and long term health needs. The unit remains an area of focus and enhanced support. The CQC report published in September 2017 assessed the unit as requiring improvement. Progress has been made in relation to the original QIP plan and a further detailed local action plan is in place. Regular updates have been provided to SMT, Board and Quality Committee. A further update was provided in June as part of the Quality Committee new focus meetings which started with the Children's Business Unit. A senior manager is based on the unit supporting the new manager and there is Director level oversight of the action plan and support to the unit on a weekly basis.

9.2 Recruitment has significantly improved for both registered and non-registered staff. Safe Staffing has been maintained on the unit. The quality board is updated each day and safety huddles are being implemented.



9.3 The unit has maintained safe staffing levels at this time. Clear processes are in place in relation to any stays that are cancelled due to any staffing issue.



Hannah House				
Date	Nurse Day	Nurse Night	Care Day	Care Night
Jan-18	100.0%	102.2%	100.0%	100.0%
Feb-18	100.0%	102.0%	100.0%	100.0%
Mar-18	98.4%	100.0%	100.0%	100.0%
Apr-18	103.4%	98.3%	100.0%	102.0%
May-18	90.4%	117.2%	102.1%	117.3%
Jun-18	90.4%	117.2%	102.1%	117.3%

9.4 Key Quality Indicators:
As previously described a new detailed action plan is in place and reported against to board and quality committee. Good progress has been delivered against the original quality improvement action plan.

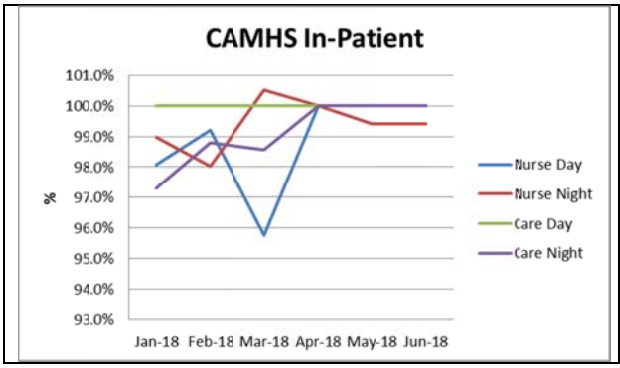
Hannah House

Indicator	Jan	Feb	Mar	Apr	May	June
FFT	No Data	No Data	No Data	100%	100%	No Data
Complaints Concerns PALS	1 (withdrawn by pt.)	0	0	0	0	0
Incidents	3	11	2	5	8	5
Serious Incidents	0	0	0	0	0	0

10.0 Little Woodhouse Hall

10.1 Little Woodhouse Hall provides the CAMHS inpatient service. The CQC report published in September 2017 assessed the unit as requires improvement. Progress has been made against the improvement plan and reported to Quality Committee and Board. Plans are continuing to progress the plans to build a new purpose built unit and delivery model. The unit recently had a CQC Mental Health Act Visit and an action plan had been submitted in response and reported to Quality Committee.

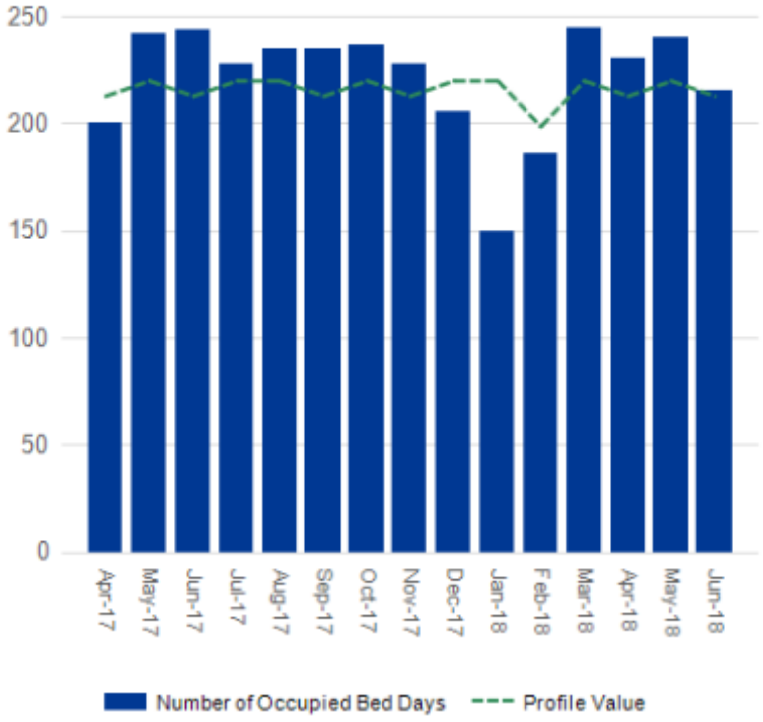
10.2 The unit has maintained safe staffing levels during this reporting period as set out in the table below:



CAMHS In-Patient				
Date	Nurse Day	Nurse Night	Care Day	Care Night
Jan-18	98.1%	99.0%	100.0%	97.3%
Feb-18	99.2%	98.0%	100.0%	98.8%
Mar-18	95.7%	100.5%	100.0%	98.6%
Apr-18	100.0%	100.0%	100.0%	100.0%
May-18	100.0%	99.4%	100.0%	100.0%
Jun-18	100.0%	99.4%	100.0%	100.0%

CAMHS Inpatient Unit Detailed Activity Report

Performance Against Activity Profile



10.3 Key Quality Indicators:
The unit has a quality board in place and no concerns have been escalated.

Little Woodhouse Hall

Indicator	Jan	Feb	Mar	Apr	May	June
FFT	No Data	100%	No Data	No Data	No Data	No Data
Complaints Concerns PALS	0	0	1	0	0	0
Incidents	12	11	15	7	5	2
Serious Incidents	0	0	0	0	0	0

11.0 Neighbourhood Teams

11.1 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 Director of Nursing has met with both local Universities re this work and to seek potential academic support for this work. Further response and update is awaited.

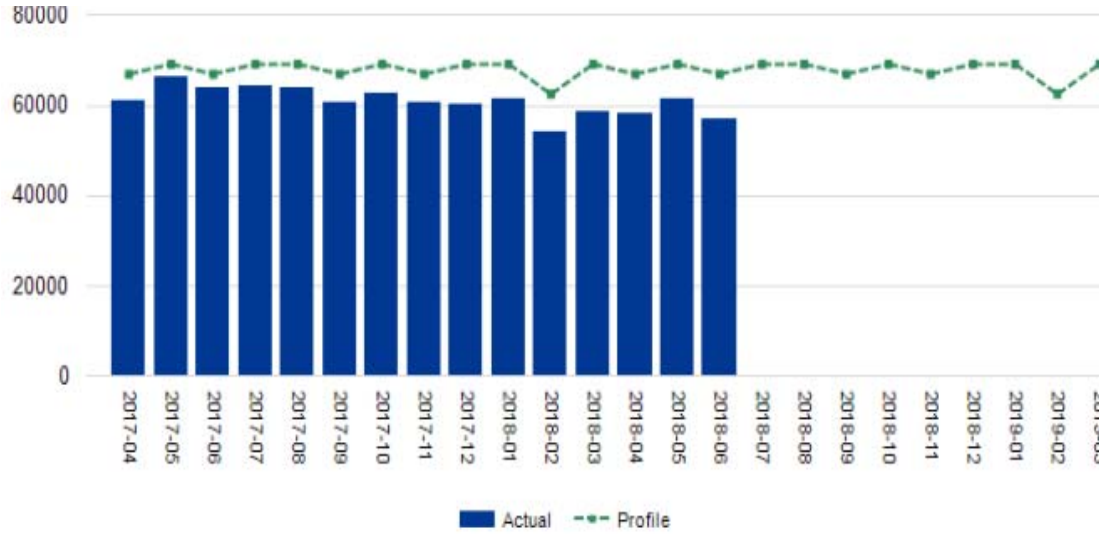
11.2 Staffing is monitored and manged on a daily basis through the Capacity and Demand reporting tool with senior clinical and operational oversight seven days a week. The work continues to be developed and refined. Teams continue to operate at the top of capacity on a daily basis with very limited call out capacity and work to support each other through moving staff. A small group is going to be convened to look at developing more training for teams in completing the tool and further refine this.

11.3 Staff experience remains variable and is influenced by a number of factors. . A number of teams currently have significant challenge with band 5 nurse vacancies. Bank and agency are used where available. A current piece of work is in progress with framework agencies with the aim of increasing support. In addition the contract continues with a local provider to support care home work in a number of teams.

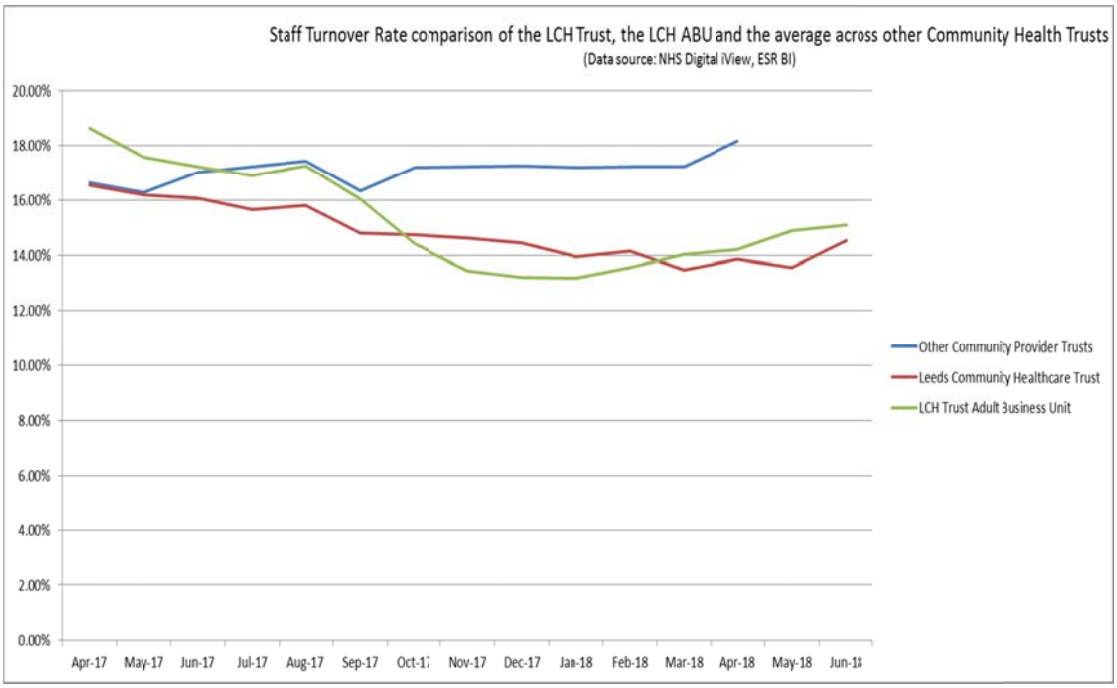
There are a number of ways in which regular conversations happen within the teams and this includes:

- Monthly team meetings
- Conversations with Director of Nursing and other Board member visits
- Regular time with ABU leadership team
- Monthly quality review meeting and performance panel
- Presentations at Quality Committee e.g. End of Life

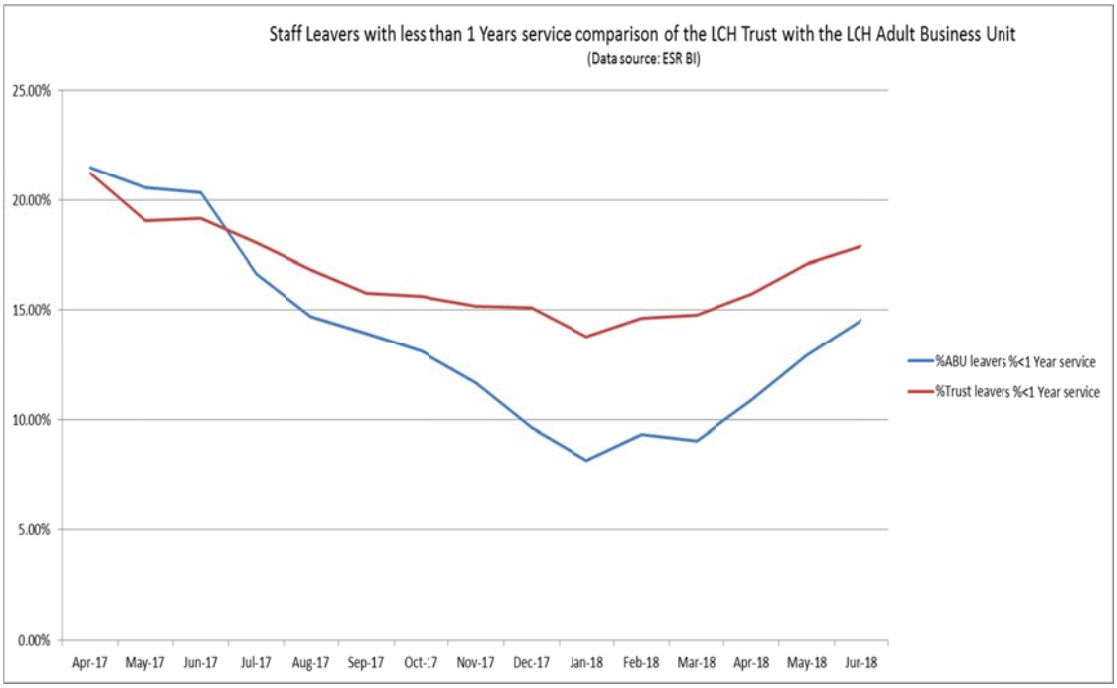
Neighborhood Team Activity by Month



11.4 Staff Retention:
Staff retention remains below 15% at this time and continues to compare positively to the community trust average.



11.5 Number of leavers in their first 12 months of employment for LCH has continued to fall to 13% at the end of quarter 2 compared to 24% at the end of 2016-17. This is being carefully monitored though as the curve has turned in Quarter 1. The area with the largest number of leavers in the first 12 months is in Corporate and operations where 17% of leavers, leave within the first 12 months of employment. The ABU has made positive progress in this area.



11.6 Current Staffing

The community staffing numbers for June are below. There are currently over 44 vacancies across the thirteen neighbourhood teams. The teams with the highest vacancy levels at this time are Armley, Middleton. Morley and Woodsley. Quality, safety and patient experience are monitored through:

- All essential work is completed on the day
- Daily handovers
- Safety huddles
- Quality board-incidents, complaints, patient FFT returns
- Caseload reviews (this remains an area where there is on-going work to embed)
- Clinical supervision and safeguarding supervision
- Review meetings post incidents.

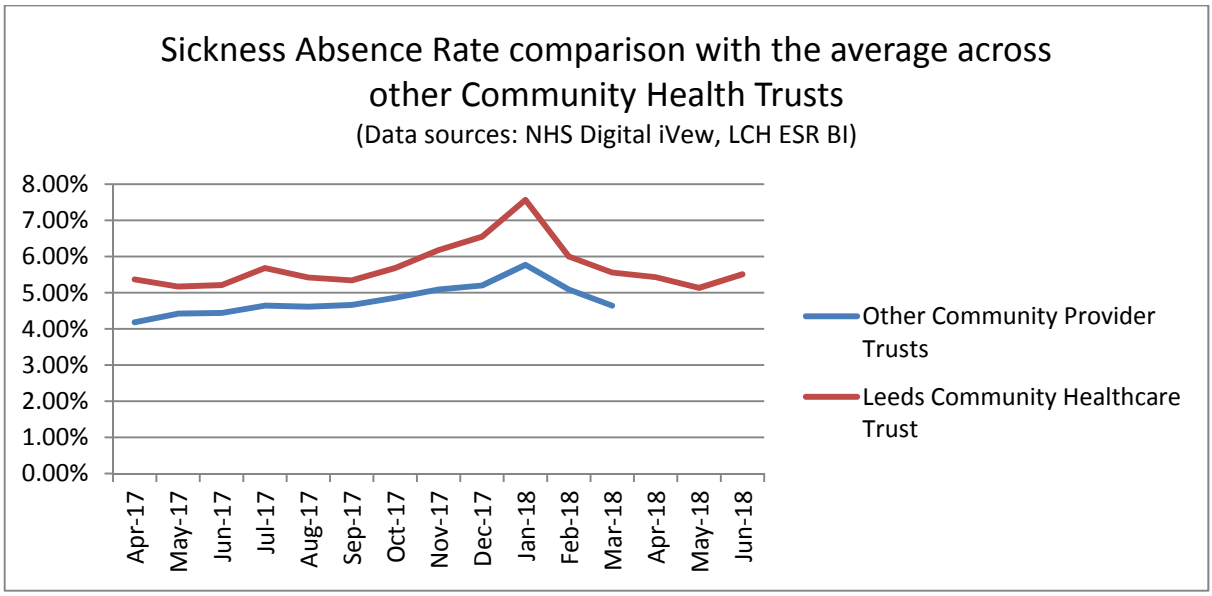
		Funded WTE	Contracted WTE	Variance WTE
Jun-18	Armley Neighbourhood Service	20.65	13.11	(7.54)
Jun-18	Pudsey Neighbourhood Services	15.82	15.93	0.11
Jun-18	Holt Park Neighbourhood Services	11.12	11.00	(0.12)
Jun-18	Woodsley Neighbourhood Services	18.56	13.45	(5.11)
Jun-18	Yeadon Neighbourhood Services	20.89	16.96	(3.93)
Jun-18	Chapletown Neighbourhood Services	21.50	18.56	(2.94)
Jun-18	Seacroft Neighbourhood Services	21.70	19.99	(1.71)
Jun-18	Wetherby Neighbourhood Services	11.60	12.51	0.91
Jun-18	Meanwood Neighbourhood Services	22.07	17.80	(4.27)
Jun-18	Beeston Neighbourhood Services	11.10	7.86	(3.24)
Jun-18	Middleton Neighbourhood Services	22.56	16.24	(6.32)
Jun-18	Morley Neighbourhood Services	15.84	8.11	(7.73)
Jun-18	Kippax Neighbourhood Services	16.26	13.49	(2.77)
		229.67	**185.01**	**(44.66)**

This position is offset through the judicious use of bank, agency, overtime and partnership working with a provider of registered staff to bolster capacity.

NT	Funded WTE	Contracted WTE	Variance WTE	Maternity Leave	Sickness WTE	Sickness YTD	Appraisal rate	6 Stat&Mand Compliance	4 Clinical Compliance	Agency Use WTE	Bank Use WTE	Overtime
Armley Neighbourhood Service	50.85	44.40	(6.45)	1.9	2.6	6.6%	94.12%	91.99%	64.55%	1.06	1.76	2,839
Pudsey Neighbourhood Services	42.15	43.78	1.63	0.5	2.9	5.7%	78.43%	87.18%	68.94%	3.97	1.91	2,377
Holt Park Neighbourhood Services	32.20	32.68	0.48	0.8	2.1	5.5%	89.19%	88.60%	84.24%	0	0.19	52
Woodsley Neighbourhood Services	50.09	43.61	(6.48)	-	2.6	5.2%	85.42%	87.50%	82.92%	0.9	1.47	2,429
Yeadon Neighbourhood Services	51.22	46.65	(4.57)	-	2.8	0.0%	96.15%	90.38%	85.65%	1.85	2.82	79
Chapletown Neighbourhood Services	54.17	55.31	1.14	1.0	1.6	9.2%	83.33%	92.86%	91.74%	0	0.88	0
Seacroft Neighbourhood Services	53.79	49.74	(4.05)	-	5.5	7.8%	87.10%	86.83%	74.29%	3.03	1.19	1,653
Wetherby Neighbourhood Services	32.48	30.37	(2.11)	-	2.0	5.8%	77.78%	83.80%	61.33%	3.04	2.56	313
Meanwood Neighbourhood Services	58.28	54.12	(4.16)	0.4	4.6	9.0%	89.09%	88.10%	67.69%	0.34	1.52	58
Beeston Neighbourhood Services	30.14	26.79	(3.35)	1.5	1.7	6.2%	68.75%	89.06%	68.70%	0	0.31	585
Middleton Neighbourhood Services	56.31	51.08	(5.23)	1.9	2.0	4.0%	64.29%	87.80%	68.46%	0	1.04	3,659
Morley Neighbourhood Services	47.75	36.72	(11.03)	4.3	1.3	8.0%	86.11%	86.57%	67.27%	2.5	2.76	1,015
Kippax Neighbourhood Services	42.97	42.37	(0.60)	3.7	3.5	8.8%	89.36%	89.01%	66.83%	0.28	0.88	1,984
	602.40	**557.62**	**(44.78)**	16.1	35.1	82.0%	1089.12%	1149.67%	952.61%	16.97	19.29	17,041

11.7 Sickness levels

There is an ongoing focus on staff health and wellbeing and staff sickness



11.8 Recruiting and supporting Newly Qualified Nurses:

26 newly qualified community staff nurses are due to start in the autumn (Sept – 8, Oct – 13, Nov. – 3, Dec – 2). In addition rolling recruitment for community staff nurses is ongoing with 4 new starters with experience recruited in most recent round (start dates tbc autumn 2018). The support and training systems to support newly qualified nurses continue to be refined and further developed.

11.9 Other action to support NT capacity
The following approaches to maintaining capacity are in train:

- Risk is managed on a daily basis via review of the NT capacity and demand tool. This supports prioritisation of work and redeployment of capacity to ensure on the day essential work is covered. The risk is also managed via the Trust's Risk Register process to ensure that actions to improve capacity and manage demand are maintained/progressed.
- Maintain focus on staff wellbeing and retention through work on staff engagement.
- Maintain focus on ongoing recruitment to NTs, in partnership with recruitment team. To include advertising posts for specific NTs, support for newly registered staff, rolling recruitment for B5 and B6 roles.
- Maintain partnership with CLASS for short term capacity gaps to be covered by existing CLASS and agency staff paid at framework rates.
- Consider 'head hunting' in partnership with Healthier Recruitment.
- Maintain partnership to secure guaranteed level of cover. This would initially be to end October 2018 with option to review. We have maintained a partnership over the period with a private provider to deliver capacity specifically to support patients in care home settings.

12.0 Health Visiting

12.1 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.

12.2 The table below is used to look at the staff figures and weighting the HV resource across the city. The measurement for the calculation is the IDM the teams with the highest IDM (the more need the smaller the caseloads). There have been changes in teams. Teams have been merged where there have been challenges in relation to sickness or maternity leave.

12.3 Safe staffing Health Visiting

Team	No's of under 5's	Staff in post June 2018	% achieved	Caseload size per WTE	Tool to adjust caseload	vacancy
Parkside	5740	13.60	86	324.66	15.79	2.19
Bramley	5431	10.40	83	387.93	12.50	2.10
East Leeds	5112	16.50	103	286.23	15.95	-0.55
Kirkstall	3398	9.20	101	332.16	9.13	-0.07
Seacroft	7298	14.60	94	369.53	15.58	0.98
Reginald Centre	8774	19.00	94	386.35	20.28	1.28
Middleton	6089	14.90	101	368.81	14.74	-0.16
Thornton	3032	9.71	113	314.52	8.61	-1.1
Yeadon	5869	8.49	81	491.28	10.43	1.94
Total	**50743**	**116.40**	95	**368.34**	**123.00**	**6.61**

12.3.1 The staffing as of the end of June 18 in Health Visiting was 116.40 WTE with a vacancy factor of 6.61. Vacancy factor and capacity within teams is a standard agenda item at the leadership management team meeting.
Recently recruitment includes 4 new health visitors into post and a further 5 newly qualified health visitors will be starting in post in September 18. The service is currently managing safe staffing levels by using health visitors registered with Class and also with existing staff in post working additional hours. Mobilising staff around the city to support service delivery in areas where there is current vacancies is also another way that the service ensures safe staffing levels in all teams.

12.4 Health Visiting The service continues to provide safe care and uses tools such as a quality board and completion of Quality Challenge+

Indicator	Jan	Feb	Mar	Apr	May	June
FFT	99.60 %	99.45 %	100.00 %	98.35%	97.65%	97.76%
Complaints Concerns PALS	3	0	1	1	3	2
Incidents	15	10	19	20	9	12
Serious Incidents	0	0	0	0	0	0

12.5 School Nursing The school nursing service continues to meet key safety indicators and key performance indicators such as 100% attendance at initial care conference.

Indicator	Jan	Feb	Mar	Apr	May	June
FFT	77.78 %	100%	50.00%	100.00 %	100.00 %	100.00 %
Complaints Concerns PALS	1	0	2	0	0	1
Incidents	2	0	5	0	3	3
Serious Incidents	0	0	0	0	0	0

13.0 Conclusion

13.1 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.

14.0 Recommendations

14.1 The Board is asked to support to:

- 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 work streams underway in neighbourhood teams
- Note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting

Appendix 1

- Patients can be treated with care and compassion.
- 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. 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

Appendix 2

National Guidance

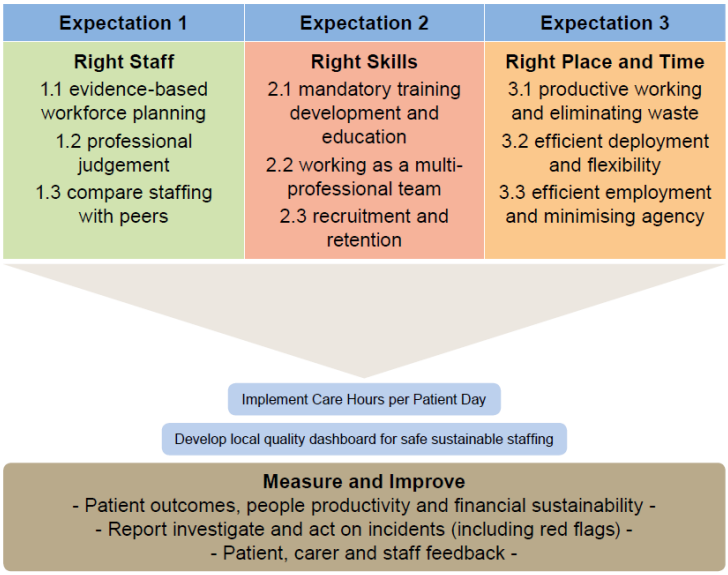
In line with the NHS England requirements and the NQB recommendations, this paper presents the six monthly nursing establishment's workforce review. The focus remains on The National Quality Board framework of 9 characteristics of good quality care in District Nursing. This builds on the three expectations which were published in 2016 (Right Staff, Right Skills, Right Place and Time)

Appendix 3

Board responsibilities

It is helpful to reiterate for the board the responsibilities as set out in the 2016 guidance.

Triangulated approach to staffing decisions



Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (30)

Meeting: Trust Board 3 August 2018	**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 Freedom To Speak Up Guardian work, basic activity data and the future direction on this stream of work. The report covers the period from 1 April 2017 to 31 March 2018.

Main issues for consideration

This report addresses matters relating to working in the Freedom to Speak Up role: the work, its spread and its links to other areas 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 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 role is working well in the Trust and receives strong support from the chief executive, directors and the wider organisation. A clear form of work has been established which aligns with the CQC well-led domain's aspect of LCH's work.

3.2 Communication of the role across the Trust and a positive relationship with Staffside has been accomplished. Regular meetings of co-support and co-learning with the Freedom Guardians from LTHT and Locala are occurring. The Freedom to Speak Up Guardian has attended the national conference organised by the Freedom to Speak Up Guardians National Office. The Trust received an award at the conference for its work on Freedom Guardian work. The Guardian has also attended the national training for Freedom Guardians

3.3 The policy on Speaking Up / Whistleblowing has been approved. There is now a national requirement to develop a Speaking Up Strategy as well as a policy. Work on this is ongoing. There is a need for assurance around the Freedom Guardian role. As first tentative steps towards this, we have been working on three basic measures (sharing nationally, organisation spread and staff numbers). These measures are (1) Are we reporting nationally on a quarterly basis? (2) Is the Freedom Guardian seeing staff from all four business units of the Trust and all positions / occupations? (3) Are we, in comparison to neighbouring trusts, seeing a significant number of our staff? On all three we are performing well at this present time.

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 April 2017 and 31 March 2018. The table also indicates the nature of the issues raised with the Freedom To Speak Up Guardian.

Business Unit	Method of contact	Numbers of staff	Issue
Adults	Phone, emails, texts and personal approach and recommendations from other staff	18	Culture, leadership, morale and been listened to
Children's	Emails and face to face	10	De-commissioning decision, culture and leadership approaches
Corporate	Face to face and email	9	Culture, leadership and behaviours
Specialist	Emails	5	Commissioning decision, culture, and behaviours.

4.2 42 staff members have met directly and worked with the Freedom to Speak Up Guardian. This doesn't include work with whole teams. This whole team work has been with two teams in the Trust. One was with a Children's Business Unit service where weekly visits took place from July 2017 to February 2018. The other is a Specialist Business Unit service starting in February 2018 and presently ongoing. This work is to meet and listen to staff and reflect into the wider organisation their concerns and ideas. Both team pieces of work have been at the invitation of managers.

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 recurrent back story around staffing and demand. There is also an understanding that this is a widespread NHS issue and challenge.
- ***Commissioning decisions.*** Staff raised concerns last year over three LCH services which were either de-commissioned or LCH didn't win the tender. They were concerned about the commissioning decisions and the impact on patients and staff.
- ***Leadership and culture in teams and services.*** This is the key issue coming through the Freedom Guardian work. Staff report not been included and listened to. Staff describing certain management approaches that are not person-centred and supportive. This narrative is usually connected to comments about staff leaving or planning to leave.

- ***Actions.*** The process we have established works well - from Freedom Guardian to Chief Executive to senior managers. The most difficult part is the next section about seeing what is happening on the ground and what actions are needed to seek positive change.

6.0 Conclusions

6.1 The Freedom to Speak Up Guardian role has been welcomed and well-received within the Trust. This is a sign of the commitment of the organisation to its patients, staff and values. Conclusions from the work would be the following:

- The Freedom to Speak Up Guardian role has had a positive impact with strong support from 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 although nearly all had spoken to their manager about the issue before speaking to the Freedom Guardian.
- The role illustrates the centrality of workplace culture. It validates the Trust's commitment to a workforce 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 its staff and services.
- This is work we develop as we proceed to work with the National Office, and local Freedom to Speak Up Guardians is key.
- There is the question of how to balance the role with national and regional meetings. There is a need to keep connected to national work but focus energy and work primarily on our staff and their voice.
- There seems a correlation between morale, sickness, staff wellbeing and the work of the Freedom to Speak Up Guardian. A significant number of staff have expressed their strong thanks for someone to listen to their concerns, support them and feedback to the organisation their voice.
- The feedback to and work with managers has been a constructive experience and the concerns have been shared via managers into the services.
- The role links well with the other mechanisms we have for staff to share concerns. As a Trust we have a rich variety of options for our staff to share concerns and ideas.

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 2018-19 (31)

Meeting Trust Board 3 August 2018	**Category of paper** *(please tick)*	
Report title Quarterly Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director Executive Medical Director **Report author** Guardian of Safe Working Hours	**For assurance**	x
Previously considered by Quality Committee 23 July 2018	**For information**	

Purpose of the report

To report on issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including morale, training and working hours.

Main issues for consideration

- Understand the role of the guardian of safe working hours (GSWH) to highlight issues affecting the training and working lives of trainees

Recommendations

- Continue to promote interface between GSWH and trainees
- Keep administrative support for GSWH under review
- Develop database for trainees
- Install exception reporting software

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

1.1 To report on issues affecting trainee doctors and dentists such as working hours, quality of training and morale.

2.0 Background

2.1 The role of guardian of safe working has been introduced as part of the 2016 junior doctor's contract. The guardian role was created through negotiation between the BMA and NHS employers as an assurance that the protections included 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.

3.0 Quarterly Report of Guardian of Safe Working Hours

3.1 There are 21 Junior Doctors employed in the Trust as detailed in the table below.

Department	No.	Grade	Status
Geriatrics	2	ST	Employed
CAMHS	3	STs	Employed (fulltime)
	3	CTs	Honorary
GP	3	GP trainee	
Community Paediatrics	1	STs	Employed
	6	STs	Honorary
Sexual Health	1	ST	Honorary
Dental	2		Honorary

QUARTERLY OVERVIEW

Vacancies		There is 1 vacancy in the CAMHS Core trainee establishment. There are 2 vacancies in the CAMHS Specialty Trainee (ST) establishment. LCH produce and populate an St 2nd on call rota in CAMHS					
Rota Gaps (number of nights uncovered)		May		June		July	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	19	n/a	21	n/a	19
	Internal Cover	n/a	0	n/a		n/a	0
	External cover	n/a	19	n/a	21	n/a	19
	Unfilled	n/a	0	n/a	0	n/a	0
Exception reports (ER)		0	0	0	0	0	0
		No exception reports for this quarter					
Fines		None.					
Patient Safety Issues		None					
Junior Doctor Forum		August 2018 date TBC					

4.0 Rota gaps

4.1 The CAMHS ST rota is not fully recruited to. There are 2 FTE posts unfilled. There was a further gap on the rota due to sickness in May and June 2018.

4.2 External locums have been sourced directly by the Trust to populate the CAMHS 2nd on call rota.

5.0 Implementing the role of GSWH

5.1 Feedback from trainees

The GMC National training survey released its results this week (9th July 2018). Findings included high levels of reported work-related burnout in trainee doctors and reports of missed training opportunities due to the demands of service provision, especially on-call rotas.

This Guardian has previously reported that paediatric trainees have reported that their community training can be adversely affected by their on-call commitments at LTHT. In response, proposals to change delivery of training are being considered. This requires ongoing negotiation with LTHT.

One CAMHS trainee indicated that their training was affected by very high levels of demand in relation to following up deliberate self-harm presentations. Negotiations are currently taking place within CAMHS, as part of New Care Models (NCM) to develop more effective response to crisis presentation (including deliberate self-harm). This will considerably free up time for future trainees.

5.2 Challenges

Engagement

Engagement continues to pose a challenge. As previously reported, low levels of exception reporting are more likely to indicate a lack pf engagement with the process, rather than an absence of concern.

There are also challenges in recruiting to the Local Negotiating Committee (LNC). Two LNC meetings have been cancelled this year.

Administrative support

Following the retirement of the previous medical HR adviser, no single person has been identified to take on that role. Elements of the role have been dispersed across HR. This presents challenges with obtaining accurate workforce information. Update from regional GoSWH meeting indicates that LCH should implement exception reporting software.

6.0 Impact

6.1 Quality

This report has been informed by discussions with trainees and supervisors in Leeds Community Trust along with meetings with guardians of safe working hours from other trusts, human resources and guidance received from NHS employers and Health Education England.

7.0 Recommendations

7.1 Leeds Community Trust is recommended to:

- Continue to support GSWH to effectively interface with trainees Ensure adequate support for supervisors in preparation of generic work schedules
- Develop database of Junior Doctors trainees
- Install exception report monitoring system

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (32)

Meeting: Trust Board – 3 August 2018	**Category of paper** *(please tick)*	
Report title: LIFT Under Lease Plus Agreements (ULPAs) from Community Health Partnerships (CHP)	**For approval**	√
Responsible Director: Executive Director of Finance and Resources **Report author:** Property Advisor	**For assurance**	
Previously considered by – Business Committee, 27 June 2018	**For information**	

Purpose of the report

LCH are required to regularise their existing occupation of the LIFT properties. Initially, the Under Lease Plus Agreements (ULPAs), based on agreed Heads of Terms, for the first 5 properties will be presented by Community Health Partnerships (CHP) for signature and therefore this report sets out the costs involved and any issues to be considered following the detailed legal review. The 5 properties are characterised by not including dental services as they are subject to further complications associated with the on/off NHS England community dental service tender.

The Business Committee considered an extended version of this report at its meeting on 27 June 2018 and recommended that he Board approve the signing of the leases. Due to the need to progress this issue in advance of this Board meeting, the Chair and Chief Executive exercised the approval as an urgent decision. Ratification is sought from the Board.

Main issues for consideration

By approving the ULPAs for the 5 sites identified, LCH will be committed to a minimum of 3 years charges before which a break in the agreement could be enacted. The gross cost for the 5 sites for a 3 year period will be a total of £9,668,972.

The terms of the ULPA allows LCH to occupy the building until the end of the head lease unless a Break is agreed; a Break in the ULPA is possible on each 3rd anniversary of the date signed. The overall cost of all 5 buildings until the end of each Head Lease is £44,390,447 (based on 2018/19 costs).

Recommendations

The Board is asked to ratify the urgent decision that the ULPAs for the 5 properties specified in this report should be signed with a probable minimum cost commitment over three years of £9.7m and, if no changes are made to LCH's occupation, a total financial commitment to the end of the lease of £44.4m.

LIFT Under Lease Plus Agreements from Community Health Partnerships

1. Purpose of this report

1.1. LCH are required to regularise their existing occupation of the LIFT properties. Initially, the Under Lease Plus Agreements (ULPAs), based on agreed Heads of Terms, for the first 5 properties will be presented by Community Health Partnerships (CHP) for signature and therefore this report sets out the costs involved and any issues to be considered following the detailed legal review. The 5 properties are characterised by not including dental services as they are subject to further complications associated with the on/off NHS England community dental service tender.

1.2. Importantly, by agreeing the terms of the ULPAs, LCH will be able to terminate their occupancy with "break rights" every 3 years or hand back specific areas when service contracts change. This will enable the flexible use of the estate and assist in the future management of these buildings.

1.3. Over time, the Trust will ensure that it only owns or leases estate that it needs for the efficient delivery of high quality, accessible healthcare. As of today, there is no scope to reduce further the space leased in these 5 LIFT buildings.

1.4. The Business Committee considered an extended version of this report at its meeting on 27 June 2018 and recommended that he Board approve the signing of the leases. Due to the need to progress this issue in advance of this Board meeting, the Chair and Chief Executive exercised the approval as an urgent decision. Ratification is sought from the Board.

2. Background

2.1. The 5 facilities provide high quality, fit for purpose buildings which have been specifically designed for clinical services. They are maintained to a high standard and enable the accommodation to be utilised in a flexible manner with the ability to support a wide range of services as well as the office hub and spoke model in the future. The following table will be referred to at points in this report.

2.2. The occupation of the LIFT buildings was transferred to LCHT under a Transfer Order in 2013 and, following a lengthy negotiation with CHP, the first 5 of 10 ULPA documents will be completed and require signing by LCH. This table shows the current occupancy by LCH and the expiry dates for each head lease.

Table 1

Site	LCH Occupancy	Head lease expiry date	Service Context
East Leeds	30.56%	01/06/2033	A key site for the locality and offers a strategic location for the delivery of a wide range of services.
Parkside	67.62%	01/01/2031	Primarily a clinical hub and a main base for the CAMHS specialist service.
Wetherby	72.18%	01/05/2033	A strategic location for outlying services.
Woodhouse	47.59%	01/12/2030	A good location and currently providing a number of offices and a range of services.
Wortley Beck	37.75%	01/06/2033	A key site for children's services.

3. Agreements reached on ULPAs

3.1. Following long negotiations with CHP, the ULPA terms have now been finalised with the key issues as follows:

3.1.1. Ability to Break the ULPA after 3 years from the agreed date and each subsequent 3 years.

3.1.2. "Lettable Units" can be handed back to CHP without CCG approval if the accommodation is no longer required.

3.1.3. CHP will be responsible for booking space that becomes vacant. This will enable LCH to book and pay for exactly the number of sessions required to deliver clinical services.

3.1.4. Any Variations that have been approved via the agreed process will not have to be reinstated at the end of the term. Any future Variations will be signed off by LCH prior to any expenditure.

3.1.5. The % occupancy upon which the costs are based have been agreed and finalised as of now, reflecting any changes since the original 2013 Transfer Order

3.1.6. If service contracts are terminated and the related accommodation is no longer required by LCH, it can be handed back to CHP. Similarly, if the utilisation is under 50%, CHP can request the return of that space to provide accommodation that can be booked on a sessional basis as necessary.

4. Costs

4.1. Appendix 1 provides a breakdown of the Lease Plus Payment for each site showing an annual charge based on 2018/19 costs with an estimated commencement date of October 2018. The costs will increase annually in line with RPI.

4.2. By approving the ULPAs for the 5 sites identified, LCH will be committed to a minimum of 3 years charges before which a break in the agreement could be enacted. The gross cost for the 5 sites for a 3 year period will be a total of £9,668,972.

4.3. Table 1 included the Head Lease expiry date for each building. The terms of the ULPA allows LCH to occupy the building until this date unless a Break is agreed; a Break in the ULPA is possible on each 3rd anniversary of the date signed. The overall cost of all 5 buildings until the end of each Head Lease is £44,390,447 (based on 2018/19 costs).

4.4. Although there has been no formal lease in place the Trust has been paying for its occupation of the LIFT properties since the 2013 Transfer Order and this has been affordable with the Trust's total budget.

4.5. As described in 3.1.2 it is possible for LCH to hand back groups of rooms (Lettable Units) which will reduce the payments accordingly.

5. Next steps

5.1. Further work is required before the ULPAs for the remaining 5 sites (Armley Moor, Beeston Hill, Middleton, Reginald Centre and Yeadon) are completed and ready for

approval. It is planned to split the accommodation so that separate ULPAs are created for the Community Dental Service and other LCH services.

6. Recommendations

6.1. The Board is asked to ratify the urgent decision that the ULPAs for the 5 properties specified in this report should be signed with a probable minimum cost commitment over three years of £9.7m and, if no changes are made to LCH's occupation, a total financial commitment to the end of the lease of £44.4m.

Appendix 1: site ULPA costs

Site	East Leeds	Parkside	Wetherby	Woodhouse	Wortley Beck	TOTAL
% occupancy	30.56%	67.62%	72.18%	47.59%	37.75%	
Annual cost of occupancy (2018-19)(NET)	438,391	705,446	825,103	279,776	437,109	2,685,826
VAT	87,678	141,089	165,021	55,955	87,422	537,165
Annual cost of occupancy (2018-19)(GROSS)	526,069	846,536	990,124	335,731	524,531	**3,222,991**
Lease start date (assumed)	01/10/2018	01/10/2018	01/10/2018	01/10/2018	01/10/2018	
Lease end date	01/06/2033	01/01/2031	01/05/2033	01/12/2030	01/06/2033	
Gross Cost for 3 years to 30/9/21 - first break point	1,578,207	2,539,607	2,970,372	1,007,194	1,573,592	**9,668,972**
Cost to end of lease	7,759,518	10,370,062	14,439,308	4,084,730	7,736,828	**44,390,447**

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (33)

Meeting: Trust Board 3 August 2018	**Category of paper**	
Report title: Organisational development refresh update	**For approval**	
Responsible director: Director of Workforce **Report author:** Director of Workforce	**For assurance**	
Previously considered by N/A	**For information**	✓

Purpose of the report

To provide the Board with an overview of development of a successor strategy to the existing LCH Organisational Development Strategy (2017-19).

Recommendation

The Board is invited to note and comment upon the content of this paper

Organisational Development Refresh Update

1. Background

1.1 The current Organisational Development Strategy (OD Strategy) for LCH is to be reviewed and refreshed, in light of:

1.1.1 Current strategic objectives

1.1.2 Integrated working opportunities across primary care and citywide partners

1.1.3 Lifespan of the existing OD Strategy (2017-19) drawing to a close

1.1.4 Changes of leadership within the Workforce Directorate

1.2 This short paper sets out broad details of the review and refresh; and invites Board members' contributions to it.

1.3 A framework for the refreshed strategy is due to be considered by the Board in October 2018.

2 Remit and content

2.1 The strategy will be led by the Director of Workforce, and developed with engagement from a broad range of stakeholders. It will be rooted in "Our Eleven": the vision, values and behaviours at the core of LCH.

2.2 The strategy will closely align its priorities with both the strategic objectives of the organisation and the increasingly integrated context of our health and care landscape. It will incorporate a full range of workforce subject matter, including Organisational Development.

2.3 The impact of work carried out under the existing OD Strategy will be recognised, with initiatives sustained or revitalised where appropriate.

2.4 Expected outcomes and outputs will be specified, with an associated delivery plan detailing key performance indicators (KPIs) and milestones. Where appropriate, KPIs will be benchmarked against comparator organisations.

2.5 The strategy's content, which is subject to ongoing stakeholder engagement, is expected to include, but is not limited to, the items on the following page:

2.5.1 **Single Resourcing plan** to address systemic and periodic recruitment and retention challenges, talent management and succession planning

2.5.2 **Increased shared and integrated working practices** with partners in primary care, across Leeds and within the ICS

2.5.3 **Flagship Health and Wellbeing project**, underpinned by Quality Improvement methodology, recognising that employee attendance can be affected by a broad range of factors

2.5.4 **Leadership development,** to equip our current and aspiring leaders and managers with core skills and behaviours to operate effectively in tomorrow's health and care system

2.5.5 **Relentless focus on employee engagement** as a predictor of improved performance across factors including retention, motivation, performance and attendance

2.5.6 **Stronger Workforce Systems & Intelligence function**, to drive analysis-based decision making and targeted interventions

2.5.7 **Development of the Workforce Directorate's service offer**, to more closely align with strategic objectives and business needs and prepare for increased system-wide working.

3 Next Steps

3.1 Internal and stakeholder conversations will continue over the summer, to inform production of a framework document.

3.2 The framework document will be brought for Board consideration in October 2018.

4 Recommendation

4.1 The Board is invited to note and comment upon this update.

Laura Smith and Jenny Allen
Director of Workforce
25 July 2018

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (34)

Meeting: Trust Board 3 August 2018	**Category of paper**	
Report title: Research and Development Strategy Implementation	**For approval**	
Responsible director: Interim Medical Director, Dr Ruth Burnett **Report author:** Head of Research & Development, Dr Liz Allen	**For assurance**	√
	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 undertaking work that addressed the aims of the research and development strategy.

Main issues for consideration:

- The Trust was successful in exceeding its target accrual number of 720 for 2017/18 by recruiting 750 to portfolio studies. This success was achieved despite the reduction in our two main research funding allocations.
- The Trust's accrual target for 2018/19 remains at 720, however overall, the external funding allocations from the NIHR CRN and DH (which support the corporate research team) have fallen for 2018/19
- The Corporate research team was supported by SMT in a restructure. This provides more stability and greater generic capacity to deliver studies across all parts of the Trust.
- Over the past year progress has continued in most areas however specific aspects of the strategy have proved difficult to deliver.
- Plans are ongoing to address the specifically challenging aspects of the existing strategy and develop a new Trust research strategy for 2019- 2022.

Recommendations:

The Board is requested to:

- Receive reasonable assurance on progress of research delivery within the Trust
- Accept the strategy implementation report Aug 2017 to July 2018

Research and Development Strategy Implementation

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 August 2017 to July 2018

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

2.2 The strategy was ratified by the Trust board on 3 July 2015. An initial year of significant change both locally and nationally, led to a slow start. Progress gathered momentum during 2016-17 with accruals significantly over target reported in the last report. Accrual targets were raised to reflect delivery capabilities.

3.0 CURRENT POSITION

Progress against the specific strategic aims is as follows:

3.1 <u>Embed research and development into the culture of the organisation</u>

The research team contributed to the Innovation and Research council, which in its earlier days proved a valuable forum for engaging frontline staff with ideas, making links and facilitating work with quality improvement colleagues, library staff, innovation champions, Medipex, and academics in local Higher Education. Recent attendance at the council has however been poor. The development of “innovation huddles” and other approaches for staff and external stakeholder engagement are being developed. At the last (July) meeting of the council it was agreed that the council format be changed to a community of practice format in order to facilitate and promote more active engagement in quality improvement, innovation and research activities. It was felt that a community of practice could be a helpful way to develop engagement with practitioners and frontline clinical staff. The July CEG workshop also explored these issues.

Recruiting to the Yorkshire Health Study (YHS) has continued throughout the Trust, this time with a focus on patients in clinic settings. Recruitment

has been led by one of our generic research nurses. This has provided an opportunity to raise the profile of research activity and discuss the subject of participation in research in general with both patients and staff working in those areas. Whilst it is a low complexity study, YHS recruitment provides a relatively consistent/stable level of study accrual and over recent months has averaged 80 per month recently.

3.2 Excellence in the delivery of research

The Trust's challenging study recruitment (accruals) target of 720 in portfolio studies for 2017/18 was successfully exceeded, with the Trust achieving total accruals of 750.

Our target for 2018/19 remains at 720, however within this we have been asked to improve the complexity ratio of studies that we host. i.e. host more complex studies (e.g. randomised controlled trials)

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

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

The Trust's small corporate research team received support for a restructure from the Senior Management Team (SMT) during December. Funding for the team had been wholly dependent upon annual funding allocations from NIHR Clinical Research Network (CRN) and small amounts of commercial and other external income. This meant that research staff had been employed on a series of short fixed term contracts. This caused uncertainty and instability amongst staff members. It was also apparent that research nurses with specialist research delivery expertise within the Trust worked in the specific fields of wound care and also palliative care. In order to deliver studies across the Trust we require a more flexible generic workforce. In restructuring research delivery staff were awarded substantive posts with job descriptions that enables flexibility in their fields of practice. SMT agreed to underwrite the costs of the team to enable the establishment of substantive research positions.

Recently long term sickness affecting two staff members of the corporate research team has affected the team's capacity to respond to and deliver support for research set up and study development. Both members of staff are now undertaking a phased return to work and it is anticipated the team will be back to full strength over the summer.

Flexibility around creating capacity within different services is key to successfully responding to calls from HEIs and the CRN for involvement in

NIHR funded studies. The Trust was delighted to have successfully participated in "OTIS" a trial of an OT delivered a falls prevention assessment tool using a different approach to research delivery. Within the Trust the service was unable to free up capacity to deliver the trial. Two OTs working part time in other parts of the Trust were recruited to deliver OTIS as a specific CLASS assignment during their usual days off. This has provided both OTs with excellent experience of research involvement and trial delivery, as well as links with the corporate team. We anticipate exploring further options for delivering research using CLASS employed staff for future studies.

Trust employed Physiotherapist (Dr Christine Comer) was successful in her application for an NIHR Clinical Lectureship award which she started in April. This is a huge achievement. It represents the Trusts only externally held NIHR grant award at present. Christine's study will help to improve the care of people with Spinal Stenosis.

Support continues for Trust staff making NIHR applications. Trust R&D Development Manager Karen Lamb has been seconded to the University of Leeds for a day a week to develop an NIHR PhD application about recruitment to research in community settings. One of our podiatry staff made an unsuccessful application for an NIHR clinical lectureship but will be redeveloping the application with the input of her academic mentors for a resubmission next year

The Trust's YOI care team is named as participant in a recently awarded NIHR RfPB application about effective ADHD diagnosis in collaboration with staff from the Pennine NHS Trust.

3.4 <u>Increase the amount of funding into the organisation to enable investment and grow additional return</u>

As previously reported, our research related income last year (2017/18) primarily comprised the annual core CRN allocation (£182K) and the NIHR Research Capability Funding (RCF).(£31K). This year the core allocation increased modestly to £187K but the RCF has decreased £20K.

As reported last year, CRN allocations to partner organisations (Trusts) appear relatively unaffected by increases in accrual activity and more likely linked to the levels of previous allocations. Funding for the expansion and development of research activity related to CRN support is required via the submission of contingency bids. In view of the structural developments of the CAMHS service and potential to develop activity there, a contingency bid has been made to the CRN for funds to support development of embedded research activity in CAMHS via a band 5 Clinical Support Officer post.

Our RCF funding of £20K for 2018-19 was awarded based upon our Trust achieving levels of study accrual totalling over 500 during the period from Oct 2016-Sept 2017. In previous years our RCF allocations have taken account of our previous participation in and grant holder status of Prison studies which we are no longer able to undertake due to the departure of

that service from the Trust in 2016. In order to increase RCF funding in the future, our Trust needs to be an active participant/fund holder in future NIHR research. Due to Dr Comer's clinical lectureship success, this should support an increased RCF in future years, assuming RCF funding continues in its current form. (A review of this funding stream is currently underway)

Medipex have continued to support the Trust in the assessment and exploitation of Intellectual Property issues.

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 Head of Research and R&D development managers have attended external meetings which have fostered collaborative relationships with neighbouring Trusts, CRN staff, pharmaceutical companies, medical device companies and academic colleagues. Academic collaborations involve staff in various departments of the Universities' in Leeds and York

Plans are ongoing to explore how the Research departments of Community Trusts across England can better network, share information, ways of working, and collaborate on developing and supporting future studies.

The Corporate Research team have been providing the Clinical Effectiveness group with bi-monthly reports about current Trust Research activity as capacity has allowed.

3.6 Dissemination of research

The Elsie based Innovation and Research Hub continues to host research output that the department receives. The 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.

The department has started to publish internal R&D newsletters which publicise on-going work research across the Trust, raise the profile of the team and highlight output from recently published studies.

4.0 IMPACT

4.1 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

As previously reported, the Research team had almost wholly been funded by external sources; predominately the NIHR via the CRN allocation and the Research Capability Funding (RCF) allocation. Following the support of SMT from Dec to underwrite the costs of team, there may be a small funding gap between Research income and expenditure of up to approximately £30K. The team are seeking to address this through the generation of income (predominantly via delivery of commercially sponsored studies and studies sponsored by academic partners).

As outlined in previous reports, the loss of research activity in the prison healthcare sector specifically in terms of NIHR grant activity has had a significant impact upon the structural resource/finance made available to the Trust by the NIHR CRN and DH – particularly with regards to the RCF allocation. RCF funding is about to undergo a review so it is by no means certain that this funding stream will remain allocated in its current format during 2019/20

Structural changes to the way in which excess treatment costs for research are allocated are currently being enacted. In the current system, when excess treatment costs are identified within a study, the provider trust is required to source the costs from the commissioner of the service. The issues around securing funding via commissioners often have resulted in delays to research or even stopped the research from taking place. The details pertaining to the way in which the new approach will work have still to be clarified however in the new system, CRNs will oversee the allocation of the costs to provider Trusts. Provider trusts will however be expected to meet a minimum level of identified costs. The level of cost that trust would be expected to meet will depend on the Trust “banding” which reflects overall Trust income with higher income Trusts expected to meet a higher minimum excess treatment cost. As I understand it, the banding levels and threshold costs have yet to be confirmed.

4.3 It is uncertain how much income can be derived from commercial studies being planned this year. Hence it is not currently possible to make an educated estimate about any potential costs of underwriting the employment of the research team this year, however in view of current team costs and income we do not envisage it being more than £30k.

The Trust needs to be cognisant of the challenges that might ensue from the new excess treatment cost framework due to be implemented from October 2018. Currently we have one application for excess treatment costs totalling £10K with commissioners however we envisage this will have gone through the approval system with specialist commissioners at NHS England before October.

4.4 Legal/Regulatory

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

5.0 NEXT STEPS

During the next 6 months it will be important to;

- Agree the new 2019 – 22 Research Strategy for LCH, taking account of existing infrastructure, service provision and LCH priorities. In particular it will be important to contextualise the strategy alongside those of established networks, neighbouring Trusts, healthcare providers and academic organisations. This will require agreement regarding research ambitions and priorities. In particular;
    - Whether or not the Trust wishes to develop its research focus in specific areas
    - How the Trust might better develop and consolidate partnerships to bid for and deliver studies with Research organisations within academia and the commercial sector.
- Continue to work closely with the Clinical Research Network (CRN) and the series of strategic workshops being held to determine their strategy to 2021 particularly ensure that their strategic direction
- Develop work to better integrate and embed the work of the research delivery staff with service teams.
- Identify portfolio studies that the Trust is has the capacity and capability to participate in areas of work that the Trust has prioritised. In particular developing 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
- 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

6.0 RECOMMENDATIONS

The Board is recommended to:

- Receive reasonable assurance on the progress of Research delivery within the Trust.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (35)

Meeting Trust Board 3 August 2018	**Category of paper** *(please tick)*	
Report title Medical Director's Revalidation Report	**For approval**	✓
Responsible director Executive Medical Director **Report author** Responsible Officer Manager	**For assurance**	
Previously considered by: Quality Committee 23 July 2018	**For information**	

Purpose of the report

An annual Executive 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.

Main issues for consideration

This Executive Medical Director's report covers the period of 01/04/17 to 31/03/18 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 23 July 2018.

Recommendations
The Committee is recommended to:

- Approve the 2017/18 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

Medical Director's Revalidation Report

1 Executive summary

An annual Medical Director's report in relation to revalidation is a national requirement to provide assurance of the appraisal process to the Trust Board. This report covers the period of 01/04/17 - 31/03/18 and includes the Annual Organisational Audit (AOA) submitted to NHS England on 08/06/2018 (**Available on request**). 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 2018 who had a completed appraisal between 01/04/2017 and 31/03/2018 was **37/39** (**95%**). This was lower of the 2017/18 figure of **100%** due to 2 deferments (one ill health, one adoption leave).

The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2017 – 2018 was **48/50** (**96%**). This was lower than the 2017/18 figure of **98.5%**, again due to the two deferments.

The number of Police Custody self-employed doctors who confirmed that they had been appraised by 31/03/18 was **20/20 (100%)**.

The total number of doctors who were revalidated in this time period was **0**.

2 Purpose of this report

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.

2.6 Purpose of the report

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

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.

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

[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'

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 of 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 2016/17 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 and were exempt from quarterly returns and provided 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.

4.1 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, they are currently being revised.

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 2018, LCH as a Designated Body had a prescribed connection (and reported on for the purposes of the AOA) for **39** doctors:

- **28** Consultant (including honorary contract holders)
- **7** Staff Grade/Associate Specialist/Specialty Doctors (SAS)
- **1** Temporary /short term locums /Fixed term contracts
- **3** Other doctors (directly employed FMEs) with a prescribed connection to LCH.
- **10** salaried Dentists,
- **1** Consultant Dentist,

Non Designated Body doctors employed by included:

- **6** locums with a prescribed connection to a locum agency

Self-employed non designated body doctors included:

- **20** 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 08/06/2018. This self-assessment covered the final end of year period to 31/03/18 and the report is attached separately.

The numbers of doctors with a prescribed connection to LCH who had a completed appraisal between 01/04/2017 and 31/03/2018 was **37/39** (**95%**) (one doctor was on long term sick leave and one doctor was on adoption leave)**.**

The exception report for missed or incomplete appraisals is attached at **Appendix A**.

The audit highlighted:

- All doctors (with the exception of two doctors, One adoption leave and one long term sick) completed appraisals between 01/04/2017 and 31/03/2018. The exception report details the two doctors and rationale for non-completion in this time frame.

- All Service Level Agreement (SLA) and contracted sessional doctors are compliant within their own designated body.

  The number of dentists to include the consultant dentist who completed an annual appraisal between 01/04/2017 and 31/03/2018 was **11/11** (**100%**).

  The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2017 – 2018 was **48/50** (**96%**).

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 undertakings imposed by the GMC.

5.2 Appraisers

5.2.1 Appraiser Numbers

LCH had **9** appraisers for designated body doctors between 31/03/2017 and 01/04/2018. 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 received an enhanced appraisal training update in February 2017. In October 2017 LCH arranged for a full day of 'Appraiser Training' in conjunction with Leeds Teaching Hospitals NHS Trust, one doctor and one dentist attended, becoming new appraisers and carrying out appraisals within the cycle.

One appraiser was unable to attend the training but is due to receive supplementary training in 2018.

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'. The Consultant Dentist had their appraisal undertaken by the AMD. the AMD assisted in completing any additional dental appraisals.

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 was re-procured in 2016. It has been used for all doctors with a prescribed connection to LCH for the appraisal years 2013/14, 2014/15, 2015/16, 2016/17 and 2017/18.

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 administrative support to doctors on request.

5.3.2 Quality Assurance Process
All appraisers participated in a quality assurance exercise in 2017 which included a sample of output forms which were critiqued and reviewed alongside 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 2017 the RO Officer and the 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) for the 2016/17 cycle.

Samples of appraisals were randomly selected, and in total 14 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 were no complaints or appeals and appraisers all received positive feedback.

Work is currently underway to undertake the same exercise for the 2017/18.

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 01/04/17 – 31/03/18

The RO made **0** positive recommendations to the GMC **(Appendix B** Audit of revalidation recommendations) as no medical staff were due to revalidate within the cycle.

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.

8. Monitoring Performance

Doctors and Dentists are monitored for their performance through appraisal and job planning processes. Where there are concerns with regard to a doctors 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. There will be a cost related to dentists moving to an electronic appraisal system and registering for 360 feedback.

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 non-completed 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. **83.3%** of medical job plans were completed. Incomplete job plans were due to the operational service reviews during this period (meetings were held but job plans were not formally agreed within the 2017/18 cycle, but have been or will be agreed within 2018/19), sick leave and maternity leave. Job planning has been a focus for the first quarter of the next reporting period.

Required to job plan: 36*
Complete, agreed and signed within 17/18 cycle: 30
Job plan meeting held but job plan was not formalised within the 17/18 cycle: 4
Non-complete due to sickness: 1
Non-complete due to adoption leave: 1

*The three Forensic Medical Examiners are not required to complete a job plan.

The dentists have 100% completed annual job plans.

13 Annual Medical and Dental Conference

Leeds Community Healthcare Trust's annual 'Medical and Dental Conference' was held on the 6th November 2017 at the Thackray Medical Museum in Leeds.

The conference was attended by 48 delegates (excluding speakers, stall holders and the RO Team as organisers). The breakdown is shown below:

Service	Total
CAMHS	7
CASH	2
Child Health	13
ICT /Neuro Rehab	3
MSK	2
Dentists	4
FME	0
Directors	7
Senior managers	1
Trainee Doctors	4
Head Office	5
Total	48

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 conference was a mixture of workshops and presentations and during the lunch break a flu clinic was held to provide flu jabs for anyone that missed the opportunity during morning registration.

The morning session was chaired by Professor Ian Lewis; Non-executive Director of Leeds Community Healthcare NHS Trust, followed by an introduction by Thea Stein, Chief Executive of LCH.

Following on from the main introductions, the morning session began with 'An introduction to New Models of Care' from Thea Stein and Dr Andy Sixsmith from Thornton Medical Practice in Armley.

This was followed by a talk from Professor Ian Lewis on his professional journey and leadership; Professor Lewis incorporated a 'round table' discussion into his session, inviting delegates to think about the following four questions:

- Three things that tell you that you are doing a good job:
- What are the barriers you might face in doing your job well?
- Who else might you need to work with to successfully achieve outcomes for doing your job well?

- What improvements in outcomes would you want to see for your service; and your patients over the next three years?

A report compiling the responses from the round table exercise was written by the Research team and is attached at **Appendix D.**

After lunch the afternoon session was opened up by Neil Franklin, Chair of Leeds Community Healthcare (LCH) NHS Trust.

The afternoon began with a break-out session for medics and dentists, the dentists were led in a tutorial of the PReP appraisal system by Zaheer Khan, Director of Premier IT; whilst the remaining delegates listened to Ian Wilson from the General Medical Council talk about 'Fitness to practice and Doctors use of social media'.

This was followed by a talk from Caroline Britten 'Head of information Governance' on 'General Data Protection Regulation'; including the changes to the legislation around consent and accountability.

After coffee's the final session was led by Dr Ashley Weinberg 'Senior Lecturer in Psychology' from the 'University of Salford', Dr Weinberg spoke about 'Resilience in the workplace'.

Evaluation forms were in each delegates pack and the return rate was 20 (41.7%)

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 Committee is recommended to:

- Note the contents of the 2017/18 Medical Director's Report
- Note the guidance and requirements by NHS England to include the statement of compliance from the Board.
- Approve the report and submission to the Board

Appendix A

Audit report to identify reasons for missed or incomplete appraisals 2017/18 Leeds Community Healthcare NHS Trust

Doctor factors (total)	**39**
Completed appraisals 2017/18 = 36 (95%)	
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	1
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	0
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:
Two appraisals were postponed to the next cycle, one due to maternity leave, the other due to long term ill health.

Appendix B

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2017 to 31 March 2018	
Recommendations completed on time (within the GMC recommendation window)	0
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	0
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 appraiser 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;

Comments: All incidents /complaints notified to the RO office are followed up and information is uploaded into their individual portfolios. All doctors

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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.

APPENDIX D MEDICAL DENTAL CONFERENCE DELEGATE FEEDBACK

November 2017

This document pulls together feedback from all delegates of the conference on 4 main questions asked. The feedback given has been collated into themes

Table of Contents

Introduction

All delegates of the November 2017 Medical and Dental Conference were asked, in groups, to provide feedback to four key questions being addressed throughout the day. These four questions were:

1. How do you know that you are doing a good job?
2. What are the barriers you might face in doing your job well?
3. Who else might you need to work with to successfully achieve improving outcomes for doing your job well?
4. What improvements in outcomes would you want to see for your service and your patients over the next 3 years?

Responses to these four questions were collated and themed; this feedback is now provided in this report and is structured to provide themes under each specific question.

Themes according to question

Question 1: How do you know that you are doing a good job?

Theme 1: *Feedback – formal or informal:*
This was mentioned by all groups in relation to 360 feedbacks, 3 month appraisal processes, peer reviews, and feedback from a variety of sources including patients, colleagues, stakeholders, personal reflection, peers reviews and feedback on investigations. A lack of complaints was also thought to be a good indicator of how well you were doing your jobs.

Theme 2: *Measurements:*
Outcomes were mentioned by all groups as a way of benchmarking what was a good job, and indicating quality: and this was mentioned alongside service evaluation and audit.

Theme 3: *"Just knowing":*
Your own personal satisfaction as a clinician, seeing people leave happy, balancing work and life effectively and being able to reflect on your own practice. Having satisfaction in your work and a seeing a positive morale in your team were also indicators to you that you were doing a good job.

Question 2: What are the barriers you might face in doing your job well?

Theme 1: *Information:*
Mentioned by most groups as being a barrier to doing a job well, this was specifically in terms of not being able to share information effectively: Lack of a

central database, I.T issues, sharing information with other services and organisations with different systems, and systems not being aligned to look across MDT restrictions – all of these things were seen to impact on the ability to collect data and outcomes that lead to better performance.

Theme 2: *Time:*
Time was seen to be a barrier – or more specifically a lack of it, and this was felt by some to impact on opportunities to focus or prepare.

Theme 3: *Management/Clinical conflict:*
Management and clinical conflicts were mentioned, with a feeling that managers do not always understand the demands of clinical roles, or the current issues facing clinicians. There was also sentiment from many groups that communication and engagement with corporate or more direct management was not good which meant that there was a lack of sharing goals across the whole system.

Theme 4: *Finance:*
Paying for study leave, money being moved from one area to another, staff cuts, less accessible materials and resources, and overlaps with health and social care impacts on funding.

Question 3: Who else might you need to work with to successfully achieve outcomes for doing your job well?

Themes on this subject seemed to divide naturally into either internal or external links.

<u>Internal links</u>

Theme 1: *Service users:*
This linked back to feedback – gaining feedback from patients on their experiences and identifying what their needs are so that we can make more effort to meet them.

Theme 2: *Information technology:*
Identified as a barrier to doing a good job, I.T is also identified here as something that can facilitate a good job being done. This focussed on improving access to I.T systems, upgrading systems and enabling a more efficient use of ELSIE.

Theme 3: *Research:*

Using outcome measures such as PROMS, linking more closely with research and innovation, ensuring more collection of data from outcomes and identifying who can help with this.

External links

This seemed to be more about linking up and signposting to improve systems and pathways and ensure earlier intervention/ discharge as needed. Across groups these links varied depending on the services represented at that table, however this can be broadly described as primary and acute care, social care, local authority, voluntary sectors and education providers. It was also suggested that making stronger links with other community trusts would be helpful.

Question 4: What improvements in outcomes would you want to see for your service and your patients over the next 3 years?

Theme 1: *Improvement to service:*

Provision of inpatient beds, out of hours services, services to come back to LCH that have been re-contracted to other providers, ensuring the right patient accesses the right service, quicker referral times, reduced waiting times and less hospital admissions.

Theme 2: *Work planning:*

More medic time to be clinical: There was a general feeling that the weighting of the workload of the medics is not balanced enough in terms of clinical/administrative tasks. Discourse around medical workloads identified that there was a group feeling that more clinical time for the medics would result in quicker diagnoses, which would in turn improve clinical outcomes.

Theme 3: *Workforce:*

Better retention of good medics and better support for trainees was felt to be vital to the goal of improving outcomes for services and patients.

Theme 4: *Patient centric:*

A patient centric approach was favoured among all groups with outcomes being thought across the board to be valuable and something that should be at the heart of all services. Better informed patients, and better assessment of who is in real need. Joined up working between professionals and families, and services that cross boundaries to meet the needs of their patients

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (36)

Meeting Trust Board 3 August 2018	**Category of paper**	
Report title Nursing and AHP revalidation	**For approval**	
Responsible director Executive Director of Nursing **Report author** Interim 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 in relation to nursing and AHP revalidation. The paper describes the support and systems put in place to prepare and support staff for the revalidation process. For the first time we have also included Allied Healthcare revalidation

MAIN ISSUES FOR CONSIDERATION

There has been significant challenge in completing the report at this time due to issues with ESR. This means that at this point it is not possible to provide an update on numbers completing revalidation. The detail on failure to validate is compiled from the Director of Nursing Notes.

Monitoring systems are in place and appear to be effective.
Feedback from nurses indicates they find this a straightforward process.
During the course of the last year, two nurses failed to comply with the process.
One Allied Healthcare Professional failed to complete registration in time and had received appropriate advice and alerts. This re registration is currently being progressed.

RECOMMENDATION

The Board is recommended to:

- Note this update on nurse revalidation

Nursing and AHP 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 Staff continue to receive email reminders from both the NMC and from ESR three months prior to revalidation being due to allow time for them to complete this. This system appears to be effective.

2.0 Information regarding detail of revalidation for nurses

2.1 This report covers from April 2017 to June 2018.

2.2 Due to issues with ESR it has not been possible to ascertain at this point how many nurses have revalidated in the last year. An update will be provided as soon as available.

2.3 Based on the Director of Nurses notes during this time period, two nurses have failed to revalidate. The alert systems in place worked and managers were aware and had provided prompts and offers of support. One of these cases did lead to a separate investigation.

2.4 One Allied Healthcare Professional failed to revalidate in this time. Managers were aware. Appropriate alerts and support had been offered. This re-registration is currently being progressed.

3.0 Conclusion

3.1 The current system is effective and staffs report they find the process straightforward. 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.

4.0 Recommendation

4.1 The Board is recommended to:

- Note this update on nurse revalidation

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (38)

Meeting: Trust Board 3 August 2018	**Category of paper** *(please tick)*	
Report title: Significant risks and Board Assurance Framework (BAF) report	**For approval**	
Responsible director: Chief Executive **Report author:** Risk Manager (interim)	**For assurance**	√
Previously considered by: Senior Management Team (SMT) 18 July 2018	**For information**	

Purpose of the report:

This summary report is part of the governance processes supporting risk management in that it provides SMT 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 SMT with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received in June 2018.

The Board Assurance Framework (BAF) summary advises on 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 June 2018:

- Four risks currently scoring 15 or above (extreme)
- No new risks scoring 15 or above
- One new risk scoring 12
- One escalated risk scoring 12
- One deescalated risk previously scoring 12

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by the Quality and Business Committees, and the Board.

BAF strategic risk 4.2 is retained by the Board for scrutiny (all other BAF risks are assigned to a relevant committee). The Board should consider the risk scores, the controls to manage the risk and the sources of assurance.

Recommendations

The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary
- Consider strategic risk 4.2 (scores, controls, assurance sources)

SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Introduction

1.1 The risk register report provides SMT with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures.

1.2 SMT'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 SMT (20 June 2018), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to reassure SMT 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.

1.4 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 strategic risk.

2.0 Summary of current risks scoring 15 or above

2.1 There are four risks with a current score of 15 (extreme) or above on the Trust risk register as at 6 July 2018. These are as follows:

Risk ID	Risk description	Risk score	Risk movement
Risk 224	Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.	16 (extreme)	
Risk 872	Difficulties recruiting to and retaining staff within neighbourhood teams.	16 (extreme)	
Risk 939	New CAMHS Tier 4 building costs	16 (extreme)	
Risk 940	Risk of delays to new CAMHS Tier 4 service model	16 (extreme)	

2.2 There are no new risks scoring 15 (extreme) or above.

2.3 There are no escalated risks now scoring 15 or above.

2.4 There are no deescalated risks, which previously scored 15 (extreme) or above.

3.0 Risks scoring 12 (high)

3.1 There is one new risk scoring 12 reported since June 2018

3.2

Risk 944	Initial risk score **16** (extreme)	Current risk score **12** (high)	Target risk score **3** (low)

Myplan self-harm risk assessment tool within CAMHS is not being used systematically by clinicians.

Reasons for this includes lack of confidence in use of the MyPlan tool in A&E setting as part of the risk assessment process (including discussion with family/carers).

Risk: Young persons and their families may not be receiving the necessary support to prevent/control suicidal ideation or self-harm. Impact: patient safety, organisation's reputation.

Controls in place are:

- Staff are trained in use of the existing mandatory risk document
- The current Myplan document is available to all relevant LYPFT/LCH staff - attached to Standard Operating Procedures available on Elsie

Planned actions include:

- Review of the Myplan document
- Review of Standard Operating Procedures for 'out of hours working' mental health assessment for junior and specialist practitioners
- Dissemination and training to all relevant personnel on the amended documentation

4.0 Risks escalated to a score of 12 (high)

4.1 One risk has been escalated to a score of 12 since June 2018.

Risk 798	**Caseload management in children's dietetics**	Current risk score **12** (high)	Previous risk score **9** (high)

Reason for escalation:

- Current vacancy of Band 3 dietetic
- An incident has occurred which may be linked to this risk (investigation underway)
- There is evidence of delayed/inadequate monitoring of enterally fed children on the existing caseload

5.0 Risks deescalated from a score of 12 (high)

5.1 One risk has been deescalated from a score of 12 since June 2018

Risk 929	**Compliance with General Data Protection Regulations**	Current risk score **9** (high)	Previous risk score **12** (high)

Reason for de-escalation:

- The high level privacy notice that lets the public know how LCH is processing their personal data, and for what purpose, is available on the LCH website
- A review of the contracts and agreements held by LCH is underway with support from Procurement and Contract Management to ensure compliance.
- Data mapping exercises are progressing.

6.0 Closed risks previously scoring 12

6.1 No risks have been closed, which previously scored 12

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 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.

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 i.e. 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 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 3** (BAF risk assurance levels). Where adjustments have been made to the level of assurance, an explanation is provided.

8.6 Since the last BAF report in May 2018, the current level of assurance for the following BAF risks has been adjusted as follows:

Positive assurance movement

- BAF risk 1.2 (risk of not implementing and embedding lessons from internal and external reviews) has moved further into reasonable. The mortality review process, and information about the never events and patient safety alert process was presented to the Quality Committee providing reasonable assurance.
- BAF risk 2.1 (risk of not achieving internal projects) has moved further into reasonable as the E-rostering business case, a presentation on the admin review and details of the composite board programme reports provided reasonable assurance to Business Committee.

Negative assurance movement

- BAF risk 1.1 (risk of not having effective quality assessment systems) has moved further into 'limited' as there is concern about the outcome measures process.
- BAF risk 1.3 (risk of not maintaining or improving the CQC rating) has moved from reasonable, towards limited as Quality Committee recognised significant progress at Hannah House in some areas but there was still much to achieve in relation to its business and culture.

8.7 The attached BAF summary reflects the amended assurance levels.

9.0 BAF strategic risk 4.2

9.1 BAF strategic risk 4.2 **(appendix 2)** is retained by the Board for scrutiny (all other BAF risks are assigned to a relevant committee). The Board should satisfy itself that the controls are adequate, that the current risk score is an accurate reflection of the level of risk, and the sources of assurance listed should provide it with enough information to evaluate whether the strategic risks assigned to the Committee are being managed.

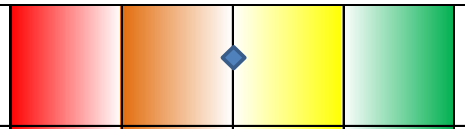
10.0 Recommendation

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
- Consider strategic risk 4.4 (scores, controls, assurance sources)

Appendix One: Board Assurance Framework summary

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score				Current Level of Assurance (denoted by ◆).					
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	MP	QC	4	4	16			◆			Clinical audit plan 2018/19 received reasonable assurance. Outcome measures process has stalled and provides only limited assurance.	←
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships.	MP	QC	2	4	8				◆		Quality Committee determined reasonable assurance for the mortality review process. Never events and patient safety alert process provided reasonable assurance.	→
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	MP	QC	2	3	6				◆		Reduction in numbers of pressure ulcers and progress with QIP action plan provided reasonable assurance. Quality Committee recognised significant progress at Hannah House in some areas but there was still much to achieve so limited assurance provided	←
	RISK 1.4 If the Trust does not achieve external and internal quality priorities and targets then this may cause damage to reputation and loss of income.	MP	QC	3	2	6				◆			
Provide sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects (integrated neighbourhood teams, EPR, E-rostering) then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	3	4	12				◆		E-rostering business case, a presentation on the admin review and details of the composite board programme reports provided reasonable assurance to Business Committee	→
	RISK 2.2 If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	4	3	12				◆			
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	4	12					◆		
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12					◆		
	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					◆		

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	AH	BC	4	4	16			
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	AH	BC	4	4	16			
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	BC	4	3	12			
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing .	AH	BC	3	3	9			
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC	3	3	9			
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	3	4	12			
	RISK 4.3 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage.	MP	QC	2	3	6			
	RISK 4.4 If there is insufficient capacity across the Trust to deliver all planned change programmes and strategic projects, including the Leeds Plan, then organisational priorities may not be delivered.	TS	BC	3	3	9			
	Risk 4.5 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships	BM	BC	3	3	9			

Appendix Two: Board Assurance Framework strategic risk 4.2 (Board owned)

Strategic Goal	**Work in partnership to deliver integrated care and care closer to home**		**Risk score**	**Likelihood**	**Consequence**	**Score**
Strategic Risk 4.2	*Description of risk:* ***(4.2) If the Trust does not maintain relationships with stakeholders, including commissioners and City Council then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .***		**Initial**	3	4	**12**
			Current	3	4	**12**
Lead Director	**Thea Stein**		**Target**	1	4	**4**

Responsible committee
Trust Board

Key controls (lead director)

Control Ref	**Control** (what are we doing already to manage the risk?)	Lead director	Adequacy of control
4.2.1c	Proactive involvement by CEO and directors in wider health economy as part of directors objectives	T Stein	Adequate
4.2.2c	External Communications strategy	T Stein	Adequate
4.2.3c	Senior management attendance and involvement in important strategic meetings / forums	T Stein	Adequate
4.2.4c	Communication with NEDS- bulletins, emails etc, ensuring NEDS are better informed for managing relationships with external stakeholders	T Stein	Adequate
4.2.5c	Stakeholder analysis reviewed by SMT quarterly	T Stein	Adequate
4.2.6c	Continuous updates to Board by CEO in public and private sessions	T Stein	Adequate

Gaps in controls (lead director and SMT)

Gap (what else could we do to manage the risk?)	**Action?** (how are we going to do it?)	**Actionee**	**Date**	**Progress**

Sources of Assurance (lead director)

Ref	**Source of Assurance** (what can we look at to see whether or not it is being successfully managed?)	Type of assurance (1,2 or 3?)	Received by which committee
4.2.1a	Chief Executive's report to Board (CEO monthly report plus a six monthly summary of all stakeholder engagement and stakeholder feedback every 2 Board meetings))	1	Board
4.2.2a	Reports from Scrutiny Board (via CEO report) December and April	3	Board
4.2.3a	Minutes from Contracts Management Board	3	BC
4.2.4a	Business and commercial developments report	1	BC

Gaps in sources of assurance (lead director and SMT)

Gap (What other sources of assurance do we need to establish?)	**Action?** (how are we going to do it?)	**Actionee**	**Date**	**Progress**

Appendix Two: Glossary- BAF risk assurance levels

Risk assurance levels	Definition
Substantial	Substantial assurance can be given that the system of internal control and governance will deliver the clinical, quality and business objectives and that controls and management actions are consistently applied in all the areas reviewed.
Reasonable	Reasonable assurance can be given that there are generally sound systems of internal control and governance to deliver the clinical, quality and business objectives, and that controls and management actions are generally being applied consistently. However, some weakness in the design and / or application of controls and management action put the achievement of particular objectives at risk.
Limited	Limited assurance can be given as weaknesses in the design, and/or application of controls and management actions put the achievement of the clinical, quality and business objectives at risk in a number of the areas reviewed.
No	No assurance can be given as weakness in control, and/or application of controls and management actions could result *(have resulted)* in failure to achieve the clinical, quality and business objectives in the areas reviewed.

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (39)

Trust Board public workplan 2018-19
Version 7 25 July 2018

Topic	Frequency	Lead officer	29 March 2018	25 May 2018 (revised from 1 June 2018)	3 August 2018	6 October 2018	4 December 2018	1 February 2019
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	EDN	X (Children's SLT)	X (MSK)	X (End of life care)	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X
Care Quality Commission inspection reports	as required	EMD						
Quality account	annual	EDN		X				
Staff survey	annual	DW	X					
Safe staffing report	2 x year	EDN			X			X
Seasonal resilience	annual	EDO	X CEs report			X CE's report		
Serious incidents report	4 x year	EDN		X	X	X		X
Patient experience: complaints and incidents report	2 x year	EDN		X Annual report			X Six monthly report	
Freedom to speak up annual report	annual	CE			X			
Guardian for safe working hours report	4 x year	EMD		X Annual report	X		X	X
Strategy and planning								
Operational plan including financial plan	2 x year	EDFR	X	X End of year report		X		
Service strategy	as required	EDFR	X Chidren's strategy					
Quality strategy	annual	EDN						X
Professional strategy	annual	EDN					X	
OD strategy	2 x year	DW		X Deferred	X		X	
Research and development strategy	annual	EMD			X			
Other strategic service developments	as required	EDO						
Reports								
Equality and diversity report	annual	EDN					X	
Safeguarding annual report	annual	EDN				X		
Infection prevention control annual report	annual	EDN				X		
Emergency preparedness annual report	annual	EDO				X		
Governance								
Medical Director's report: doctors' revalidation	annual	EMD			X			
Nurse revalidation	annual	EDN			X			
Well-led framework (in CE's report)	2x year	CS			X CEs report		X	
Annual report	annual	EDFR		X				
Annual accounts	annual	EDFR		X				
Letter of representation	annual	EDFR		X				
Audit opinion	annual	EDFR		X				
Audit Committee annual report	annual	CS		X				
Standing orders/standing financial instructions review	annual	CS	X Deferred	X				
Annual governance statement	annual	CS	X					
Going concern statement (part of corporate governance update)	annual	EDFR	X					
NHS provider licence compliance	annual	CS		X				
Committee terms of reference review	annual	CS		X				
Board and sub-committee effectiveness	annual	CS		X				
Register of sealings	annual	CS		X				
Declarations of interest/fit and proper persons test (part of corporate governance update)	annual	CS	X					
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X
Corporate governance update	as required	CS						
Decisions for ratification	as required	CS		X Cyber security				
Board workplan	every meeting	CS	X	X	X	X	X	X
Minutes (for noting)								
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board(for noting)	every meeting	CS	X	X	X	X	X	X
Additional items								
West Yorkshire Mental Health Services Collaborative	as required	CE		X MoU				
Leeds Health and Care Academy - Partner Board briefing	as required	CE	X		X			
CAMHS Tier 4	as required	EDFR		X				
West Yorkshire and Harrogate Health and Care Partnership	as required	CE						

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
EMD	**Executive Medical Director**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required

Leeds Community Healthcare NHS Trust

Audit Committee

Boardroom, Stockdale House, Headingley Office Park, Victoria Road, Leeds, LS6 1PF
Friday 20 April 2018
9.00 am – 11.30am

Agenda item 2018-19 (40ai)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
	Ian Lewis (IL)	Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Interim Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Matthew Moore	External Audit Manager (KPMG)
	Richard Slough	Assistant Director Business Intelligence, Systems & IT (for item 6e and 6f)
Apologies:	Clare Partridge	External Audit Partner (KPMG)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2018-19 (1)	**Welcome, introductions and preliminary business** The Chair welcomed members and others in attendance. The Chair of the Committee agreed to re-order the agenda as set out in these minutes.	
2018-19 (1a)	**Apologies** Apologies were received from Clare Partridge, External Audit Partner, KPMG.	
2018-19 (1b)	**Declarations of interest** There were no declarations of interest.	
2018-19 (1c)	**Minutes of the previous meeting 16 March 2018** The minutes of the meeting held on 16 March 2018 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the previous meeting held on 16 March 2018.	
2018-19 (1d)	**Matters arising and actions' log** *Item 60a: External audit technical update: pensions tax* The Executive Director of Finance and Resources asked for this action to be deferred until the next formal meeting of the Committee on 23 May 2018 when a verbal update would be available. *Item 61:counter fraud and security management: cyber security* The Executive Director of Finance and Resources confirmed that a phishing exercise would be undertaken by the Trust.	

	All other actions had been completed or were covered by the agenda and there were no further matters arising from the minutes.	
2018-19 (2a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and management action plan. He advised that six audits had been completed since the Committee's last meeting on 16 March 2018. There were four audits with a reasonable assurance opinion and two with a limited assurance opinion These reports were received by the Committee. <u>Progress against the annual plan for 2017/18</u> The Internal Audit Manager introduced the report; particularly noting the progress already made on the remaining reports due by the end of quarter four. The Committee reviewed progress against the 2017/18 internal audit plan and the Internal Audit Manager updated the Committee on the current status of the outstanding audits, anticipated completion and reporting dates. He advised that all completed audits already in the draft report stage and those where exit interviews were imminent would be finalised in time for the next Committee meeting on 23 May 2018. He added that the assurance level on all these outstanding audits was not expected to change. The Chair of the Committee referred to the section in Appendix A which contained provisional assessments for the draft reports that had been issued and those where exit interviews were still to be completed. She particularly asked for more information about the data quality – communication aid services audit, which was anticipated as a limited assurance opinion. The Internal Audit Manager explained the rationale behind the assessment of the assurance level. He said that for reasons which were unique to this service SystmOne did not allow all the information relating to waiting lists to be drawn together to provide an accurate picture and therefore a limited assurance opinion had been given. Work was underway to bring the service in line with other services across the Trust. The Chair of the Committee asked for the final audit report to be made available to the Committee at the informal meeting on the 11 May 2018. **Action: The final report of the communication aid services audit to be available for the Committee on 11 May 2018.** The Committee discussed the executive summary and management action plans for the audits finalised since the last meeting. *Cybercrime security incident response management* In response to a question from a Non-Executive Director (RG), the Executive Director of Finance and Resources confirmed that the penetration test referred to as part on the management actions in response to recommendation one had been completed during week commencing 19 March 2018. The Chair of the Committee questioned the overall assurance assessment level as reasonable given that the report contained seven important recommendations. A Non-Executive Director (RG) suggested that it might be beneficial for an external expert to visit the Trust to discuss wider cyber security issues and he agreed to	**Internal Audit Manager (TIAA)**

	discuss this further with the Executive Director of Finance and Resources. The Chair of the Committee requested that a further update on the progress made on the recommendations from this audit at the Committee's meeting on 20 July 2018. **Action: A further update on the progress made on the recommendations from the cybercrime security incident response management audit to be made to the Audit Committee on 20 July 2018.** *Information governance toolkit v14.1 part 2* The Chair of the Committee noted that the reference in the key findings to the Information Governance Group reporting to the Trust Board should be corrected to reflect that the reporting line to the Board was through the Audit Committee and she asked for this to be amended. **Action: Key findings from the audit on the information governance toolkit v14.1 part 2 to be amended to reflect the reporting line for the Information Governance Group is through the Audit Committee.** *Payroll* The Internal Audit Manager highlighted the main conclusions from the audit which had led to the overall assurance assessment as limited. The Committee reviewed the management responses to the six important recommendations. The Committee expressed concern about the broad range of issues raised in the audit and were not satisfied with the management responses to the recommendations; the Executive Director of Finance agreed to speak to the Interim Director of Workforce about the management responses and request an updated version for the next meeting on 23 May 2018. **Action: The Executive Director of Finance to speak to the Interim Director of Workforce about the management response to the payroll audit recommendations and request an updated version for the next meeting on 23 May 2018**. The Chair of the Committee noted that the new Directors of Workforce would take up post in June 2018 and the Committee agreed that they should be invited to attend the Committee meeting scheduled for the 20 July 2018 to discuss more generally control mechanisms within the Directorate and their suggestions for how to improve the current position. **Action: The new Directors of Workforce to be invited to the Audit Committee on 20 July 2018 to provide an update report on the implementation of the recommendations from the payroll audit and to discuss more generally control mechanisms within the Directorate and their suggestions for how to improve the current position.** *Managing CAMHS waiting times* The internal audit of CAMHS waiting time management received limited assurance, with one urgent, one important and two routine recommendations. The urgent recommendation concerned the average daily appointments offered, which at the time of the audit was 2.56, which contrasted with the management target of 4.0 appointments. The Chair of the Committee asked for the report from this audit to be made available to the Quality and Business committees as soon as possible and	**Executive Director of Finance and Resources** **Internal Audit Manager (TIAA)** **Executive Director of Finance and Resources** **Interim Company Secretary**

	verbal feedback on their respective reviews of the audit be provided at the meeting on the 23 May 2018. **Action: The audit report on managing CAMHS waiting times to be made available to both the Quality and Business Committees for consideration and verbal feedback on their comments to be provided to the Audit Committee on 23 May 2018.** In response to concerns raised by the Chair of the Committee about the strength of the management comments on the recommendations, the Internal Audit Manager said that he was confident that all the responses and actions were underpinned by a robust action plan which would be monitored by the Head of Service to ensure that implementation was completed to meet the agreed timetable. The Chair of the Committee suggested that in future a schedule should be produced to make it clear which sub-committee had oversight of each audit report. **Action: A schedule to be produced to make it clear which sub-committee has oversight of each audit report.** **Outcome:** The internal audit update report was received and the contents noted.	**Interim Company Secretary** **Interim Company Secretary**
2018-19 (2b)	**Head of Internal Audit opinion** The Head of Internal Audit introduced the final year-end report, he stated that the final opinion was that reasonable assurance could be given and that there was a generally sound system of internal control, designed to meet the organisation's objectives and that controls were generally being applied consistently. However, some weaknesses in the design and/or the inconsistent application of controls put the achievement of particular objectives at risk. The Head of Internal Audit explained that at the time of drafting his report there were five assurance reviews where a final report had not been issued but it was not anticipated that any changes to the outcome of these review would impact on the overall audit opinion. The Chair of the Committee said that given the caveat included in the Head of Internal Audit Opinion report relating to all audit reports being finalised, a final opinion should be included in the internal audit annual report and submitted to the Committee at the informal meeting on 11 May 2018. In addition, she asked for the internal audit annual report to include the rationale and basis for the overall reasonable assurance opinion, given that the overall assessment from three of the audits to date in 2017/18 were a limited assurance opinion. This rationale would also need to be included in the annual governance statement. **Action:** • **The final Head of Internal opinion to be included in the internal audit annual report to be submitted to the informal meeting of the Committee on 11 May 2018 and include the rationale and basis for the overall reasonable assurance opinion.** • **This rationale to be included in the annual governance statement.** **Outcome:** The Head of Internal Audit opinion was noted.	**Internal Audit Manager** **Interim Company Secretary**
2018-19 (2c)	**Internal audit annual plan 2018/19** The draft internal audit annual plan for 2018/19 was presented by the Internal Audit Manager. He advised that during March 2018, meetings had been held with all the executive directors to discuss and review the plan and the Business and Quality	

	committees had reviewed and commented on the plan. The Committee reviewed the plan and agreed that the audits should be re-prioritised as follows: • Well-Led Framework moved from quarter 1 to quarter 3 • CQC compliance removed and replaced with an audit on partnership governance to take place in quarter 1 • Complaints management brought forward from quarter 3 to quarter 2 • Cyber security brought forward from quarter 3 to quarter 2 A final version of the plan would be presented for approval at the Committee meeting on 23 May 2018 for approval. **Action: The Internal Audit Manager to make changes to the draft plan for 2018/19 in response to the changes requested by the Committee and present a final plan to be available at the 23 May 2018 for approval.**	**Internal Audit Manager (TIAA)**
2018-19 (2d)	**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 had an agreed implementation date by 31 March 2018 and the more detailed report on the outstanding actions. He noted that there were seven recommendations to report that had not been completed by the due date and these were reported in detail with an update on progress from the responsible manager. The Committee discussed the overdue recommendations. Referring to the audit on bank and agency staff the Chair of the Committee observed that if the revision to the due date was a consequence of the delay in the implementation of e-rostering then this should be made more explicit in the status report. Referring to the audit on the neighbourhood teams capacity and demand, a Non-Executive Director (IL) confirmed that the Quality Committee would be considering the clinical risks associated with the delay in implementing the recommendations related to allocation processes and caseload reviews. **Outcome: The Committee received and noted the status report.**	
2018-19 (3a)	**External Audit** **External Audit 2017/18:progress report** The External Audit Manager reported that the audit was proceeding to plan and the external audit annual report for 2017/18 would be presented to the Audit Committee on 23 May 2018. He reported on one issue which related to the valuation of the Trust's estate where work was underway to ensure that accurate figures would be included in the finalised year-end accounts. **Outcome:** The Committee received and noted the verbal update.	
2018-19 (3b)	**External audit technical update** The External Audit Manager presented the technical update for April 2018.	

	Outcome: The Committee received and noted the update	
2018-19 (4a)	**Annual report and accounts: progress report** The Executive Director of Finance and Resources said that all aspects were being completed to timescale. **Outcome:** The verbal update was noted.	
2018-19 (5a) **2018-19** (5b) **2018-19** (5c)	**Financial controls** **Losses, compensation and special payments report** The Executive Director of Finance and Resources presented the report which covered any such transactions made in March 2018. **Outcome:** The losses, claims and special payments report was received and noted by the Committee. **Tender and quotations waiver report** The Executive Director of Finance and Resources introduced the report. He reported that there were no new waivers in March 2018. **Outcome:** The Committee received the report and the content was noted. **Treasury management procedure** The Executive Director of Finance and Resources reported that no changes were requires to the procedures. **Outcome:** The Committee received and noted the verbal report.	
2018-19 (6a)	**Board assurance framework: summary report** The Interim Company Secretary presented the BAF risk summary report which described the strategic risks and aligned them with the corporate objectives for 2018-19. She explained that each strategic risk had been assigned to an Executive Director and to a committee for oversight. In previous BAFs, strategic risks had been assigned to the Senior Management Team (SMT) and the Trust Board, as well as to the Quality and Business Committees. Internal Audit had recommended that all strategic risks should be assigned to either the Quality or Business Committee. This recommendation was now reflected in the 2018-19 BAF, with the exception of BAF risk 4.2 (maintaining relationships with stakeholders), which SMT agreed should be retained by the Board. One new strategic risk has been added, which was in the (BAF) risk (4.5) of not having robust agreements when working with complex partnership arrangements. The Committee reviewed the BAF strategic risks for 2018-19 and noted the amendments. The Committee suggested that at the mid-year review of the BAF strategic risks should take place in October 2018, consideration should be given to adding a strategic risk under the Providing Sustainable Services which would consider the sufficiency of critical enabling infrastructure within the organisation to provide resilience against risks for example the increasing cybersecurity threat.	

	Action: • A mid-year review of the BAF strategic risks to take place in October 2018 and consideration given to adding a strategic risk under the Providing Sustainable Services to consider the sufficiency of the critical enabling infrastructure within the Trust to provide resilience against risks for example the increasing cybersecurity threat.	**Interim Company Secretary**
2018-19 (6b)	**Outcome:** The Committee agreed the strategic risks for the 2018-19 BAF and the allocation of each strategic risk to a Director and Board committee.	
2018-19 (6c)	**Audit Committee annual report and review of terms of reference** The Chair referred to the reports prepared by the Interim Company Secretary. This item contained the Audit Committee's annual report, annual reports from other committees, annual review of committee effectiveness and areas for future development. **Committees' annual reports** The Chair reviewed the reports for each committee. *Quality Committee Annual Report 2017/18* The Chair asked that the attendance table be amended to include only members of the Committee and executive directors in attendance. A Non-Executive Director (IL) noted typographical error on page 2 paragraph 3: membership and attendance, namely: In the first asterisk paragraph the reference to July 2018 in the last paragraph to be amended to January 2018. The Chair of the Committee asked that future annual reports for the Business and Quality committees reflect their role in the scrutiny of risks by reviewing BAF risks. **Action:** • **To amend the typographical error on page 2 paragraph 3 of the Quality Committee Annual Report 2018.** • **For the future annual reports for the Business and Quality committees to reflect their role in the scrutiny of risks by reviewing BAF risks.** There were no additional comments or issues raised about the report or any of the components of the governance framework included within it. **Outcome:** The Committee noted the annual reports from the other committees and the assurances they contained, endorsed the changes to the terms of reference and recommended that the Audit Committee annual report be submitted to the Board for approval.	**Interim Company Secretary**
2018-19 (6d)	**Review of standing orders and standing instruction** The Executive Director of Finance and Resources presented the report to the Committee on the work undertaken to update the Trust's standing orders and standing financial instructions. The report summarised a number of amendments. The Chair of the Committee noted the amendments to the budgetary delegation limits which had been previously approved by the Audit Committee.	

	Outcome: The Committee noted and approved the updated standing orders and standing financial instructions in line with the summary of changes.	
2018-19 (6e)	*The Assistant Director of Business Intelligence, Systems and IT joined the meeting.* *GDPR compliance: update report* The Assistant Director of Business Intelligence, Systems presented the report which updated the Committee on progress to ensure the Trust's compliance with the General Data Protection Regulation legislation which comes into effect from 25 May 2018. The Committee noted that Phase 1 of the action plan had been achieved by the end of March 2018 in accordance with the planned timescales. A new Head of Information Governance/Data Protection Officer had been appointed on 3 April 2018 and awareness around GDPR had significantly increased. In line with the communications and stakeholder engagement plan the System Access Request Network has been re-established and significant progress has also been made with regard to Personal Identifiable Data processed within the Communications Team, in particular the Foundation Trust membership database, which contained contact information for potential members and interested stakeholders, had been deleted. Current activities included identifying information asset owners within all services. In response to a question from a Non-Executive Director (RG), the Assistant Director of Business Intelligence, Systems and IT confirmed that all the actions taken were clearly evidenced in the action plan. The Chair of the Committee thanked the Assistant Director of Business Intelligence, Systems and IT for presenting the comprehensive update report and requested that the Head of Information Governance attend the Audit Committee on 20 July 2018 to provide a further update report on progress. **Action: The Head of Information Governance to attend the Audit Committee meeting on 20 July 2018 to provide a further update report.**	**Interim Company Secretary**
2018-19 (6f)	**Outcome**: The Committee received and noted the report. **Cyber security submission approval** The Assistant Director of Business Intelligence, Systems and IT advised that NHS Improvement (NHSI) required all providers confirm that they are complying with national data and cybersecurity standards outlined in the 2017/18 Data Security Protection Requirements (DSPR). The report presented to the Committee provided a compliance position statement assessing the Trust's level of compliance against each of the DSPR requirements. The Assistant Director of Business Intelligence, Systems and IT advised that the Trust was either compliant or partially compliant against each of the ten data and cybersecurity standards. The Committee reviewed the information and agreed it was an accurate reflection of the Trust's position. As the submission to NHSI was required in advance of the next Trust Board meeting, it was agreed that the Committee, from its review and discussion, felt comfortable to recommend that the Trust Chair and Chief Executive approve its submission under the emergency powers and urgent decisions section of the Trust's reservation and delegation of powers. Confirmation of this action will be reported to the 25 May 2018 meeting of the	

	Trust Board in public session for formal ratification. **Outcome:** The Committee received the assessment of the Trust's level of compliance against the DSPR and recommended that the Trust Chair and Chief Executive Officer approve the submission to NHSI to meet the required deadline of 10 May 2018.	
2018-19 (7)	**Minutes for noting** The minutes of the Information Governance Group on 13 February 2018 were presented. **Outcome:** The minutes were noted.	
2018-19 (8)	**Audit Committee work plan** There were no matters removed from the workplan. **Outcome:** The workplan was noted.	
2018-19 (9)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to be referred to Board colleagues: • Assurance in relation to GDPR compliance • Internal audit annual report and Head of Internal Audit opinion • Finalised internal audit plan 2018/19; committees to receive the finalised plan • Annual report and accounts • Board and sub-committees' annual reports 2017/18 • Cyber security submission to NHS Improvement • BAF critical enabling infrastructure risk for consideration in October 2018	
2018-19 (10)	**Any other business** No matters of any other business were raised.	
	Date and time of next meeting Friday 11 May 2018 9.00am- 11.30am,(Informal page turner meeting) Wednesday 23 May 2018 8.30am-10.00am Friday 20 July 2018 9.00am – 11.30am Boardroom, Stockdale House Leeds Community Healthcare LS61PF	

23 05 2018

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (40aii)

Audit Committee

Room 1, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Wednesday 23 May 2018
8.30am–10.00am

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Cherrine Hawkins	Deputy Director of Finance and Resources
	Diane Allison	Interim Company Secretary
	Matthew Moore	External Audit Manager (KPMG)
	Clare Partridge	External Audit Partner(KPMG)
	Tim Norris	Internal Audit Manager (TiAA Limited)
	Thea Stein	Chief Executive (for Item 18a)
Apologies:	Professor Ian Lewis	Non-Executive Director
	Peter Harrison	Head of Internal Audit (TiAA Limited)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2018-19 (16)	**Welcome, introductions and preliminary business** The Chair welcomed members and attendees.	
2018-19 (16a)	**Apologies** Apologies were noted from Professor Ian Lewis (Non-Executive Director) and Peter Harrison (Head of Internal Audit. TiAA Limited).	
2018-19 (16b)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2018-19 (16c)	**Minutes of the previous meeting 20 April 2018** The minutes of the meeting held on 20 April 2018 were reviewed and agreed as an accurate record subject to the following amendments: Item 2a: *Information governance toolkit v14.1 part 2* 'The Chair of the Committee noted that the reference in the key findings to the Information Governance Group reporting to the Trust Board should be corrected to reflect that the reporting line to the Board was through the Audit Committee. Item 2a: *Payroll* The Internal Audit Manager highlighted the main conclusions from the audit which had led to the overall assurance assessment as limited. The Committee reviewed the management responses to the six important recommendations. The Committee expressed concern about the broad range of issues raised in the audit and was not satisfied with the management responses to the recommendations. The Committee members had met informally to review the draft annual report and	

	accounts in detail on Friday 11 May 2018; no minutes had been taken of this meeting. **Actions' log**	
2018-19 (16d)	The Chair asked for verbal updates on five completed (blue) actions: • *External audit update: pensions tax:* The Executive Director of Finance and Resources said that it was not appropriate for the Trust to provide financial advice to individual employees in relation to the changes in pension tax thresholds. He advised that the changes would not affect a significant number of staff employed by the Trust but steps would be taken to identify those individuals who might be affected and suggest that they might wish to seek independent advice. • *Trust Annual Report - remuneration disclosures:* The Deputy Director of Finance and Resources confirmed that the Nominations and Remuneration Committee had reviewed the remuneration disclosures and that all the individuals on the Trust Board had separately given confirmation that their entries in the remuneration reports were accurate. Referring to the information about the number of off-payroll engagements included in the annual report, the Chair of the Committee suggested that more narrative be included about the nature of the staff covered by those arrangements. • *Audit on data quality- communications aid service, waiting lists and loaned IT devices:* The Executive Director of Finance and Resources drew members' attention to the full audit report which was included in the Summary Internal Controls Assurance (SICA) Report. He provided a verbal update on the progress against the eleven important recommendations and two routine recommendations from the audit. The Committee noted the urgent action taken to address the important recommendations and discussed the management responses and implementation timetables relating to all the remaining recommendations. • *Audit of payroll:* The Executive Director of Finance and Resources provided a verbal update regarding the management responses to the six important recommendations from the audit. He said that work was continuing to review the detailed findings from the audit and put in place action plans to address the recommendations. The Committee noted the update regarding the management responses however, members were keen to see more evidence that effective actions were being taken which would have an immediate impact. The Chair of the Committee noted that the newly appointed Directors of Workforce had been invited to attend the Audit Committee meeting on 20 July 2018. She requested that a further report be submitted to that meeting which included an update on the progress made against each of the recommendations and details of the monitoring arrangements which had been put in place to assess the impact and effectiveness of the actions taken. • *Audit of managing CAMHS waiting times:* The Interim Company Secretary confirmed that the audit report had been made available to the Quality and Business committees. She advised that since the report had been	

	completed in February 2018 significant improvements had been made in managing waiting time arrangements and current data showed that 70% of practitioners were now meeting the management daily target of four appointments. Both committees were content that progress was being made to address all the recommendations. The completion of actions from previous meetings was noted. **Matters arising from the previous meeting held 20 April 2018** One item was raised : • *GDPR compliance:* In response to a question from the Chair of the Committee, the Executive Director of Finance and Resources said that he was confident that the Trust was on track to complete the actions in the GDPR action plan to ensure a satisfactory compliance position by 25 May 2018 and that the outstanding actions and associated timescales would be regarded as sufficient by the ICO. There were no other matters arising from the minutes.	
2018-19 17(a)	**Internal audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that since the Committee's last formal meeting on 20 April 2018, all remaining audits had now been completed and final reports issued. These were: CQC; stakeholder engagement; communication aid service (CAS) waiting lists and loaned IT devices; focus on falls; neighbourhood team demand and capacity tool follow up; and safeguarding children. The Committee discussed the executive summaries and management action plans included in the report; four indicated a reasonable assurance opinion, one was a limited assurance opinion and one was a follow up audit of the neighbourhood team demand and capacity tool. *Communication aid service (CAS), waiting lists and loaned IT devices* This audit was assessed as limited assurance but the Chair of the Committee observed that it had been discussed in detail at the last formal meeting of the Committee on 20 April 2018 and a verbal update had been provided under agenda item 16d at this meeting. *Neighbourhood team demand and capacity tool follow up* The Committee noted that this was a follow up review of a previous assurance review and therefore no assurance assessment was provided. The Chair of the Committee observed that it was clear from the overall conclusions that there remained a significant amount of work to do to ensure that the tool was being used effectively across all the neighbourhood teams and that the tool's objectives were clearly and consistently understood. *Focus on falls* The Committee reviewed the overall conclusion from the audit and the management responses to the four important recommendations. The Chair noted with concern the 50/50 split between investigations carried out in line with the standard operating procedures and those not. The Committee sought further assurance that the management responses to the recommendations would be sufficient to address the issues related to the investigation and evaluation of incidents resulting from falls.	

	The Executive Director of Finance and Resources agreed to seek a view from the Executive Director of Nursing about how the actions and progress against the recommendations could be monitored effectively and their impact assessed. **Action:** The Executive Director of Finance and Resources to discuss the recommendations and management responses with the Executive Director of Nursing. *Safeguarding children* The Chair questioned the overall assessment level as reasonable given the nature of the comments which accompanied the three important and one routine recommendation. The Committee asked that the audit report be considered by the Executive Director of Nursing and an update provided for the next Audit Committee meeting on 20 July 2018. **Action:** The Executive Director of Nursing to review the audit report on safeguarding children and an update provided at the next meeting of the Audit Committee on 20 July 2018. **Outcome:** The Committee noted the contents of the summary internal controls assurance report, including conclusion of the internal audit plan for 2017-18.	**Executive Director of Finance and Resources** **Executive Director of Finance and Resources**
2018/19 (17b)	**Internal audit annual plan 2018-19** The Internal Audit Manager presented the proposed internal audit annual plan for 2018/19. He explained that the plan had been revised to take account of the comments made by the Committee at the meeting on 20 April 2018. All audits were aligned with the BAF and assigned to an executive lead and a board sub-committee. A total of 228 audit days had been factored into the plan. The Interim Company Secretary confirmed that the proposed plan had been made available to the Business and Quality Committees. Following on from the outcome of the 2017/18 audit of Focus on Falls the Committee agreed that a follow up audit of it should be added to the 2018/19 plan. The Committee noted that there were no audits planned for quarter four, which would mean that all planned audits should be carried out and finalised within 2018-19. In response to a question from a Non-Executive Director (RG), the Internal Audit Manager confirmed that good progress was being made on all the audits scheduled for quarter one. The Chair of the Committee said she looked forward to receiving a report on a significant number of completed audits at the next meeting of the Audit Committee on 20 July 2018. **Outcome:** Subject to the additional audit requested the internal audit annual plan for 2018-19 was approved.	

2018-19 (18a)	**Annual report 2017/18** The Executive Director of Finance and Resources introduced the draft annual report for 2017/18, and advised that the report presented at the meeting reflected the actions taken in response to the comments made by the Committee's members at the informal meeting held on 11 May 2018. The Chair welcomed the Chief Executive to the meeting. The Chief Executive provided an overview of the annual report and reflected on the challenges the Trust had faced in 2017/18 and its successes including the outcome of the CQC inspection. The Committee recommended that the positive story of the Trust's year should be shared widely with staff. The Chair invited the auditors to comment on the annual report. 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. The External Audit Partner asked whether all directors had confirmed that all relevant information had been disclosed. The Interim Company Secretary advised that all directors had provided her with written confirmation of this. The Chair of the Committee 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 Friday 25 May 2018.	
2018-19 (18b)	**Annual accounts 2017/18** The Executive Director of Finance and Resources introduced the annual accounts for 2017/18. 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 NHS Improvement on Tuesday 29 May 2018. The Executive Director of Finance and Resources also reported that the external auditors had undertaken a detailed examination of the annual accounts and reviewed the mandatory disclosures in the annual report; their findings being contained in the ISA 260 audit memorandum to KPMG's audit of the 2017/18 financial statements. The report from KPMG had contained no significant issues. The Executive Director of Finance and Resources referred to the informal meeting of the Committee on Friday 11 May 2018 which had provided members with the opportunity for detailed consideration of all the elements within the accounts. The Chair of the Committee agreed that the informal meeting had proved very helpful and thanked the Executive Director of Finance and Resources 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 Friday 25 May 2018.	

2018-19 (18c)	**Financial statements 2017/18: 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.	
2018-19 (18d)	**Financial statements 2017/18: ISA 260 audit memorandum** The External Audit Manager reported that all the audit work would be completed in time for the report to be presented to the Trust Board on 25 May 2018. 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 Partner reported that there were no unadjusted audit differences. 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 and conformation that the valuation of material land and buildings included in the financial statements represented a balanced valuation • 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 2018/19 • the findings from the significant risk based value for money work which concluded that the Trust had made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018. • in terms of value for money, the Trust was doing well when compared with the rest of the sector. 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. The Committee placed on record its thanks to the Trust's Finance Team for their work to deliver the Trust's annual accounts for 2017/18. **Outcome:** The Committee received the annual accounts and (subject to the completion of the outstanding matters annotated on the ISA 260) recommended the adoption of the accounts by the Board at its meeting on Friday 25 May 2018 and the signing of the letter of representation.	
2018-19 (19)	**Committee's Workplan** There were no matters removed or changes made to the workplan.	
2018-19 (20)	**Matters for the Board and other committees** The Chair noted the following items to be referred to Board colleagues: • the annual report and accounts would appear as substantive items on the Board agenda for the meeting on Friday 25 May 2018 • completion of the internal audit plan for 2017-18 • approval of the internal audit plan for 2018-19 • external auditors confirmation that in terms of value for money, the Trust was doing well against the rest of the sector.	

2018-19 (21)	**Any other business** There were no matters of any other business raised.	
	Date and time of next meeting Friday 20 July 2018 9.00 am – 11.30 am Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (40bi)

Quality Committee
Monday 23 April 2018
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations *(joined at 10:50)*
	Carolyn Nelson	Head of Medicines Management
	Diane Allison	Interim Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Stephanie Lawrence	General Manager and Clinical Lead for Children's Services
	Vanessa Hunt	Interim Professional Lead for Allied Health Professionals
	Philip Boynes	Quality Lead for Specialist Services *(deputising for Elaine Goodwin)*
	Gillian Osborne	Senior Practitioner and Pathway Lead for Podiatry Service *(item 2)*
Observing	Kezia Prince	Incident and Assurance Manager
	Angela Gregson	Clinical Pathway Lead, West 2
	Adrian Tickle	Student District Nurse
Minutes	Nicola Wood	PA to Executive Director of Nursing
Apologies	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Dr Phil Ayres	Interim Executive Medical Director
	Debbie Myers	Interim Deputy Director of Nursing
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (1a)	**Welcome and Apologies** Non-executive Director (IL) welcomed members to the meeting. Apologies were noted from Neil Franklin, Thea Stein, Dr Phil Ayres and Elaine Goodwin.	
2018-19 (1b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (1c)	**Minutes of meeting held on 19 March 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following amendments: <u>Item 2017-18 (79a) Performance brief and domain reports</u> *Amend wording:* Other contributing factors included resources within services due to reduced capacity and ~~some services had decided that audits were no longer necessary or relevant to their service~~ services that had been decommissioned	

	Item 2017-18 (79b) Director of Nursing quality and safety report *Amend wording:* A ~~large proportion~~ number of these were attributable to discharge incidents and work was ongoing to reduce these. *Amend wording:* The Executive Director of Nursing highlighted that there had been no increase in incidents in the Trust's care; however, there had been an increase in patients being discharged from ~~the acute trust~~ Leeds Teaching Hospitals NHS Trust ~~with harm~~ where incidents had been identified. *Amend wording:* Clinical Lead for adult services informed the Committee that safety huddles focused on patient risk and happened ~~daily following handover~~ weekly. One neighbourhood team was piloting daily safety huddles. Item 2017-18 (79c): Schedule of KPIs *Amend wording:* 5% reduction in falls: related to in patient units therefore ~~not~~ no longer applicable. *Remove text:* Compliance with NICE guidance: the policy had been revised to two years ~~– therefore one year compliance had been discontinued.~~	
2018-19 (1d)	**Matters arising and review of action log** Matters arising from the 19 March 2018 meeting minutes There was a brief discussion around the reporting of discharge incidents and it was agreed a method was required to identify those incidents that did not occur whilst in the Trusts care. The Clinical Lead for adult services and the Incident and Assurance Manager to action. **Action: The Clinical Lead for Adult Services to work with the Incident and Assurance Manager to devise a method of identifying and reporting on discharge incidents recorded on Datix that occurred in other organisations. To be reported back to Quality Committee at the May 2018 meeting.** 2017-18 (37a) outcome measures An update to Quality Committee on the benchmarking of national outcome measures had been delayed due to staff absence. The Committee Chair expressed some concern at the extended delay and informed the Committee that the matter would be escalated to Trust Board if an update was not provided at the Committee Meeting in May 2018. 2017-18 (79b) Director of Nursing report The Executive Director of Nursing highlighted that the Care Quality Commission and Her Majesty's Inspectorate of Prisons inspection report for Wetherby Young Offenders Institute would be presented to Quality Committee once received. This was expected to be July 2018. 2017-18 (86a) Internal audit plan 2018-19 The Interim Company Secretary highlighted to the Committee that following the request for comments at the March 2018 meeting, a review of the Clinical Effectiveness Group had been added to the internal audit plan 2018-19. It was agreed that all completed actions would be removed from the action log.	**Clinical Lead for adult services**

Service spotlight: Foot Protection Service		
2018-19 (2)	The Executive Director of Nursing introduced a colleague from the Foot Protection Service. The Senior Practitioner and Pathway Lead provided an overview of the presentation and an outline of the service. This is summarised below. **Background:** In 2017/18 NHS Leeds Clinical Commissioning Group was awarded NHS England treatment and care transformation funding on behalf of the city to support the improvement of three specific areas of diabetes care over two years (2017/18 and 2018/19). The three areas of investment were: • Expansion of the Diabetes Multidisciplinary Foot Care Team (MDFT) • Diabetes Structured Education • Diabetes Inpatient Specialist Nurse Team MDFT funding was secured to reduce amputations by improving the timeliness of referrals from primary care to a Multidisciplinary Foot Care Team for people with diabetes. This included developing an expanded MDFT with a focus on high and moderate risk patients initially and ulcer prevention. The Foot Protection Service was an expansion of the limb salvage collaboration with Leeds Teaching Hospitals NHS Trust and the Clinical Commissioning Group. The Senior Practitioner and Pathway Lead highlighted that this collaboration did not include Leeds and York Partnership NHS Foundation Trust but noted this would be helpful due to the connection between mental health conditions and diabetes. The Senior Practitioner and Pathway Lead shared the Foot Protection Service key performance indicators and weekly bulletin with the Committee and welcomed any questions. In response to a query from the Executive Director of Nursing around the staffing model, the Senior Practitioner and Pathway Lead said that the specialist staff worked alongside the community podiatry team to increase skills and allow for cross working. Non-executive Director (TD) noted that Leeds had a high amputation rate and asked if there was a trajectory to reduce that and what the expectations were. The Senior Practitioner and Pathway Lead responded that Leeds was an outlier and the aim was to reduce the number of amputations to the national average. She added that the numbers would have to be reduced to secure long term funding. The Committee Chair queried why Leeds was an outlier. The Senior Practitioner and Pathway Lead responded that over a five year period, 47% of patients who had a minor amputation had never been seen by a Podiatrist. In response to a query from the Clinical Lead for adult services around access and the take up of pathways, the Senior Practitioner and Pathway Lead said that there was no demographic theme. The Clinical Lead for adult services suggested it would be a good opportunity for the team to link in with the Health and Adult Care Talent in Chapeltown & Harehills programme (HATCH).	

	The Quality Lead for specialist services asked how the patient training sessions and pathways were being communicated. The Senior Practitioner and Pathway Lead responded that communication was the responsibility of Primary Care and the Clinical Commissioning Group. The Interim Professional Lead for Allied Health Professionals highlighted that in her experience of working with the Diabetes Team some patients were not always aware of the severity of their condition and she suggested the team link in with the diabetes patient support group held at the West Yorkshire Playhouse. In response to a query from the Committee Chair around the success of the service in terms of outcomes, the Senior Practitioner and Pathway Lead said that the patient feeling more confident in their care and a reduction in the number of amputations would evidence improved outcome measures. A separate measure would not be introduced as this was dependent on the national audit. The Committee Chair asked for an example of a change that had been made as part of the quality improvement initiative. The Senior Practitioner and Pathway Lead responded that the patient leaflets had now been unified so that there was no longer conflicting information being communicated across the city. The Senior Practitioner and Pathway Lead added that a verified foot screening competency programme had been devised and was being introduced into Primary Care which should improve referrals. The Executive Director of Nursing suggested that it would be helpful to seek support from the Leeds Institute for Quality Healthcare around outcome measures. The Committee Chair and the Executive Director of Nursing thanked the Senior Practitioner and Pathway Lead for the presentation. The Committee Chair added that it would be good to hear about the improved patient outcomes in due course. **Action: An update on improved patient outcomes for the Foot Protection Service to be provided as part of the specialist business unit workshop in October 2018.**	**Clinical Lead for specialist services**
Performance Brief and Domain Reports		
2018-19 (3)	**Performance brief and domain reports** The Committee reviewed the document and the Executive Director of Nursing highlighted the following for the Committee to note under the safe, caring, effective and responsive domains: **Safe** The Trust had achieved most of its targets within the safe domain for the year. The exception was avoidable category 4 pressure ulcers where three had been recorded in the year, although there had been none in Q4. The Percentage of VTE Risk Assessments completed had not improved in Q4 (83.9%) and was rated red as it was below the target of 95% There was a peak in performance in Q3 with a sustained improvement in January 2018 and February 2018 but there was a decline in March 2018. The Executive Director of Nursing stated that the percentage of VTE risk assessments completed did not seem to be correct and agreed to clarify this with the Performance Team.	

	Action: Executive Director of Nursing to clarify the percentage of VTE risk assessments completed with the Performance Team.	**Executive Director of Nursing**
	Caring All indicators were rated green at year end.	
	Effective The number of clinical audits completed in the year was 76. In response to a query from Non-executive Director (TD) around the rating of the end of year position for clinical audit, the Executive Director of Nursing confirmed that a detailed assurance report would be presented to Quality Committee at the May 2018 meeting. The Committee Chair highlighted that a robust programme would be required for the 2018-19 plan.	
	Action: Executive Director of Nursing to present a detailed assurance report on clinical audit at the May 2018 meeting.	**Executive Director of Nursing**
	There was a discussion around the inconsistency of clinical supervision data and the recording issues on ESR. The Committee Chair requested that the issues be resolved before the next Quality Committee meeting in May 2018. **Action: Executive Director of Nursing to investigate the inconsistencies with clinical supervision data and report the outcome to Quality Committee in May 2018.**	
	Responsive The Trust had performed well in its indicators relating to waiting lists with all rated as green at March 2018. There was an exception in March 2018 with the percentage of patients waiting less than six weeks for a diagnostic test dipping below 100% which had been consistently reported since Q1, to 97.9% which was below the target of 99%. Patient Contacts was reported as -12.2% below profile in March 2018 but remained amber rated YTD at -6.4% below profile. There was a brief discussion around patient appointments in the children's business unit and the Executive Director of Nursing assured the Committee that the previous issues had been resolved and patients now had appointments diarised. She added that focus in this area continued. The General Manager and Clinical Lead for children's services said that there was potential for some children currently waiting to be seen by a doctor to be seen by other clinicians and pathways and this was being explored.	
	Well Led Sickness absence rate continued on a downward trend from January 2018's 'high' of 7.5% to 5.6% in March 2018. This was broken down into long-term absence 3.4% and short-term absence at 2.2 %. The specialist business unit was an exception to this overall decreasing trend; having an increased sickness rate, the majority of which was due to long term absence. This was being pro-actively supported and managed. Appraisal rates for corporate services were notably reduced. The Executive Director of Nursing highlighted that on review this was partly due to recording and functionality issues of the ESR system. She said that she was working with the Workforce Intelligence Team to resolve these issues.	

	The rate of turnover continued to be better than the Trust target of 14.5% and remained better than other benchmark comparator community provider trusts. **Finance** The Trust's financial performance remained strong. The Trust performed well against its 2017-18 CQUIN targets. **Outcome:** The Committee: • Agreed **reasonable assurance** was provided on the safe domain • Agreed **reasonable assurance** was provided on the caring domain • Agreed **limited assurance** was provided on the effective domain based on the clinical audit • Agreed **reasonable assurance** was provided on the responsive domain	
Quality Governance and Safety		
2018-19 (4a)	**Director of Nursing quality and safety report** **Clinical Governance exception report** The Executive Director of Nursing presented the report and highlighted that a deep dive into the number of avoidable pressure ulcers was underway with the Incident and Assurance Manager and that they were working with the Performance Team to review how incidence was recorded to ensure a detailed understanding of the information available. The Trust was 100% compliant with the Duty of Candour regulations. There were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to the Trust in March 2018. There were 127 medication incidents attributable to the Trust in the three month period January to March 2018. Of the 118 no harm incidents 47 did not impact directly on patient care and related to storage or record keeping. **Director of Nursing Report** The Executive Director of Nursing provided an update on Hannah House, the clinical professional conference and the UNICEF gold standard accreditation visit. <u>Hannah House</u> The Executive Director of Nursing provided an update on the programme of work being undertaken at Hannah House and the recent concerns that had been raised. This was discussed in depth by the Committee. The Executive Director of Nursing informed the Committee that concerns had recently been raised by two families about clinical issues at Hannah House. One family had approached the Care Quality Commission and one had approached the Trust. The Executive Director of Nursing expressed her disappointment particularly following recent reports of an improving picture and evidence in improved audits. The Executive Director of Nursing said that there would be significant work in the development of the band 6 clinical role and an increase in enhanced quality monitoring including a weekly 'walk around' by senior staff.	

	The Committee expressed its considerable concern, recognising that the latest issues had been raised despite apparent improvements being reported from the position last year in two different action plans. The Executive Director of Nursing highlighted that investigations into the complaints were ongoing and confirmed that a detailed action plan would be drafted and presented to the Quality Committee in June 2018. **Action: Executive Director of Nursing to present a detailed action plan from the complaints investigations to the Quality Committee in June 2018.** In response to a concern expressed by the Committee Chair around providing assurance to the Trust Board, the General Manager and Clinical Lead for children's services reassured the Committee that she was confident the children were safe and the care they received was effective. Following further discussion, it was agreed that information about the current situation at Hannah House would be included in the Chief Executive's report to the Trust Board and any confidential details would be discussed in the private session in May 2018. **Action: Information about the current situation at Hannah House to be included in the Chief Executive's report to the Trust Board and further details to be discussed in the private session in May 2018.** The Committee Chair asked for there to be a focus on Hannah House at the Quality Committee workshop on children's services in June 2018 **Action: The June 2018 workshop on children's services to have a focus on Hannah House.** The General Manager and Clinical Lead for children's services highlighted that Hannah House would have a Quality Challenge+ visit prior to the Quality Committee workshop in June 2018, and suggested it would be helpful for a Non-executive Director to join the visit. **Action: A Non-executive Director to be invited to join the Quality Challenge+ visit at Hannah House.** In response to a query from the Committee Chair, the General Manager and Clinical Lead for children's services said that there had been open and transparent communication with the new unit manager about the issues that had been experienced at Hannah House. The unit manager would be taking up the post on a secondment basis. The Executive Director of Operations highlighted that senior leadership being visible at the unit seven days a week was under consultation. The Executive Director of Nursing shared details of the Care Quality Commission (CQC) review meeting and engagement visit to Hannah House on 12 April 2018 with the Committee. There had been no additional request for information following the visit and the Executive Director of Nursing was confident the CQC received a level of assurance. **Outcome:** The Committee: • The Committee felt that it had only received **limited assurance** about the quality of services provided at Hannah House.	**Executive Director of Nursing** **Executive Director of Nursing** **General Manager/Clinical Lead for children's services** **General Manager/Clinical Lead for children's services**

	Clinical professional conference On 27 March 2018 the Trust welcomed more than 50 staff and partners to the second annual registered clinical conference. The theme of the day was the 'Culture of Capturing Excellence'. UNICEF gold standard accreditation visit The Trust and in particular the Health Visiting Service had worked to promote breastfeeding across Leeds and this work had been recognised through the UNICEF accreditation programme. The 2017 Unicef baby friendly initiative audit recognised Leeds health visiting service's approach to infant feeding as 'implementing outstanding standards across all levels of the service in achieving excellent support for mothers around feeding practice whilst also promoting close relationships between mother and baby'. Following a query from the Committee Chair, the Executive Director of Nursing agreed to clarify the statistics on the city's position on the breastfeeding national outcome data. **Action: Executive Director of Nursing to clarify the statistics on the city's position on the breastfeeding national outcome data.** **Clinical Leads' quality reports** A summary of the reports appended to the Director of Nursing Report was provided by the Executive Director of Nursing. *Adult services:* • Positive end of year position for preferred place of death • Further progress in reducing the neighbourhood team therapy and CUCs waiting lists • Period of change in the ABU clinical leadership team – a focused plan to support this change was being developed. *Children's services:* • Concerns at Hannah House remained a focus *Specialist services* • Foot protection service • Mobilisation of the police custody contract • Dietetics member of staff successful in being offered a clinical fellowship • Capacity and demand was being actively managed	**Executive Director of Nursing**
2018-19 (4bi)	**Quality account 2017-18** The Executive Director of Nursing introduced the draft quality account 2017/18. The quality improvement priorities for the 2018/19 quality account were approved by the Quality Committee on 19 February 2018. The report had been sent to external stakeholders on 13 April 2018 for their review and comments in line with national requirements and these would be included in the final report, as well as any amendments following the consultation period. The final quality account document would be presented to Trust Board for approval on 25 May 2018.	

	Following feedback from the Committee Chair, there was a discussion around how the account reflected the wide range of work that was going on across the organisation and how the Trust could demonstrate the improved outcomes and contribution to the health and wellbeing of the city. It was agreed that some consideration should be given to how that would be measured next year. Non-executive Director (TD) suggested that a section be added to the Trust Chair and Chief Executive's opening statement to headline the Trust's achievements and priorities for the year ahead. He also suggested that information should be included about how services had improved as a result of clinical audit. The Executive Director of Nursing agreed to liaise with the Trust's Clinical Audit & Effectiveness Manager and incorporate more information around the learning from audits in the account. **Action: Executive Director of Nursing to liaise with the Trust's Clinical Audit & Effectiveness Manager and incorporate more information around the learning from audits in the account.** The Committee Chair asked for feedback on the quality improvement priorities to be sent to the Executive Director of Nursing by 27 April 2018. **Action: Feedback on the quality improvement priorities to be sent to the Executive Director of Nursing by 27 April 2018.** Following a request from Non-executive Director (TD), the Executive Director of Nursing agreed to share any comments from stakeholders with Committee members once received, prior to the final draft being presented to Trust Board for sign off in May 2018. **Action: Executive Director of Nursing to share any comments from stakeholders with Committee members once received.** **Outcome:** The Committee: • Noted the progress of the quality account document in its current state of production	**Executive Director of Nursing** **Committee members** **Executive Director of Nursing**
2018-19 (4bii)	**Quality account: quarter four update** The Executive Director of Nursing introduced the report which provided the quarter four position on progress against the 2017-18 quality account quality improvement priorities and outlined what further actions would be taken to keep those quality goals on track to achievement. Of the 17 outcomes from the ten quality improvement priorities: • Eight had been completed and fully achieved • Six had an agreed target or timescale that was at risk of delay or not being achieved • Three had not met the agreed progress/target/timescale for achievement of the priority Actions were identified against all priorities to ensure risk to achievement was mitigated; and progress towards achievement was made or continued.	

	Outcome: The Committee • Noted the end of year position against the 2017/18 quality improvement priorities and that further actions were needed to keep the quality goals on track.	
2018-19 (4c)	**Quality strategy action plan** The Executive Director of Nursing presented the report, which outlined the implementation plan for the quality strategy 2018-21. The quality strategy 2018-21 was approved by the Trust Board in February 2018. The Strategy described the overarching quality objective to strengthen the Trust's approach to quality improvement with a focus on four priority areas: • Prevention, proactive care and self-management • Patient experience and engagement • New models of care • Workforce There were seven wide reaching actions identified across these action areas. The implementation plan contained the actions that would be taken within the first year of the strategy and progress to date against these. Additional plans would be developed for subsequent years. In response to a query from the Committee Chair the Executive Director of Nursing said that there would be a workshop led by the Interim Deputy Director of Nursing and the clinical leads to bring together other action plans that had not yet been reflected in the strategy and to make the actions SMART so they could be measured effectively. **Outcome:** The Committee • Noted the update on the implementation of the Quality Strategy	
2018-19 (4d)	**Professional strategy update report** The Executive Director of Nursing introduced the Interim Professional Lead for Allied Health Professionals who presented the report. The report provided an update on the progress of actions relating to the professional strategy for clinical staff 2016-2020 and its implementation. This was the second time that progress against the aspirations in the strategy had been reported to Quality Committee. In response to a query from the Committee Chair around how the clinical council was viewed in the organisation, the Interim Professional Lead for Allied Health Professionals said that staff were enthusiastic about the council and it was an enabler for new ways of working. She added that it helped assist in joint working rather than staff working in silos and this would shape and develop over time. The Head of Medicines Management highlighted that the council enabled connectivity at a clinical level. The General Manager and Clinical Lead for children's services said that advanced clinical practice across the three business units was an example of this. Non-executive Director (TD) asked how the progress made through the council would be demonstrated. The Interim Professional Lead for Allied Health	

	Professionals responded that this would be reported as part of the strategy update and presented to Quality Committee again in October 2018 following a further two/three council workshops. The Executive Director of Operations said that progress would be evidenced in the staff survey results. **Action: Any measurable changes to be included in the Professional Strategy update when presented to Quality Committee in October 2018.** **Outcome:** The Committee: • Noted the progress made in the implementation of the Professional Strategy for Clinical Staff.	**Interim Professional Lead for Allied Health Professionals**
2018-19 (4e)	**Mortality Surveillance Group update** The Executive Director of Nursing introduced the General Manager and Clinical Lead for children's services to present the report which provided an update on the work of the Mortality Surveillance Group over the last 12 months. A 'Learning from Deaths Policy' had been developed. The death of every patient within the Trust's care was subject to a level one investigation, which established if there was any reason to investigate the circumstances of the death further; these cases would then be subject to a level two investigation. The General Manager and Clinical Lead for children's services highlighted that there were a number of services that were exempt from the process as per the business unit specific pathways. The General Manager and Clinical Lead for Children's services stated that there was still some work to do to ensure the reporting was accurate, but advised the Committee that the Trust was a long way ahead of other community trusts in country. It was agreed that there would be a substantive discussion at the June 2018 Quality Committee meeting, where some case studies would be presented. **Action: A substantive discussion at the June 2018 Quality Committee meeting, where some case studies would be presented by the General Manager and Clinical Lead for children's services.** **Outcome:** The Committee: • Noted the update	**General Manager and Clinical Lead for children's services**
2018-19 (1f)	**Risk Register** The Interim Company Secretary introduced the report which outlined risk movement amongst risks scored at eight or above, since the last report in March 2018. The Committee noted there was one new risk, two risks with an increased score, no risks with a decreased score and one risk closed since the last report. There were two extreme risks in total, scoring 15 or more. <u>Risk 932: short term lack of leadership capacity in community CAMHS</u> The Interim Company Secretary asked the Committee to note that the risk was significant as three out of the four team manager posts were vacant. The General Manager and Clinical Lead for children's services responded that recruitment was underway and she was confident one post had been recruited to. The Executive Director of Operations highlighted that this was a short term concern and viewed it as a positive opportunity.	

	Outcome: The Committee: • Noted the recent revisions made to the risk register	
Clinical Effectiveness		
2018-19 (5a)	**Education and training strategy** The first draft of the Education and Training Strategy had been presented to Senior Management Team. The next stage of the work was to undertake further consultation with different staff groups. This work would be led by the Interim Deputy Director of Nursing who was developing plans to take this forward. **Outcome:** The Committee: • Noted the update	
2018-19 (5b)	**NICE Guidance** The Head of Medicines Management presented the report and highlighted to the Committee the key items for note. The report provided an update on National Institute for Health and Care Excellence (NICE) Guidance issued between January and December 2015 relevant to Leeds Community Healthcare and the reported compliance position as of 13 April 2018. The standard for implementation of NICE Guidance within the Trust was two years. During the 2015 calendar year, NICE issued 81 pieces of guidance, of which 27 were relevant to the Trust and had been circulated for implementation. 31 services have achieved full compliance within two years of publication, four services had identified areas of partial compliance, and are working through action plans and one service had not engaged in the feedback process so compliance status was unknown. In response to a query from Non-executive Director (TD) around the implementation of 'NICE CG 97 lower urinary tract symptoms in men', the Clinical Lead for adult services agreed to investigate the position and report back to Quality Committee at the May 2018 meeting. **Action: Clinical Lead for adult services to investigate the position around the implementation of NICE CG 97 lower urinary tract symptoms in men and report back to Quality Committee at the May 2018 meeting.** The Committee Chair commended the Head of Medicines Management for the improved position since the last report in October 2017. The Head of Medicines Management highlighted that the clinical leads and quality leads had worked hard with services in implementing the guidance. In response to a query from Non-executive Director (TD) around the implementation of 'NICE CG 28 depression in children and young people' and the outstanding recommendation that 'children in remission be reviewed regularly by a CAMHS professional', the Head of Medicines Management confirmed that the wording was taken from the NICE Guidance and the issue was around ensuring that the most appropriate professional 'followed-up' with the child. The General Manager and Clinical Lead for children's services advised the Committee that this was not unique to the Trust. **Outcome:** The Committee: • Received the report and noted the progress to date with implementation of NICE Guidance	**Clinical Lead for adult services**

2018-19 (5c)	**Internal audit reports** The Interim Company Secretary presented the report which provided a summary of the outcomes from the completed internal audit report(s), where the report related directly to the role and functions of the Quality Committee. The paper covered the completed audit(s) from the 2017/18 plan and the audit opinion related to the 'managing waiting times in the Child and Adolescent Mental Health Service (CAMHS)' report. In response to a query from the Committee Chair around the number of appointments being offered not meeting the daily recommendation and the potential for quality implications and risk to patient care, the Executive Director of Operations assured the Committee that all referrals were triaged and any 'priority waiters' were advanced to the front of the queue. Non-executive Director (TD) queried the variance in daily appointments. The Executive Director of Operations responded that the audit had been concluded in February 2018. Currently 70% of practitioners were meeting the target of four appointments per day. The Committee Chair acknowledged that some of the variance could be due to complexity. The Audit Committee had requested the Quality Committee discuss the roll out of the capacity and demand tool in neighbourhood teams. The Executive Director of Operations acknowledged that this had taken longer to implement that initially planned. In response to a concern raised by the Committee Chair, the Executive Director of Operations advised the Committee that there was no clinical risk to patients as a result of the delay. Resource was being moved to ensure capacity met demand and that senior management worked together to mitigate any potential risk. **Action: Committee Chair to advise Audit Committee of the outcome of discussions about the capacity and demand tool.** **Outcome:** The Committee: • Noted the audit completed as part of the approved 2017/18 plan	**Committee Chair**
Patient experience		
2018-19 (6a)	**Annual patient experience and incident thematic report** The Executive Director of Nursing presented the paper which provided an annual review of the themes of patient experience and incidents within the Trust for the financial year 2017-18. The information used in the report had been taken from complaints, concerns and incident data and the Friends and Family Test. In response to a query from Non-executive Director (TD) around the reduced number of compliments, the Executive Director of Operations said that winter pressures may have impacted on services capacity to record the compliments. **Outcome:** The Committee: • Agreed reasonable **assurance** that actions and learning were in progress to address the themes identified	
Governance		
2018-19 (7a)	**Revised Quality Committee terms of reference** The Interim Company Secretary presented the revised Quality Committee terms of reference for approval.	

	Outcome: The Committee: • Agreed the revised terms of reference for recommendation to the Board for approval on 25 May 2018.	
Reports and minutes for approval and noting		
2018-19 (8a)	**Board members' visits** The Interim Company Secretary presented the report which detailed service visits undertaken since Quality Committee in March 2018. One report has been submitted by Non-executive Director (Brodie Clark) which detailed a visit to the CAMHS Community and Infant Mental Health Team, South Wedge. The report had been shared with the Team Manager, Head of Service and the Director of Operations. It was noted that board members' visits would be discussed at the Trust Board workshop on 4 May 2018. **Outcome:** The Committee: • Received the report on non-executive directors' service visits April 2017-March 2018.	
2018-19 (8b)	**Mental Health Act Governance Group: draft minutes: 16 March 2018** The Executive Director of Nursing presented the draft minutes from the Mental Health Act Governance Group meeting held on 16 March 2018 and highlighted to the Committee that there had been a discussion around the role of searching young people and added that the Trust policy had been changed in line with other organisations. In response to a query, the Executive Director of Nursing confirmed that the Child and Adolescent Mental Health Services specific training was modular training based on national good practice. **Outcome:** The Committee: • Received the draft minutes	
2018-19 (9)	**Quality Committee future work plan** The future work plan was received for information. **Action: The Interim Company Secretary will present the updated work plan based on the new format of meetings to Quality Committee at the May 2018 meeting.**	**Interim Company Secretary**
2018-19 (10)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair would provide an update to the Board at the meeting on 25 May 2018. Items to be reported include: • Service spotlight: Foot Protection Service • Performance brief and domain reports: safe, caring and effective domains • Director of Nursing Report: Hannah House • Quality Account • Quality Improvement Priorities quarter four position • Quality strategy (2018/21) action plan • Professional strategy update • Mortality Surveillance Group update	

	• Quality Committee's terms of reference – amendment • ESR – inconsistent / inaccurate information • UNICEF GOLD **Assurance levels:** • Performance Brief o Safe: **reasonable** o Caring: **reasonable** o Effective: **limited** based on clinical audit • Director of Nursing Report o Hannah House: **limited**	
2018-19 (11)	**Any other business** None recorded	
	Dates and times of next meetings (09:30 – 12:30) Monday 21 May 2018 Monday 25 June 2018 Monday 23 July 2018	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (40bii)

Quality Committee
Monday 21 May 2018
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Diane Allison	Interim Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Stephanie Lawrence	General Manager and Clinical Lead for Children's Services
	Sarah McDermott	Clinical Service Manager, Palliative Care and Neighbourhood Night Service *(item 13)*
	Sam Austin	Palliative Care Clinical Lead *(item 13)*
Observing	Suzanne Slater	Clinical Governance Manager
Minutes	Nicola Wood	PA to Executive Director of Nursing
Apologies	Neil Franklin	Trust Chair
	Dr Phil Ayres	Interim Executive Medical Director
	Carolyn Nelson	Head of Medicines Management
	Elaine Goodwin	Clinical Lead for Specialist Services
	Debbie Myers	Interim Deputy Director of Nursing

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (12a)	**Welcome and Apologies** Committee Chair welcomed members to the meeting. Apologies were noted from Neil Franklin, Dr Phil Ayres, Carolyn Nelson, Debbie Myers and Elaine Goodwin.	
2018-19 (12b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (12c)	**Minutes of meeting held on 19 March 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2018-19 (12d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>2018-19 (1d) Matters arising and review of action log</u> Following conversations between the Clinical Lead for adult services and discharge facilitators at Leeds Teaching Hospitals NHS Trust, for incidents that were not attributable to Leeds Community Healthcare NHS Trust, a process has been agreed which will accurately reflect this data.	

	2018-19 (3) Performance brief and domain reports Following discussions with the Performance Team, it had been agreed that Performance Information Portal (PIP) would in future be used for performance reporting where relevant to ensure consistency.	
Service spotlight: End of Life Care Service		
2018-19 (13)	The Executive Director of Nursing introduced colleagues from the End of Life Care Service. The Clinical Service Manager provided an overview of the service. The presentation detailed: • How the service was performing in relation to quality measures and KPIs • Palliative and end of life care service review • Priorities for 2018-19 • Citywide perspective The Executive Director of Operations drew the Committee's attention to the low 'bereaved carers survey' response rates and suggested that carers may prefer to provide feedback via the Carers Leeds Network, rather than directly to the Trust. The Chief Executive suggested Healthwatch could provide the survey as part of their work. The Clinical Service Manager confirmed that Healthwatch was involved and said the service was raising awareness of the survey. The Chief Executive added that response rates had improved since the survey had been made available online. Non-executive Director (TD) commended the team for the range of evidence presented to the Committee. He asked if the service experienced any problems accessing equipment such as syringe drivers and specialist beds. The Clinical Service Manager responded that the process for sourcing syringe drivers had changed, so previous problems had been rectified. She said that beds were now provided on the same day due to fast track funding. Non-executive Director (TD) acknowledged the improved situation. In response to a query from Non-executive Director (TD) around signed 'do not resuscitate' forms being transferred when the patient was admitted to hospital, the Clinical Lead for adult services responded that a new process where the electronic form could be accessed and shared by clinicians from the community and acute trusts was being piloted. The Clinical Service Manager said that there were some technical challenges that needed to be overcome for it to work effectively. The Clinical Lead for Adult Services praised the team for the exemplary care delivered across the City. She emphasised to the Committee the positive impact the service had on neighbourhood teams and highlighted how this would continue to develop in the future. She also explained how therapists were undergoing a joint training programme with hospices in the City to provide a whole team response. In response to a query raised by the Chief Executive around the 19% increase in end of life care patient contacts not being reflected in the overall number of neighbourhood team contacts, the Clinical Lead for Adult Services said that end of life care was a small percentage of the overall cohort of patients the neighbourhood teams visited. The Chief Executive acknowledged this and stated that it was important that was captured in the narrative.	

	Non-executive Director (TD) asked what support systems were in place to support staff in delivering emotionally challenging care. The Clinical Service Manager responded that staff could access support from the hospitals and from clinical supervision. She said that it was important staff were involved in other areas of work to provide a break from delivering palliative care, such as education and training and updating policies and guidelines. The Palliative Care Clinical Lead said that debriefing sessions were held in team meetings. In response to a query from the Committee Chair around those end of life patients the Trust were not providing care for, the Clinical Service Manager said they were working with the public health service and were hopeful they were caring for between 40 and 50 percent of patients across the City. In response to a query from the Committee Chair, the Clinical Service Manager said that there had been an increase in identifying end of life patients with long term conditions at an earlier stage. The Palliative Care Clinical Lead said that this had increased with the neighbourhood palliative care leads involvement. The Clinical Lead for Adult Services highlighted that there had been an increase in reporting on Electronic Palliative Care Coordinating System following the mortality review. The Committee Chair asked for an example of a situation that had provided some learning or change in practice. The Clinical Service Manager described a challenging case the team had faced recently and the critical nature of supervision and the importance of debriefing. There had been differences of opinion within the team who were dealing with a very difficult and upsetting situation. The Clinical Lead said that she was assured the team learnt from incidents. The Executive Director of Nursing commended what she described as a complex and crucial service for it's exceptional work. The Committee Chair thanked colleagues for the clear and excellent presentation.	
Performance Brief and Domain Reports		
2018-19 (14)	**Performance brief and domain reports** The Committee reviewed the document and the Executive Director of Nursing highlighted the following for the Committee to note under the safe and caring domains: **Safe domain** The annual target for avoidable category three pressure ulcers was to have no more than 10 and three had been reported in April 2018. There were no avoidable category four pressure ulcers reported in April 2018. There was a discussion around the number of avoidable category 3 pressure ulcers reported in April 2018. The Executive Director of Operations clarified that there were three avoidable category 3 pressure ulcers but only two incidents as one patient had two pressure ulcers. **Caring domain** The Trust had inpatient beds in both specialist and children's business units. The percentage of inpatient respondents recommending care had remained 100% for three months and was rated green. 95.6% of respondents would recommend care in the community. The adult business unit (90.1%) was rated red against a target of 95.0%. Both children's and specialist business units were	

	rated green. **Effective domain** The measures in this domain were reported quarterly so would first appear in the Performance Brief for June 2018. The Committee found the bar chart for this section confusing as it displayed information in thirds, which was inaccurate as there was no measure to display. In response to a point raised by the Committee Chair, the Executive Director of Nursing agreed to provide more narrative around the trends to support the numbers displayed in the 12 month run charts. **Action: Executive Director of Nursing to provide more narrative around the trends to support the numbers displayed in the 12 month run charts.** **Responsive domain** The Trust had performed well in its indicators relating to waiting lists with all rated as green for April 2018. Patient contacts were reported as -11.6% below profile in April and -1.4% below the April 2017 level. The Executive Director of Nursing highlighted that focus would remain on the 18 week waits. The Executive Director of Operations stated that gaps in the medical workforce had impacted on this. She assured the Committee that she was sighted on it and the new appointments into the medical workforce would rectify the situation from June 2018. **Well Led domain** Staff turnover was rated green for April 2018 (13.9%) against a target of 14.5%. Staff leaving the organisation within 12 months (13.0%) was rated as green. Total sickness absence was below the Trust target of 5.8% at 5.4%. Short term sickness (1.9%) and long term sickness (3.5%) were both rated green for April 2018. April had seen a small improvement to 81.9% of staff having an appraisal but remained below the target of 95.0%. The percentage of staff reported as being compliant with the six statutory and mandatory training requirements was reported as 91.4% but remained below the target of 95.0%. **Finance domain** At this early point in the year the Trust was overall in line with the planned financial performance. **Outcome:** The Committee: • Agreed **reasonable assurance** was provided on the safe domain • Agreed **reasonable assurance** was provided on the caring domain	**Executive Director of Nursing**
Quality Governance and Safety		
2018-19 (15a)	**Freedom to Speak Up Guardian** The Trust's Freedom to Speak Up Guardian attended the Committee to present 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. The Freedom to Speak Up Guardian commenced in post in December 2016 and had worked with staff from all three business units and corporate services since that time. Strong support was received from the Chief Executive and the wider Trust. A clear form of work had been established offering a significant contribution to the development of the best culture for the Trust. The Freedom to Speak up Guardian shared with the Committee the themes that had emerged from the work to date and the ways to develop quality assurance. In response to a query from Non-executive Director (TD), the Freedom to Speak Up Guardian stated that evidence to underpin the themes was obtained through communication with staff and management, the friends and family test and staff survey. The Chief Executive emphasised that every concern raised by a member of staff was shared with her by the Freedom to Speak Up Guardian, the majority of staff were happy to be named however, some remained anonymous. There was a discussion around some of the challenges that were presented, and often the issue was that managers were doing difficult jobs, often without the right support, skills and tools to do so. The Chief Executive highlighted that this learning was being fed into the leadership model. The Freedom to Speak Up Guardian highlighted that no concerns around direct patient care had been raised. In response to a query from the Committee Chair, the Chief Executive indicated that there would be further discussion at Trust Board on 25 May 2018. The Freedom to Speak Up Guardian thanked the Committee for support of the role and added that he was open to ideas and suggestions from Committee members. **Outcome:** The Committee: • Noted the report, activity to date and continued to support the embedding of the work across the Trust.	
2018-19 (15b)	**Guardian for Safe Working Hours** The Executive Director of Nursing presented the report, which provided an outline of the issues affecting trainee doctors and dentists in the Trust, including morale, training and working hours. The Executive Director of Nursing highlighted that there had been one exception to report, raised by a paediatric trainee using annual leave to complete administrative tasks, including attending supervision. The Committee noted that from April 2018 there had been regular rota gaps in the CAMHS second on call rota. The Trust was attempting to cover these gaps as locum shifts, using both existing and external workforce. This was part of a longer term plan to develop a 'bank' of suitable doctors, to safeguard against future rota gaps. The Executive Director of Operations assured the Committee that she was	

	confident this issue created no clinically associated risk to the organisation. **Outcome:** The Committee: • Noted the Guardian for Safe Working Hours report.	
2018-19 (15c)	**Director of Nursing quality and safety report** **Clinical Governance exception report** The Executive Director of Nursing presented the report and highlighted that trends remained stable in month with no exceptions to escalate to the Committee. <u>Overdue incidents</u> This month there was a continued focus on overdue incidents, with Morley neighbourhood team reporting 14 overdue records. In response to a point raised by the Committee Chair around the high number, the Clinical Lead for adult services pointed out that the team reported double the amount of incidents compared to similar size teams, and added that the incidents were predominantly low or no harm. <u>Never events</u> There had been no never events reported in April 2018 <u>Safety alerts</u> There were two alerts that had been identified as overdue by the Medicines and Healthcare products Regulatory Agency (MHRA). These dated back to March 2011 and had only been highlighted to the Trust in April 2018. Clarification had been requested from MHRA as to why these alerts had not come to light before April 2018, and if any actions were required. **Action: Executive Director of Nursing to provide an update on the safety alert process.** <u>Duty of Candour</u> The Trust was 80% compliant in April 2018, pending further enquiries into one outstanding case. <u>Infection Prevention Control</u> There were no reported cases of MRSA bacteraemia or C difficile infection assigned to the Trust in April 2018. There had been one case of measles reported. Incident control meetings were continuing to review the ongoing situation. <u>Friends and Family Test (FFT)</u> FFT remained on track. <u>Complaints, concerns, PALS and claims</u> Remained on track with no exceptions to escalate. The Executive Director of Nursing drew the Committee's attention to appendix two of the report which provided an example of the learning tool developed by the Quality Lead for Specialist Services. The Executive Director of Nursing highlighted that the tool had now been launched on Elsie. **Director of Nursing Report** The Executive Director of Nursing provided an update on Hannah House, the	**Executive Director of Nursing**

UNICEF gold standard accreditation visit, caseload complexity in neighbourhood teams, clinical audit and engagement and the pressure ulcer incidence 2017-18 review.

Hannah House

Please refer to private minutes.

UNICEF gold standard accreditation visit

The Executive Director of Nursing reported that following the baby friendly initiative (BFI) gold audit assessment interviews on 8 and 9 May 2018, the team had been provided with some initial positive feedback. The accreditation panel were meeting in July 2018 and an update would be provided to the Committee in due course.

Caseload complexity in neighbourhood teams

The Executive Director of Nursing outlined the ongoing work relating to caseload complexity in neighbourhood teams. She explained that meetings had taken place with both local universities to share the work undertaken to date and discuss the potential for an academic partnership to take this work forward. Both universities were considering this and the shape of any potential offer.

In addition, work was ongoing to meet with Birmingham Community Trust to look at the work they had undertaken and tools they were using.

A number of community trusts were also engaging in early e-mail dialogue in relation to testing a new community currency model. The Trust had expressed interest in joining these early conversations.

Clinical audit and engagement

The Executive Director of Nursing highlighted how the Clinical Audit Team was engaging with services following the learning from the 2017-18 clinical audit plan. She emphasised that this learning had influenced the 2018-19 plan.

Pressure ulcer incidence 2017-18 review

The Executive Director of Nursing outlined the pressure ulcer incidence 2017-18 review for the Committee. Over the last year the Trust had continued to develop and deliver the action plan to reduce the incidence of avoidable pressure ulcers. It was positive to note that over the year there had been a 42.8% decrease in the incidence of avoidable category 3 pressure ulcers. This work continued and would be further developed as the Trust had joined the second wave of the pressure ulcer collaborative.

In response to a query from Non-executive Director (TD), the Executive Director of Nursing said that Leeds Community Healthcare NHS Trust was ahead of other trusts in relation to recording unstageable pressure ulcers. She said that following intense training, staff were now identifying pressure ulcers at a much earlier stage and treating them.

Non-executive Director (TD) asked for assurance that unstageable pressure ulcers were being captured when there was deterioration. The Executive Director of Nursing confirmed that if deterioration of an unstageable pressure ulcer was identified, a separate investigation was carried out.

The Executive Director of Nursing confirmed that no new themes had been identified during the pressure ulcer incidence review. She continued to say that tools and frameworks that were already in place were being reinforced.

The Committee Chair highlighted that the significant reduction in avoidable

	pressure ulcers was encouraging. Non-executive Director (TD) drew the Committee's attention to the year-end target of no more than 10 avoidable pressure ulcers and the three cases that had been reported in April 2018, he expressed the need to be vigilant. **Clinical Leads' quality reports** A summary of the reports appended to the Director of Nursing Report was provided by the Executive Director of Nursing. *Adult services:* • Clinical focus on wound care • CQUIN • Clinical care framework launched at May 2018's Clinical Forum • Changes in the leadership team over the coming months The Clinical Lead for adult services highlighted that Armley neighbourhood team had no avoidable pressure ulcers in seven months. The Chief Executive suggested the Committee Chair write to the team to commend them and suggested an article be added to Community Talk. **Action: Executive Director of Nursing to draft a letter to Armley neighbourhood team from the Committee Chair, to commend them on the seven months with zero avoidable pressure ulcers and provide an article for Community Talk.** *Children's services:* • Hannah House *Specialist services* • Introduction of quality boards to services • Staffing challenges The Executive Director of Nursing informed the Committee that the initial Care Quality Commission and Her Majesty's Inspectorate of Prisons inspection report of Wetherby Young Offenders Institute had been received for factual accuracy. She confirmed that this would be shared at the Quality Committee meeting in July 2018. **Outcome:** The Committee: • Agreed **reasonable assurance** was provided on the pressure ulcer incidence 2017-18 review	**Executive Director of Nursing**
2018-19 (15d)	**Clinical audit plan 2018-19** The Executive Director of Nursing introduced the clinical audit plan 2018-19. The organisation's statutory and contractual requirements for participation in national and local clinical audit had been reviewed and included in the rolling clinical audit programme 2018-19. The Committee noted the programme included outstanding clinical audits from three services; systems were in place to ensure these were included in the 2018-19 plan.	

	There was an approximation that additional clinical audit activity would be required (up to 10%), to allow for high risk, mandatory or other essential audit or re-audit work arising through the year that had not been identified at the time of compiling the annual clinical audit programme 2018-19. The Executive Director of Nursing highlighted that the Clinical Audit and Effectiveness Manager had been engaging with services. The Executive Director of Operations asked that the Clinical Audit Team had regular communication with the business unit senior leadership teams, as some services had enrolled in the 2017-18 programme without the knowledge of the General Manager or Clinical Lead. In response to a query from the Committee Chair about the level of direct and ongoing support the teams would receive, the Executive Director of Nursing confirmed that support would be tailored to each team's needs. The Executive Director of Nursing acknowledged a concern raised by Non-executive Director (TD) around the majority of planned end dates being in March 2019, and suggested that in-year milestones should be set. In response to a query from Non-executive Director (TD) around the monitoring of the plan, the Executive Director of Nursing informed the Committee that progress against the clinical audit programme would be provided to the Clinical Effectiveness Group and quarterly reports would be received at Quality Committee. Non-executive Director (TD) pointed out that there was some inconsistency with the start and end dates. The Executive Director of Nursing stated that those audits could relate to the ones carried over from the 2017-18 programme. The Executive Director of Nursing agreed to check the dates on the clinical audit programme. **Action: Executive Director of Nursing to check the inconsistency in 'start' and 'end' dates on the clinical audit 2018-19 plan.** The Committee Chair asked if there were services within the organisation that had not contributed to the clinical audit programme. The Executive Director of Nursing agreed to review the programme with the clinical leads from the three business units. **Action: Executive Director of Nursing to review the clinical audit 2018-19 plan with the clinical leads from the three business units to establish if there were services within the organisation that had not contributed.** The Committee Chair suggested the quality of some 'could do' actions was variable and suggested the clinical leads review these with their services. **Action: Clinical leads to review the quality of the 'could do' actions with their services.** The Committee Chair queried the number of documentation audits. The Executive Director of Nursing agreed to clarify the numbers.	**Executive Director of Nursing** **Executive Director of Nursing** **Clinical Leads**

	Action: Executive Director of Nursing to clarify the number of documentation audits. In response to a query from the Committee Chair, the Chief Executive confirmed that the comment within the clinical audit plan report, 'benchmarking against other organisations not being advantageous at this time' was a challenge to the programme. **Outcome:** The Committee: • Agreed **reasonable assurance** on the rolling clinical audit programme 2018.	**Executive Director of Nursing**
2018-19 (15e)	**Quality account 2017-18 (update on feedback)** The Executive Director of Nursing introduced the quality account 2017-18 feedback from stakeholders report. The quality account was disseminated to stakeholders on 13 April 2018 for comments in line with the agreed quality account production plan. A response from Healthwatch was received on 11 May 2018 and Leeds Care Commissioning Group (CCG) on 16 May 2018, comments received were included within the report. The CCG were supportive of the 2018-19 quality priorities, which they described as 'strong and strategic'. Both sets of feedback identified that details of patient engagement and involvement was a little bit light. Both also felt that there was not enough information on learning and improvement results and too much emphasis on the learning process. The information would be utilised in the drafting of the 2018-19 quality account. The Trust's formal response to the feedback was being prepared and would be disseminated in due course. Feedback would also be included in Section four of the Quality Account. Final sign off of the Quality Account 2017/18 would take place at Trust Board on 25 May 2018. The Executive Director of Nursing shared some positive informal feedback with the Committee from the Executive Director of Quality at Leeds Clinical Commissioning Group. The Committee Chair acknowledged the positive feedback that had been received overall, and emphasised that the focus for 2018-19 should include evidence of outcomes and patient engagement. **Outcome:** The Committee • Received the report • Noted the feedback from Healthwatch and Leeds CCG	
2018-19 (15f)	**Quality Challenge+ annual update and NED visits** The Executive Director of Nursing presented the report which summarised the findings from the Quality Challenge+ process in 2017-18, including what could have gone better and how the learning from this had influenced the Quality Challenge+ 2018-19. The Executive Director of Nursing reported that 17 services did not have a quality visit, and therefore the goal of 'every service having a visit in 2017/18' was not met. Factors for this included a reduced number of available visitors and	

	late cancellation of visits due to clinical demands of the visitors or the service. The issue was escalated to clinical leads and the Executive Director of Nursing. Following this escalation additional visitors had been recruited and a development programme organised. The Executive Director of Nursing highlighted that the quality visit provided an opportunity for services to describe what had been done as a result of the Quality Challenge+, which was included in the formal feedback report. Additionally, 'impact from improvements' were identified through posters submitted by services describing at least one improvement as part of the Quality Challenge+. All posters were available for staff on ELSIE and displayed at Stockdale House. In response to a query from the Committee Chair, the Executive Director of Nursing confirmed that Quality Challenge+ visitors were not just senior staff, and that staff from all levels and services were encouraged to join the programme and become a 'visitor'. She added that the taking part in Quality Challenge+ visits provided good learning opportunities for staff. The General Manager and Clinical Lead for Children's Services proposed that service users be included in the visits and added that although this was not current practice, it could be a consideration for future visits. There was a discussion around the need for clarity on what assurance the Quality Challenge+ provided. The Chief Executive provided an example of one team that had significant cultural issues, however all Quality Challenge+ indicators presented the team as 'good'. She added that although Quality Challenge+ was an important form of assurance, it only offered the organisation partial assurance. The Clinical Lead for Adult Services agreed with this statement and said that the evidence needed to be triangulated with other information. The Committee Chair suggested the approach could be varied slightly to focus on the cultural strength of the organisation. The Executive Director of Nursing highlighted that Quality Challenge+ would be used as one framework for Non-executive Director visits and added that there would be further discussions with the Trust Chair at Board on 25 May 2018. The Committee Chair had agreed to join the Quality Challenge+ visit to Hannah House on 6 June 2018. **Outcome:** The Committee • Noted the information in the report and the changes being planned for Quality Challenge+ 2018-19	
2018-19 (15g)	**CQC Quality improvement plan** The Executive Director of Nursing introduced the report which outlined progress on the 'must do' and 'should do' actions set out in the Trust's quality improvement (QIP) action plan in response to the Care Quality Commission's inspection visit reports. The Trust had eight 'must-do' actions. Hannah House had completed all five 'must-do' actions. Little Woodhouse Hall would complete one 'must-do' action by 31 May 2018 and the other by 29 June 2018. Leeds Sexual Health would complete its 'must-do' action by 29 June 2018. The Trust had 37 'should-do' actions, of which 33 were complete. By 31 May 2018 36 actions would be complete: the final action was scheduled to complete by 29 June 2018. The Committee noted that the all outstanding actions would be completed by 29	

	June 2018 and it was agreed the QIP would be presented to Quality Committee at the July 2018 meeting for sign off. **Outcome:** The Committee: • Agreed **reasonable assurance against** progress, actions completed and the time-frames for completing outstanding actions • Agreed to receive a final report in July 2018 on QIP completion	
2018-19 (15h)	**Risk Register** The Interim Company Secretary introduced the report which outlined risk movement amongst risks scored at eight or above, since the last report in April 2018. The Committee noted there were four new risks, of which one was classed as 'extreme'; one risk with a decreased score and one risk closed since the last report. <u>Risk 940 risk of delays to new CAMHS tier 4 service model</u> In response to a query from Non-executive Director (TD), the Chief Executive highlighted that the risk was primarily a business risk and would be discussed at Business Committee on 23 May 2018. **Outcome:** The Committee: • Noted the recent revisions made to the risk register	
2018-19 (15i)	**Board Assurance Framework 2018/19** The Interim Company Secretary introduced the report which provided the Committee with details of the revised Board Assurance Framework (BAF) 2018-19 and the responsibilities of the committees and the Board. The Interim Company Secretary asked the Committee to note the sources of assurance listed and evaluate whether the strategic risks assigned to the Committee were being managed. <u>Strategic 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</u> In response to a query from the Committee Chair around what more could be done to manage the risk, the Chief Executive explained that a great deal of work was going on across the organisation with regards to patient and public engagement, however, agreed that more evidence needed to be presented to the Committee. The Executive Director of Operations suggested the quarterly business unit reports incorporate a section on key highlights around patient engagement. The Chief Executive proposed that 'how services engage with patients' should form part of the service spotlight presentations. The Executive Director of Nursing pointed out that each business unit had their three patient engagement priorities. Non-executive director (TD) declared that patient engagement needed to have a higher profile in the 2018-19 quality account. **Action: Senior Management Team to discuss how patient engagement**	**Executive**

	could be evidenced. An update to be provided to Quality Committee at the July 2018 meeting. **Outcome:** The Committee: • Noted the revised BAF 2018/19 and the strategic risks assigned to the Quality Committee • Noted the controls and sources of assurance for these strategic risks	**Director of Nursing**
Clinical Effectiveness		
2018-19 (16a)	**Patient group directions** The Executive Director of Nursing confirmed that the patient group directions (PGDs) had been through the correct processes and recommended all for ratification. **Outcome:** The Committee ratified the five approved PGDs • 064-08 Administration of Mebeverine 135mg Tablets • 061-09 Administration of Domperidone 10mg Tablets • 089-06 Administration of Prochlorperazine 5mg Tablets • 110-03 Administration of GTN Spray • 107-04 Administration of Inhaled Salbutamol	
2018-19 (16b)	**Outcome measures** The Executive Director of Nursing outlined the programme of work that had been undertaken in 2017 relating to outcome measures and explained that the Project Manager who had been appointed to progress this work had been on sick leave for some time. She continued to say that there would be a discussion at Senior Management Team meeting to agree how this work would be taken forward. The Committee remained concerned over the lack of progress with the outcome measures process. The Committee Chair said that it appeared a number of services had clear plans on individual outcomes; however there appeared to be less clarity on the Trust as a whole and how it wanted to approach outcome measures and the broader contribution to public health outcomes. He agreed that this should be discussed in more detail by the Senior Management Team. The Clinical Lead for Adult Services assured the Committee that patient reported and clinical reported outcome measures were captured. The Chief Executive accepted that these were not well presented to the Committee and would consider how presentation could be improved. There was a discussion around the timeframe for an update to be presented to the Committee. The Chief Executive reported that the Interim Medical Director would not be in post until August 2018 and suggested that the update be provided to the September 2018 meeting to allow the new director to have some contribution.	

	The Executive Director of Nursing agreed to include outcome measures as part of the revised service spotlight presentation template, as an interim measure. The General Manager and Clinical Lead for Children's services indicated that outcome measures would be included in June 2018's workshop. **Action: Chief Executive agreed an update on outcome measures would be provided to the Committee at the September 2018 meeting.** **Action: Executive Director of Nursing to include outcome measures as part of the revised service spotlight presentation template.** **Outcome:** The Committee: • Agreed **limited assurance** on outcome measures	**Executive Director of Nursing** **Executive Director of Nursing**
2018-19 (16c)	**Internal audit reports** The Interim Company Secretary presented the report which provided a summary of the outcomes from the completed internal audit reports, where the report related directly to the role and functions of the Quality Committee. The paper covered the completed audits from the 2017/18 plan and the audit opinion related to 'safeguarding children', 'CQC compliance' and 'focus on falls' reports. The Committee noted that all three audits received reasonable assurance. In response to a query from Non-Executive Director (TD), the Interim Company Secretary confirmed that all three audit reports would be presented to Audit Committee on 23 May 2018. **Outcome:** The Committee: • Noted the audits completed as part of the approved 2017/18 plan	
Reports and minutes for approval and noting		
2018-19 (17a)	**Clinical Effectiveness Group: draft minutes: 19 April 2018** The Executive Director of Nursing highlighted key items to the Committee: • The 2018/19 work plan had been reviewed and agreed by CEG members. Six meetings would be supplemented by six workshops throughout the year. Four of the meetings would focus on reviewing quarterly flash reports from each workstream. The other two meetings would feature a deep dive into one or more key areas of effectiveness. The six workshops would be opened up to key operational and clinical staff to provide wider engagement in the CEG agenda. • The impact of GDPR on clinical audit was discussed by the group. The Information Governance Manager would attend the June CEG meeting to discuss possible implications and agree a way forward.	

	Outcome: The Committee: • Received the draft minutes	
2018-19 (17b)	**Patient Safety and Experience Governance Group: draft minutes: 26 April 2018** The Executive Director of Nursing highlighted key items to the Committee: • Further review of minutes required as draft one • Workshops to be finalised for the year – key areas agreed • Terms of Reference to be reviewed at the next meeting **Outcome:** The Committee: • Received the draft minutes	
2018-19 (17c)	**Safeguarding Committee: draft minutes: 12 April 2018** The Executive Director of Nursing highlighted key items to the Quality Committee: • The workshop highlighted learning from safeguarding audits undertaken over the last year and how the learning could be shared more widely • Activity remained busy in terms of serious case reviews and domestic homicide reviews • The Safeguarding Committee received the first draft of the 18/19 work plan and commented on this to inform the next draft • Internal audit had completed a review with the service and concluded reasonable assurance The Quality Committee Chair highlighted the number of apologies received and suggested a review of membership should this continue. **Outcome:** The Quality Committee: • Received the draft minutes	
2018-19 (18a)	**Quality Committee future work plan** The draft 'new format' future work plan was received for information. The first workshop would be held in June 2018 and would focus on the children's business unit and mortality review. The Interim Company Secretary requested that all responsible directors review the work plan and provide their report authors with the amended report due dates. The Interim Company Secretary requested that any suggested topics for the focus based workshops be forwarded to the Executive Director of Nursing. **Action: Any suggested topics for the focus based workshops to be forwarded to the Executive Director of Nursing.** The Committee Chair suggested it would be a good opportunity to include patient experience.	**Committee members**
2018-19 (19)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair would provide an update to the Board at	

	the meeting on 25 May 2018. Items to be reported include: • Service spotlight: End of Life Care Service • Performance brief and domain reports: safe and caring and domains • Clinical audit • Quality Account 2017-18 • Quality Challenge+ • Quality Improvement Plan • Outcome measures update Assurance levels: • Performance Brief: o Safe: reasonable o Caring: reasonable • Director of Nursing Report: o Pressure ulcer incidence 2017-18 review: reasonable • Clinical audit: reasonable • Quality Improvement Plan: reasonable • Outcome measures update: limited	
2018-19 (20)	**Any other business** The Executive Director of Operations reported that the invitation to tender for the 0-19 service had been received by the Trust on 18 May 2018 with a submission deadline of 13 June 2018. The Executive Director of Operations invited the Non-executive Directors to join the Quality Impact Assessment (QIA) meetings. The Executive Director of Nursing agreed to share the meeting dates with the Non-executive Directors. **Action: Executive Director of Nursing to share the QIA meeting dates with Non-executive Directors.** The Executive Director of Operations highlighted that there would be the opportunity to discuss in more detail at Trust Board on 25 May 2018. Nicola Wood has provided administrative support to Quality Committee over the last year, to cover Lisa Rollitt who has been on maternity leave. Lisa is returning to work and will recommence supporting the Quality Committee from June 2018. The Committee recognises and appreciates Nicola's hard work and diligence over the last year.	**Executive Director of Nursing**
	Dates and times of next meetings (09:30 – 12:30) Monday 25 June 2018 Monday 23 July 2018 Monday 24 September 2018	

Leeds Community Healthcare NHS Trust

Agenda Item 2018-19 (40ci)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 25 April 2018 (9.00am – 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
	Sam Prince	Executive Director of Operations
Attendance:	Ann Hobson	Interim Director of Workforce
	Ann McGee	Head of Organisational Development & Improvement (in attendance for item 02c)
	Anita Simey	EPR Project Manager (in attendance for item 02c)
	Caroline Schonrock	Business Planning Manager (in attendance for item 04)
	Dan Barnett	Head of Business Development (in attendance for 03a)
	Diane Allison	Interim Company Secretary
	Megan Rowlands	GM for Adult Business Unit (in attendance for item 02c)
	Nicola Wolstenholme	Business Manager for Childrens Services (in attendance for item 03b)
Apologies:	Thea Stein	Chief Executive
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(01)**	The Chair welcomed everyone to the meeting. **01a - Apologies**: As above. **01b - Declarations of Interest**: None recorded. **01c - Minutes of last meeting:** The public and private minutes of the meeting dated 16 March 2018 were approved by the Committee subject to a minor amendment to item (97a) under well led paragraph; 'A Non-Executive Director (TD) noted that the three main domains for the clinical audit effectiveness had a disparity between clinical ~~outcome~~ audit in the summary cover paper rated as green and amber in the report'. **01d – Matters arising from the minutes and review of actions:** 97b – *Productivity group remit*: The productivity programme group (PPG) meeting had been arranged for 1 May 2018 to discuss the remit, aspects of productivity and opportunity for efficiency. The Chair said he was looking forward to understanding the remit, scope, potential delivery and feedback arrangements to the Business Committee in terms of the governance	

	structure. **Action:** An update to be provided to the next Business Committee meeting in May 2018 on the Productivity Group's remit, terms of reference and progress made with a dashboard development. **01d(i) - General Data Protection Regulation (GDPR)** The Executive Director of Finance & Resources presented an overview of progress on the actions taken in preparation for GDPR which comes into force on 25 May 2018. A detailed paper and action plan was also submitted to the Audit Committee meeting on 20 April 2018. The Executive Director of Finance & Resources said that the new Head of Information Governance made her priority to visit services to inform them of the responsibility assigned to the Trust, a requirement to be ready for GDPR, and individuals identified in services to become asset information owners. A Non-Executive Director (RG) said that the Audit Committee had been reasonably assured that a process was in place to measure against the criteria. Compliance was to be monitored by the Audit Committee through the information governance group meetings. The Executive Director of Finance & Resources said that the Audit Committee's remit is to assure itself that the systems and processes were in place in the organisation and had taken significant interest in information governance, especially in terms of cyber security. The Chair said that if the Business Committee was responsible for overseeing and monitoring of GDPR on a regular basis he would want to see an update on progress against the commitments. He said, however, if the brief progress report received had already been circulated to the Audit Committee for monitoring purposes he would welcome seeing the report for the Business Committee to note. A Non-Executive Director (TD) asked about employee data and personal information; issues with data on electronic staff record system, whether the functionality of data handling and protection was linked to GDPR. The Interim Director of Workforce said that a piece of work was underway to map out information from candidates who may join the Trust right through to individuals being employed. Safeguards were being put in place and national advice was being sought. **01d(ii) - Business Committee's effectiveness** The Chair confirmed the discussion the Committee had at its previous meeting about the shape and focus of work around the Business Committee. The Committee agreed the following: • To have presentations about business and issues within the organisation, and targeting areas of concern and risk. • Overarching report covering all the big projects. • Balance between strategic and operational representation was to continue as before. • Reports from the productivity programme group capturing some of the achievements in terms of productivity. • The Executive Director of Operations to become a substantive member of the Business Committee. • For the new Directors of Workforce to join the Committee meeting.	BM

	The Executive Director of Operations said that she wished to propose to invite services with enduring issues and difficulties rather than simply having a service demonstrating its achievements. **Action:** The Executive Director of Operations to provide a short list of such services for future service presentations to the Committee. **Outcome:** Services with enduring issues will be invited to future Committee meetings.	SP
2018/19 **(02)**	**Project management** **02a - Projects' highlight reports (administration review)** The Executive Director of Operations was pleased to advise the Committee that the administration review project was progressing to plan. The team was working through suggested templates and framework proposal from a Non-Executive Director (RG). The Executive Director of Operations said that the project team had been engaging with different parts of the organisation to create a template that everyone worked towards; migrating individual services into a central system in a planned way to be more effective. **02b - E-rostering business case** The Executive Director of Finance & Resources introduced a report outlining the business case. The Committee was asked to consider the report and to review the e-rostering business case to support the procurement of the system. The Executive Director of Finance & Resources said that a competitive tender was not necessary when going through a framework process. The Chair asked for a brief update on the evidence of the framework process. The Interim Director of Workforce visited Derbyshire Community Trust to view the e-rostering system in operation. The Committee was informed that the project board had some issues to raise with the preferred supplier at a meeting in early May 2018 and a site visit to Lancashire Community Trust. The Executive Director of Finance & Resources said that to completely assure the Trust those issues had to be considered. The Interim Director of Workforce said that Derbyshire Community Trust was the first Trust that had used the preferred system. They have had the system for 5 years and recently extended the contract for another year. The sickness absence module had not been used. The system was essentially being used for rota purposes. The Executive Director of Finance & Resources said that a decision had not been reached for the core requirement of the e-rostering system beneficial to the services. However, a stepped approach would be taken where the benefits will justify the investment. The Executive Director of Finance & Resources said that pending those additional questions, he would like to ask the Committee for approval of the business case at today's meeting. As the Committee had only received the business case the day before the meeting, it felt unable to approve it. The Committee members were asked to provide the Executive Director of Finance and Resources with feedback within the next week.	

	A number of the Committee's questions would be addressed in a project initiation document which would be expected to follow approval of a business case. In his summary, the Chair said the PID would be reviewed in terms of the plan and time frame, to support approval of the business case. **Action:** The business case to be presented at the next meeting in May 2018 including elements of a project initiation document. A brief paper was requested to evidence the framework process. **Outcome:** The committee received an update report on the renewed e-rostering project and asked to comment. **02c - Electronic patient record update (EPR) - presentation** The Committee received a presentation from members of the EPR project team. The project team described the progress to date, and benefits realisation to both patients and staff. The Chair thanked the EPR team for their presentation, especially in terms of the examples and descriptions provided, focusing on progress and plan and benefits. The Chair said that the progress to date left the Committee with a substantial level of assurance about the project and a much more meaningful understanding of the benefits. **02d - Proposed reporting mechanism for project management** The Committee was informed of the newly formed 'Change Board' meeting which had been established to oversee the projects, but had not convened its first meeting. The Committee supported a proposal to revise the format of project reports. In future the Committee would receive an overview report of all principal change projects from the Executive Director of Finance and Resources, which would highlight risks, issues, milestones, the current financial position and any inter-related issues across projects. The Executive Director of Finance & Resources said that he proposed to report to the Business Committee by means of an overview report of all projects rather than the Committee receiving highlight reports for each individual project in isolation. A Non-Executive Director (RG) said that it would be important to have a summary report of the individual projects with some of the detailed flash reports with a dashboard showing the total picture of achievements, milestones and risks. He said he was happy to share some of his templates and summary dashboards. **Action:** The Executive Director of Finance & Resources to devise a project summary report for presentation at the June 2018 meeting. **Outcome:** The Committee supported the proposal to revise the format of project reports and will receive the remit of the change board, a dashboard and terms of reference.	BM BM

2018/19 **(03)**	**Business and commercial developments** (Please see private minutes) **03a** – **Business development strategy update (quarterly)** **03b** - **Community sickle cell and thalassemia service** **03c - Neighbourhood team support for patients in residential homes**	
2018/19 **(04)**	**Business planning** Operational plan 2017/18 (year-end) The Executive Director of Finance & Resources presented the year-end overview of the 2017/18 organisational priorities and success measures as approved by the Senior Management Team (SMT). The Committee was advised that SMT had considered the reasons for those priorities not being achieved. The Executive Director of Finance & Resources said that SMT were content with the review which would subsequently go to the Trust Board. He said one reason for some of the amber ratings was that the report reflected the timescales for achievement set out at the beginning of the year, not the revision of dates made in-year. The Chair suggested that in future it would be useful if in year timeline changes could be accounted for, with proper authority, so that real time events which had caused delay might be better reported on. Some work needs to be done on any process around this. It should in the first instance come back to the Business Committee, with a view to building into 2018/19 arrangements. **Outcome** The Committee recommended that in future the appropriate committee should be approached and a case made for any requests for revised timescales.	
2018/19 **(05)**	**Performance management** **05a - Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports. The report provided a high level summary of performance within the Trust during March 2018, indicating reasonably good performance. Safe, caring and effective domains were discussed at the Quality Committee in detail on 23 April 2018. Main issues considered by the Committee were as follows: *Safe* - The Trust had achieved most of its targets within the safe domain for the year. Three avoidable category four pressure ulcers had been recorded in the year. The percentage of venous thromboembolism risk assessments were rated red as it was below the target of 95%. *Caring* - All indicators were rated green at year end. *Effective* - The number of Clinical Audits completed in the year was 76. *Responsive* - It was recognised that there were no excessive waits and no complaints and there was good provision of care, all rated as green for March 2018.	

	Well Led - Sickness absence rate continued on a downward trend from January 2018. The Committee recognised that there were a number of measures in place to improve this. The Committee heard that it was difficult to analyse specific attributes and the reduction in activity levels to specific improvements in operational delivery. The Chief Executive had set the executive team a challenge to understand and evidence the reduction in activity levels. The Committee agreed that work was needed to make the case with more conviction. The Chair referred to previous conversation about the possibility of an independent review that could be more convincing with Commissioners. The Executive Director of Finance & Resources said that the executives had taken the view that no more analytical data analysis was necessary in terms of independent review. The quality impact assessment work would be evidence based. In response to a Non-Executive Director (RG) about next steps of sickness reduction initiatives and about independent review of root causes, the Interim Director of Workforce said that a number of work streams were coming together over the next few weeks, looking at compliance with policy, promoting health and wellbeing and support offered to staff. It was noted that an external independent support was being considered. The view of SMT was to pause that until the new directors of workforce were in post. The Chair noted that there was no target set for Workforce Race Equality Standard (WRES) which was important for the Trust. The Interim Director of Workforce said that she would be reporting it in the quarterly workforce report as there was no nationally set target to measure. A project officer had been employed, and a staff network group set up to help form some of the direction of increasing BME representative in the Trust. The Interim Director of Workforce said that in the next quarterly workforce report following completion of some of the work she may be in a position to provide a more appropriate measure. The Chair believed this to be major omission, particularly as such had been in place over previous years. There was a danger that it could signal a relegation of the importance of this issue which he believed was quite unacceptable. He asked for some reconsideration on this matter. **Action:** The Interim Director of Workforce to invite 'black, Asian and minority ethnic (BAME) project officer to attend Business Committee meeting in three months' time in July 2018 to update on progress against WRES after the outcome of further initiatives. The Chair asked to reconsider adding a WRES element into the performance pack. **Outcome:** The Committee noted the levels of performance and, where appropriate, improvements across areas of challenge. **Finance** The Executive Director of Finance & Resources said that the Trust's financial performance remained strong overall. Recurrent cost improvement plan delivery continued to be a concern as it impacted on the underlying position. He said this would be addressed through the financial planning for 2018/19.	AH

The Executive Director of Finance & Resources tabled a paper to advise the Committee of the last minute finance national adjustments. A further £150k of the commissioning for quality and innovation risk reserve had been released into the surplus position. Following discussions with NHS Improvement this had been matched by additional incentive for sustainability and transformation funding income bringing the adjusted surplus to £3.338m for the year, and the control total exceeding by £1.6m.

The forecast outturn position demonstrated that the Trust achieved the control total set by NHS Improvement subject to audit. Year-end accounts had been submitted on 24 April to deadline.

05b - Workforce quarterly report / Organisational Development (OD) Strategy update

The Interim Director of Workforce presented the quarterly report covering period January to March 2018. The report had been split into three sections; up to date workforce OD strategy, associated work undertaken within the wider workforce directorate and appendices for the well-led section to enhance the performance report.

Key points noted as follows:

- Work around creating and developing leadership capability. The 'Manager as Coach Programme' continued; the next cohort was due to start in April 2018.
- Work around creating a culture of 'better conversation' linked to health coaching.
- The Trust had received £300k per annum for a three year period from the improved better care fund. Conversations had taken place with the Academic Health Science Network to support with the research and evaluation of the project with a provisional offer of £25k.
- Leeds Beckett University had been commissioned to undertake an evaluation of four health coaching streams delivered across Leeds and the summary of key findings were outlined in the report.

It was acknowledged at a previous Business Committee meeting that consideration be given to an appropriate key performance indicator to measure the timeliness of the recruitment service. The Interim Director of Workforce said that there were no national targets to streamline the processes. She said a significant piece of work was coming together around the NHS Improvement retention plan which was progressing. A range of organisational change initiatives were being considered; looking at streamlining, change in corporate induction, kit or uniform to be ready for the first day, etc.

The Chair said he would welcome serious consideration of actions taken to get the right people in, and to retain them.

Outcome:

The workforce report provided the Committee with a helpful update on a range of issues. Recruitment remained a concern; however the Committee was assured that plans were being put in place to remedy that.

05c - Triangulating quality, staffing and finance

The Committee received a report on triangulating quality, staffing and finance and noted that the Trust had developed a wide range of quality indicators and processes that offered assurance that there had not been a detrimental impact

	on patient care during the winter period. **Outcome:** The Committee received the report. **05d - Waiting times for assessment for autistic spectrum conditions** The report provided an overview of the Trust's position on waiting times for child and adolescent mental health service including assessment for autistic spectrum conditions. The Executive Director of Operations said that there had been a steady progress in recovering the consultation clinic waits and good progress around freeing up capacity and setting standards. The Executive Director of Operations said that the Quality Committee meeting on 23 April received an audit report setting out how the Trust was responding to waiting times target, and rated as limited assurance. The audit had been completed in February 2018 and at that time the average contact per day was two; 70% of practitioners were now working to target. The Executive Director of Operations said that she was confident that clinical staff will be seeing the required number of patients when new ways of working is fully operational. **Outcome:** The Committee received the update on waiting times within the CAMHS service. **05e - Operational and non-clinical risks register 8+** The Interim Company Secretary introduced the risk register. The report provided a description of risk movement since the last risk register report received by the Committee in March 2018. The summary report showed changes to note as follows: Risk 932: short term lack of leadership capacity in community CAMHS Risk 917: staff capacity issues in adult dietetics Two extreme risks on the Trust's risk register (scoring 15 or more): sickness absence across the organisation and neighbourhood team recruitment and retention. **Outcome:** The Committee noted the recent revisions made to the risk register. **05f - Internal audit reports:** The report provided a summary of the outcomes from completed internal audits where the reports related directly to the role and functions of the Business Committee. The Interim Company Secretary said that each of the reports had been considered by the Audit Committee. The Committee noted the outcome of the internal audit reports listed below: (i) Review of corporate governance (ii) Review of cybercrime security incident response (iii) Review of payroll (iv) Adel Beck secure children's home and HM YOI contract management **Outcome:**	

	The Committee noted the content of the internal audit reports.	
2018/19 **(06)**	**Minutes for noting** Contract management board: 17 November 2017 The Committee received the Contract Management Board minutes.	
2018/19 **(07)**	**Business Committee work plan** The work plan was reviewed by the Committee and no changes were requested.	
2018/19 **(08)**	**Matters for the Board and other Committees** • Reflection on 3 projects: e-rostering, electronic patient record and administration review • Project management • Business and commercial development update • Operational plan 2017/18 year-end report • Activity levels linked to triangulation work • Sickness absence • Finance - reflecting on good story for end of year 2017/18 • Workforce quarterly report	
2018/19 **(09)**	**Any other business** None discussed.	

Leeds Community Healthcare NHS Trust

Agenda Item 2018-19 (40cii)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 23 May 2018 (10.00am – 1.00 pm)

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
	Sam Prince	Executive Director of Operations
Attendance:	Ann Hobson	Interim Director of Workforce
	Diane Allison	Interim Company Secretary
	Samantha Donaldson	Admin Review Project Manager (for item 12c only)
	Catherine Scott	Administration Services Manager (for item 12c only)
	Marie Hoddell	Admin Review Project Support Officer (for item 12c only)
	Richard Slough	Assistant Director Business Intelligence, Systems & IT (for item 13 only)
Observer:	Megan Rowlands	General Manager for Adult Business Unit
Apologies:	None	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(10)**	The Chair welcomed everyone to the meeting. **10a - Apologies**: None recorded. **10b - Declarations of Interest**: None recorded. **10c - Minutes of last meeting** The public and private minutes of the meeting dated 23 April 2018 were approved by the Committee subject to a minor amendment to item (05a) to change WRES project officer to BAME project officer. **10d – Matters arising from the minutes and review of actions** No further actions were noted; all actions on the action log due for completion by May 2018 were completed. **10d(i) – Community sickle cell and thalassemia service update** (Please see private minutes) **10d(ii) – Productivity Programme Group update** The Committee received a verbal update on the activities of the Productivity	

	Programme Group (PPG). The Executive Director of Finance & Resources said that since the last Committee meeting in April 2018 two meetings had taken place; PPG and Change Board. He said in terms of PPG it had been agreed to engage more people in that agenda and to re-name the group to make the links to productivity and efficiencies. The Executive Director of Operations suggested that 'understanding variation' was an appropriate working title. The discussion at the PPG meeting were based on having a better perspective on the benchmarking data available and targeting some of the attention to the high reference cost services, and on other areas which could lead to efficiencies and improved productivity, for example, an understanding of DNA's, and timescales between first and follow-up appointments were all important aspects of productivity. The Executive Director of Finance & Resources said that the initial work programme had not yet been finalised and he would report back in greater detail at the next meeting in June 2018. A Non-Executive Director (RG) asked about the 'Carter review' and whether the Trust was in regular contact in order to make use of toolkits and benchmarking data. The Executive Director of Finance & Resources said that the initial Carter cohort work had just been concluded and the report on community services depended on national timescales and release dates. It was noted that the initial work did not include the benchmarking data that the Trust had put forward because community services work was different to district nurses. **Outcome:** The Committee was encouraged by the proposed programme in its early stages. **Action:** An update on the PPG to be provided at the next meeting in June 2018.	BM
2018/19 **(11)**	**Service area focus** Future services presentations The Executive Director of Operations tabled a paper about future service area focus for consideration by the Committee. She said that one area was where there was enduring performance or cultural issues of sustained failure of 18 weeks target. A number of work streams were being introduced to improve outcomes and also looking at associated business issues. The Executive Director of Operations said that the other area was around any service that had a number of adverse indicators that came together simultaneously. The Executive Director of Operations also provided a proposed list of expectations for the services: clearly presenting and outlining the issues, actions and remedies with outcomes before seeking the support of the Committee. A Non-Executive Director (RG) said that priority should be given to those programmes that had low delivery confidence rating. The Chief Executive felt that the issues and concerns of performance within services would be better discussed and supported at the senior management team level. SMT could then bring themes to the Business Committee. The	

	Executive Director of Operations said that the Committee had been looking for a more constructive conversation, exposure to services and to have a more useful conversation both for the Committee members and also the services. The Chair said that the outcome of Committee members' recent evaluation of its work and remit was that the regular service presentations felt reasonably encouraging but routine, providing an overview of the service, describing challenges and achievements and future business trajectory. The Committee was looking for a more constructive engagement that could be useful for the business, whilst sharing some of the difficulties, propositions and missed targets in the interest of providing support and advice. **Outcome:** The Committee agreed the means of identifying future service area focus for consideration by the Committee. **Action:** The Executive Director of Operations was asked to produce a timetable of the first services for the Committee, for the meeting in June 2018.	SP
2018/19 **(12)**	**Project management** **12a – Future programme arrangements** The Committee received an update on the newly formed 'Change Board'. The Change Board proposed to provide the Committee with an oversight report, which would focus on high level assessment of how the four key projects were progressing; electronic patient record, estates rationalisation, patient administration review and e-rostering. The Executive Director of Finance & Resources said that the Committee would receive a consolidated projects report in future and a snap shot of the dashboard for each of the projects. It was agreed, as suggested by SMT that the report would show inter-relationships, direction of travel and future vision of the organisation for staff delivering services. **Outcome:** The Committee noted the development of the Change Board programme and agreed to receive an overarching report on a bi-monthly basis. It was agreed that the six monthly deep dives into the individual projects would continue. **Action:** Work plan to be amended to show new reporting arrangements for Change Board programme **12b - E-rostering business case** The business case for e-rostering had previously been submitted to the Committee in April 2018. The Committee had asked for clarification on some of the issues that followed a site visit. There had been a further meeting with the supplier and a further site visit to a different NHS Trust to gain assurance on the outstanding questions. As a result of a further meeting with the supplier and a site visit to Lancashire with a Non-Executive Director (RG), the Executive Director of Finance & Resources was now confident to recommend to the Committee the approval of the business case to initiate the procurement of the health e-rostering system.	RL

	The Interim Director of Workforce said that she had much more assurance of the range of benefits to the services in terms of in depth understanding of the system as well as its limitations. The Executive Director of Finance & Resources said that the scope of the project was to implement the core e-rostering of staff working in police custody, the staff bank and the neighbourhood teams. The number of licenses would depend on the consideration of best value judgement. It was noted that further discussions would take place at SMT on 23 May 2018 in respect of line managing e-rostering implementation, support officers and e-rostering support system. In response to the Chair's question about capability and management, the Interim Director of Workforce said that she was looking into internal secondments to build the team up, keeping knowledge and momentum going forward. The supplier would be working with the project team until the system was up and running using a 'train the trainer' approach. A Non-Executive Director (RG) added that, in terms of staffing it was complicated; it needed to be set up for success and tracking correctly. He said that the application of solutions architecture needed to be considered, a web of different applications talking to each other to manage the emerging technical design and sharing multiple types of programmes. The Chief Executive said the issues about application; systems and architecture were important and helpful for the city in order that systems could communicate with each other. The Chair said that on the basis of today's conversation he and the Committee were more assured on the supplier, the change process, the Trust commitment and the finances. The Committee had a positive conversation about staffing and the complexities of bringing some of that work together to be a success. The Business Committee asked to be updated on a regular basis as the work progressed. **Outcome:** The Committee accepted the recommendations and approved the business case to initiate the procurement of the e-rostering system. **12c – Patient administration update (presentation)** The project team provided the Committee with an overview of the development of the patient administration function for the Trust. An efficient way of managing the patient journey from referral to discharge across the services. The team provided an update on the current stage of the project, particularly around staff engagement, in the form of workshops and engagement events, for essential feedback to shape the new service. The Committee heard that the biggest concern from staff was about possible 'de-banding' of paygrade and possible relocation. A business support network was being created to engage champions within the three business units to update staff on the progress of the project and to drive the project forward. A Non-Executive Director (RG) said that the design is often influenced by how the system is used because of the functionality within systems. He was conscious that lots of administration areas do not use SystmOne created locally. The project manager responded that, based on the skills matrix, a scoping exercise had been completed to identify different systems and	

	information so that demand and capacity auditing could be undertaken to understand which system was supporting which task and bringing systems together across each of the services. The Chair thanked the project team for an update on the essential administrative support to clinical teams and management. He was pleased to note that the project was on schedule, with no hidden costs emerging and recognised the valuable support the project team had received from the top team and from Non-Executive Director (RG). The team was invited back for a further update in November 2018.	
2018/19 **(13)**	**Strategy development and implementation** **Digital strategy update** The Assistant Director of Business Intelligence provided an update on the digital strategy and implementation plan. There had been a number of new strategic priorities which had arisen since the digital strategy was adopted by the Trust Board in June 2017, and which could impact on the Trust's strategy. One such priority was an NHS England plan to invest £7.5m in up to five localities nationally to integrate digital health and care records. The Trust was aligned to a bid for some of this funding within a group of trusts in the Yorkshire and Humber region. Another priority was the Trust's involvement with the West Yorkshire and Harrogate 'STP's' digital and interoperability work stream. It was suggested that the Board should consider the city-wide implications of digital priorities in a future Board workshop. The key points of progress against the implementation plan were highlighted: • Good progress had been made since last report on the performance information portal (PIP). • There was an increased amount of digital record through the EPR project. • Another penetration test had been completed on the network to identify any weakness and vulnerabilities. • All business continuity plans had been tested and improved in the last year in respect of cyber incidents. The Assistant Director of Business Intelligence said electronic transfer of care was linked to e-referrals and more work was needed to consider the business benefits to roll out further into services. In terms of single sign-on for all staff, an action from the original strategy had been delayed due to the move to "Shared Data Centre Project" infrastructure. The delayed area rated 'red' was noted for public access to Wi-Fi: The Assistant Director of Business Intelligence said that since submitting the paper the Trust had been allocated £127k of public dividend capital from the Department of Health to progress this work. There were specific requirements in the new information governance tool kit that may have an impact on appropriate training. The E-rostering project was approaching a critical stage after re-starting in regard to the definition of the scope and timescales and deployment out to services. The Assistant Director of Business Intelligence confirmed that the important thing was to make sure there was the right governance in place to allow	

	information to be shared more broadly and securely throughout the health records. The Chair noted a number of developments were underway in the city. He asked whether the Trust Board would benefit from understanding and appreciating some of the range of activities going ahead both within the Trust and citywide. A Non-Executive Director (RG) advised the Committee that there was some funding available for Trusts supporting Carter work and that one of the initiative was to help promote his work for e-rostering. He said it was worth looking into this offer. A meeting with the Assistant Director of Business Intelligence was to be set up to discuss solutions of architecture and other digital opportunities for the community. A Non-Executive Director (RG) was particularly interested in reflecting on the level of ambition. **Outcome:** The Committee noted the progress against each of the digital strategy priorities. It was agreed that the Board should consider the city-wide implications of digital priorities in a Board workshop. It was also noted that there were opportunities for funding, which should be followed up. **Action:** A digital strategy workshop to be planned into the Board workshop programme.	DA
2018/19 **(14)**	**Business and commercial developments** **14a - 2017/18 annual procurement report** The end of year procurement report provided the Committee with an update on the Trust's procurement activity and performance during 2017/18. The Executive Director of Finance & Resources drew attention to the delayed deployment of a catalogue solution and GS1 coding as the Shared Business Service were in the process of introducing a new purchase order system Edge4Health that was catalogue focused. Leeds Community Healthcare NHS Trust had agreed to be an early adopter and was scheduled to implement the first phase of the system in the second quarter. A Non-Executive Director (TD) noted that there was no reference made to medicines procurement. The Executive Director of Finance & Resources agreed to look into that request and provide an explanation. **Outcome:** The Committee noted the progress made in 2017/18 and the work that would be undertaken in 2018/19 to implement the Procurement Strategy. **Action:** The Executive Director of Finance & Resources to feedback on the medicines procurement issue. **14b** - **Progress on Child and Adolescent Mental Health Service (CAMHS) Tier 4 development and approval of fees** The purpose of the report was to seek approval from the Business Committee to recommend to the Trust Board to commit an estimated £1.5m of fees and associated development costs to take the CAMHS Tier 4 development to full business case**.**	BM

	The Executive Director of Finance & Resources advised the Committee that if the scheme did not go ahead (for whatever reason) these costs would be met from the Trust's own revenue resources. If the scheme is approved and proceeds, these costs would be met from the existing allocation estimate (£13m). The Executive Director of Finance & Resources said that the project and arrangements were progressing to plan in order to deliver a new build of the twenty-two bedded unit. It was noted that there was a high risk of containing the cost within £13m (more likely £15m). The Executive Director of Finance & Resources said that if the costs went over £15m a different approval process nationally would be required which would add delay. The Executive Director of Finance & Resources said that the extra resource over what has been allocated is potentially a capital cost to the Trust. He was pleased to advise that Leeds and York Partnership NHS Foundation Trust had indicated that they would contribute towards the resource gap. NHS England had been made aware of the additional cost over and above the notional bed funding element of having an eighteen bedded unit rather than a twenty-four bedded unit. This risk had also been placed on the risk register. **Outcome:** The Committee was satisfied with the explanations and the proposal, and agreed to recommend to the Trust Board that £1.5m is committed to the fees and development costs to take the CAMHS Tier 4 development to full business case.	
2018/19 **(15)**	**Performance management** **15a - Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports. The information within the performance brief was limited as it was month one of 2018/19. The report provided a high level summary of performance within the Trust during April 2018, indicating satisfactory performance. Safe, caring and effective domains were discussed at the Quality Committee meeting in detail on 21 May 2018. Main issues considered by the Committee were as follows: **Caring Domain** Inpatient respondents' recommending care had remained at 100% for 3 months and was rated green. **Effective Domain** The measures in this domain are reported quarterly, it will appear in the performance brief for June 2018. **Responsive Domain** The Trust had performed well in its indicators relating to waiting lists with all rated as green for April 2018.	

Well Led Domain
Staff turnover and staff leaving the organisation within 12 months was rated as green. Total sickness absence was below the target but both short term sickness and long term sickness were both rated green for April 2018.

The Chair reiterated that he was keen to have a diversity measurement included in performance targets and was assured that one was currently under development.

There were still serious concerns around the figures reflecting activity output which remained an important requirement to evidence what was happening with activity levels.

The Executive Director of Finance & Resources said that patient contact variation from profile continued to be measured on the basis of neighbourhood team activity profile targets currently agreed with the Commissioners, which is going to show as red rated all year round. He proposed to take into account the patient contacts for internal management purposes and last year's outturn of neighbourhood team activity before engaging with Commissioners about the activity levels. It was established that patient contacts in the neighbourhood team was significantly less than the current target agreed with the Commissioners.

The Executive Director of Finance & Resources said that he was proposing to avoid having a red measure all year round, and in his view the target for neighbourhood teams was not an appropriate target against which to measure neighbourhood team activity. This was not agreed and the Executive Director of Finance & Resources was again invited to explain the shortfall and to produce an assessment narrative on the reasons for this.

The Chair queried the comments recorded in the performance brief about the friends and family test. "Overall 95.59% of Community patients and 100% of inpatients for April would recommend LCH services" and whether this was the number of respondents, rather than the overall number of patients. The Executive Director of Finance & Resources recognised the issue and agreed to review the information before submission to the Trust Board. He was also asked to address the same point which appeared in the annual report (page 8).

Finance
At this early point in the year the Trust was in line with the planned financial performance. The forecast outturn demonstrated that there were some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks included the proposed pay-award, mitigating the loss of £1.2m of income from the Commissioners and delivery of the planned cost savings which would be monitored closely as the year progressed.

Action:

- Executive Director of Finance & Resources to produce an assessment narrative on the reasons why the current target for neighbourhood teams is not an appropriate way in which to assess neighbourhood team activity. — BM

- The Executive Director of Finance & Resources to review the friends and family test information before submission of the Performance Brief to the Trust Board, and ensure there is consistency in the annual report. — BM

	15b - Operational and non-clinical risks register 8+ The Chief Executive introduced the risk register. The report provided a description of risk movement since the last risk register report received by the Committee in April 2018. The summary report showed changes to note on four new non-clinical risks scoring 8 or above: • Risk 934 Risk of cyber-threat through the presence of unsupported software • Risk 938 Failure to achieve 2017/18 financial targets • Risk 939 New CAMHS Tier 4 Building. This was to provide reconciliation between £13m bided for and the £14.9m estimated cost now • Risk 940 Risk of delays to new CAMHS Tier 4 Service Model (Extreme) A detailed discussion took place regarding risks 939 and 940 scoring 16. The Executive Director of Finance & Resources was asked to review these risks before the Trust Board meeting on 25 May 2018. It was noted that the risks were currently being mitigated against a number of ways. **Outcome:** The Committee noted the recent revisions made to the risk register. **15c – Board assurance framework (BAF) review** This paper provided the Business Committee with details of the revised Board Assurance Framework (BAF) for 2018/19 and the responsibilities of the Committees and the Board. The Business Committee had been assigned twelve of the strategic risks. Three changes to Business Committee risks were noted as follows: 4.1 changes in commissioner landscape 4.4 systems change 4.5 partnership arrangements The Interim Company Secretary said that the new risks assigned to Business Committee did not have sufficient sources of assurance. The introduction of additional pieces of evidence to the Committees agenda and work plan would help the Committee to monitor and manage these strategic (BAF) risks. The Chief Executive suggested that the BAF should be brought back to the Committee and places higher up the meeting agenda for thorough review. **Outcome:** The Committee noted the revised BAF 2018/19 and the strategic risks assigned to the Business Committee. **Action:** The Board Assurance Framework strategic risks paper to be carried forward to July Committee agenda and to be incorporated at an earlier stage in the agenda. **15d - Internal audit reports** The report provided a summary of the outcomes from completed internal audits where the reports related directly to the role and functions of the Business Committee. The Interim Company Secretary said that each of the reports had been considered by the Audit Committee.	DA

	The Committee noted the outcome of the internal audit reports listed below: • Review of the Communication Aids Service: This review had received limited assurance from internal audit. The Executive Director of Operations advised the Committee that this service was an unusual situation. Action taken had been reported back to the Audit Committee. The Audit Committee was pleased with the management response. • Review of Stakeholder Engagement: this review received reasonable assurance from internal audit. • Review of Neighbourhood Team Demand and Capacity Tool follow up: Some concerns were raised regarding variation between teams and local systems not being robust enough to go through to the digital future. **Outcome:** The Committee noted the content of the internal audit reports.	
2018/19 **(16)**	**Business Committee work plan** The work plan was reviewed by the Committee and no changes were requested.	
2018/19 **(17)**	**Matters for the Board and other Committees** • Productivity programme group • Project management approach • E-rostering update • Digital strategy • Procurement strategy • Patient administration project update	
2018/19 **(18)**	**Any other business** The Executive Director of Operations informed the Committee that the Leeds City Council had issued a Voluntary Transparency Notice at the end of April, to advise the Trust of being their preferred provider on 0-19 service tender. A response to the tender had to be submitted prior to the next Business Committee meeting in June 2018. 13 June 2018 was the submission date with a view to starting the service on 1 April 2019 covering 4+2 x 2 extensions. A private brief would be provided to the Trust Board meeting on 25 May 2018.	

HEALTH AND WELLBEING BOARD

MONDAY, 19TH FEBRUARY, 2018

PRESENT: Councillor R Charlwood in the Chair

Councillors S Golton, G Latty, L Mulherin and E Taylor

Representatives of Clinical Commissioning Groups

Alistair Walling	NHS Leeds South and East CCG
Dr Gordon Sinclair	NHS Leeds West CCG
Nigel Gray	NHS Leeds North CCG
Phil Corrigan	NHS Leeds West CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health

Representative of NHS (England)
Moira Dumma - NHS England

Third Sector Representative
Heather Nelson – Black Health Initiative
Hannah Howe – Forum Central

Representative of Local Health Watch Organisation
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Julian Hartley - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

Safer Leeds Representative
Superintendent Sam Millar – West Yorkshire Police

46 Welcome and introductions
The Chair welcomed all present and brief introductions were made.

47 Appeals against refusal of inspection of documents
There were no appeals against the refusal of inspection of documents.

48 Exempt Information - Possible Exclusion of the Press and Public
The agenda contained no exempt information.

49 Late Items
There were no late items of business.

50 Declarations of Disclosable Pecuniary Interests
There were no declarations of disclosable pecuniary interest.

51 Apologies for Absence

Apologies for absence were received from Councillor Coupar, Jason Broch, Cath Roff and Steve Walker. Councillor E Taylor attended the meeting as a substitute.

52 Open Forum

Population Health Management Principles (PHM) - A query was raised regarding PHM and seeking support to pause the process of recognising Accountable Care systems until the outcome of two Judicial Reviews were known was raised.

In response, assurance was provided that the local Leeds Health and Care Plan had adopted a 'bottom up trajectory' approach through Local Care Partnerships and there would be no imposition of a national model. Additionally, health and care sector partners were keen to continue the Leeds integrated working approach which would allow the sector to monitor and challenge provision through collaborative practices; keeping in mind that the sector needed to understand those areas where it was required to procure services in order to provide the best service and value for money.

RESOLVED – To note the matter raised.

53 Minutes

An amendment was made to Minute No.40 'Making a Breakthrough', paragraph 2 Air Quality, to reference Chronic *Vascular* Diseases

RESOLVED – That, subject to the amendment outlined above, the minutes of the meeting held 23rd November 2017 were agreed as a correct record.

54 Leeds Health and Wellbeing Board: Reviewing the Year 2017-2018

The Chief Officer, Health Partnerships, submitted a report introducing a report on a review of the strategic direction provided by the Health and Wellbeing Board (HWB) and providing a look back over the last 12 months of HWB and partnership activity.

The Health Partnerships Manager introduced the report, which included a summary of a HWB self-assessment workshop undertaken in January 2018. This information would inform the future work planning and focus of the HWB into 2018/19. Three key issues for further focus were identified as:

- Mental health
- The workforce
- Hearing the voice of the community.

During discussions the Board considered the following:

- Previous discussions with the West Yorkshire & Harrogate Health and Care Partnership which sought to provide high support and high challenge that partners adopted the same or similar approach to health and care as Leeds as highlighted below;
- Success was predicated on building good working relationships between partners, building challenge into the process and encouraging strong, well-engaged communities within the process;

- Welcomed the sense of 'team Leeds' within the document which was evidenced by the well-connected approach to the health and care sector and service users;
- Acknowledged the work done by Board partners which had ensured that the HWB priorities were encompassed within their individual services and service plans.

RESOLVED

a) To note the collated findings of the report
b) To note the comments made during discussions intended to provide steer, commission or to clarify any future action to make further progress towards the outcomes and priorities of the Leeds Health and Wellbeing Strategy
c) That those matters identified during discussions be included within the HWB work plan as appropriate

55 Joint Strategic Needs Assessment: More Comprehensive Approach to City-Wide Analysis

The Board considered the joint report of the Chief Officer, Health Partnerships and the Head of LCC Intelligence and Policy setting out proposals for a broader, forward-looking approach to the ownership, production and utilisation of the Joint Strategic (Needs) Assessment, which will consider the wider determinants of health and wellbeing and facilitate policy linkages across the health and care system in Leeds.

The Chief Officer, Health Partnerships, introduced the report which highlighted the HWB's statutory responsibility to produce a JSNA to inform the direction and effectiveness of the Health and Wellbeing Strategy. The proposals sought to embed the 'Leeds approach' into the JSNA; be more inclusive of the Third Sector and communities; and included a name change to "Joint Strategic Assessment" (JSA).

The Board heard that officers had researched examples of good practice adopted by other areas of the country and went on to view a short video presentation entitled "Wellbeing of Future Generations (Wales) Act 2015" created by the Welsh Government to provide advice on the aims of the Act. The video was presented as the basis for discussion on a future approach to publicise the aims of the JSA and more widely - the work of the HWB; the Leeds Health & Wellbeing Strategy (HWBS) and Leeds Health and Care Plan. The Board supported the following principles around engagement and made the following comments:

- Emphasis on self-management and care
- Show what Leeds' health and care systems could look like and provide context for the individual
- Sets out a snapshot of need and reflect more of the 'one Leeds' approach

Discussion identified the following matters associated with the JSA for further consideration:

- The context should reference Leeds' focus on secure and happy childhoods to ensure the best start for children and young people
- To reference using community assets within the longer term service delivery proposals
- To be a toolkit for the whole City, including businesses and residents, not just the local health and care partners
- Acknowledged the need to broaden the scope of data collection in order to better inform the Leeds Health and Wellbeing Strategy and encompass the wider determinants of health

RESOLVED -

a) To note the contents of the report and the comments made during discussions on the Wellbeing of Future Generations (Wales) Act 2015 video and the refreshed Joint Strategic Needs Assessment;
b) To endorse the change from a Joint Strategic Needs Assessment to a Joint Strategic Assessment (JSA), reflecting the 'working with' approach and reflecting strengths and assets based approach developed in communities and neighbourhoods;
c) To endorse the extension of the JSA to cover the wider determinants of health in line with the refreshed Health and Wellbeing Strategy/Leeds Plan, Best Council/Best City priorities (paragraphs 3.1-3.3);
d) To actively support and contribute to a strong partnership approach to the JSA (paragraphs 3.6-3.10);
e) To agree the establishment of a partnership task and finish group to drive the JSA (paragraphs 3.11) and to note that the Chief Officer, Health Partnerships, will be responsible for overseeing implementation of the group.
f) Agreement that the JSA includes focus on secure and happy childhoods to ensure the best start for children and young people
g) Agreement that a wide breadth of information is used to inform the JSA including existing data sets where appropriate (e.g. mental health needs assessment framework)

56 Leeds Academic Health Partnership Strategy

The Chief Officer, Health Partnerships introduced a report providing an update on the progress made by the Leeds Academic Health Partnership (LAHP) to establish a Strategic Framework of priorities along with a summary of its programme of active projects to deliver these. The report acknowledged the role of the LAHP within the wider strategic context of the Leeds Health and Well Being Strategy, Leeds Health and Care Plan and the Leeds Inclusive Growth Strategy.

The report identified the strength and skills of LAHP members to drive the main strategic priorities of:

- Support the delivery of partners' own (and shared) strategies and plans –helping to simplify, not add to, complexity;
- Reflect the breadth of the partnership, for example: physical *and* mental health; care provided in *and* out of hospital; health *and* social care; discovery science to applied health research

- Build the reputation of and add value to all partner organisations and the city across the totality of the work programmes.
- Build on and bring together existing strengths across the city and also develop areas of new capability

Discussion focussed on the following key issues:

- The need to identify how the Third Sector will be further involved in the Partnership
- The need to clarify the role of digitalisation and digital innovation in the delivery of the priorities
- The 'one workforce' approach and how training will be delivered across the various partners to ensure this approach is implemented
- As part of a wider piece of work for the health and care partnership, three priorities of apprenticeships; organisational development and the long term future workforce had been identified for 2018, with focus commencing on 1st April 2018. From September, focus would include cultural working conditions and bringing together the workforce.

RESOLVED

1) To note the Strategic Framework priorities and progress made by the Leeds Academic Health Partnership and its programme to deliver better health outcomes, reduced health inequality and more jobs and stimulate investment in health and social care within the City's Health and Wellbeing Strategy.
2) To note that the Chief Officer, Health Partnerships Team will be responsible for overseeing implementation by the LAHP of its programme.

57 Pharmacy Needs Assessment 2018-21

The Director of Public Health, LCC, submitted a report on the new Pharmacy Needs Assessment (PNA) 2018-2021 which had been produced after a thorough and robust process, including a number of consultation measures.

Liz Bailey, Healthy Living and Health Improvement, introduced the summary findings of the report and provided assurance on the following key points:

- Leeds had a good spread and access to pharmaceutical services. No current gaps in provision of necessary services to meet the needs of the Leeds population had been identified;
- The PNA did not identify any future needs which could not be met by pharmacies/providers already on the pharmaceutical list; taking into account likely demographic changes during the three year life of the PNA

The following comments were noted during discussions:

- Welcomed the recognition given to pharmacies and pharmacists for their support to local communities
- Acknowledged a concern regarding access to pharmacies; given that residents were being encouraged to discuss health and wellbeing issues with their pharmacists in the first instance where appropriate

- Sought assurance that where there was no pharmacy service, there was provision of 'distance pharmacy' with 10 miles; noting the continuing residential expansion of Leeds into outlying suburbs
- Noted that the previous PNA included building "Safe Places" provision within pharmacies and this was not included in the 2018-21 document. It was agreed that the PNA 2018-21 would be reviewed to ensure "Safe Places" are incorporated
- Concern over how migrants/new residents to Leeds are enabled to access pharmacies
- Opportunity to progress the 'one healthcare records system'; including pharmacies

RESOLVED -

a) To note the thorough processes undertaken to compile the PNA 2018-2021
b) To note the findings and recommendations contained in the PNA 2018-2021
c) To note that there are no current gaps in the provision of necessary services to meet the needs of the Leeds Health and Wellbeing Board area population.
d) To note that there are no current gaps in the provision of other relevant services to meet the needs of the Leeds Health and Wellbeing Board area population.
e) To note that the PNA has not identified any future needs which could not be met by pharmacies already on the pharmaceutical list, which would form part of related commissioning intentions.
f) To note that as of 1st January 2018, all areas of Leeds have a reasonable choice of pharmaceutical services
g) To notes the follow up actions that have been taken, since the submission of the update paper submitted on 23rd November 2017.
h) To approve the PNA document ready for publication and placing on the Leeds Observatory website http://observatory.leeds.gov.uk/ by 1st April 2018.

58 Progressing the NHS Leeds Clinical Commissioning Groups Partnership Annual Report 2017-2018

The Board considered the report of the Communications Manager, NHS Leeds Clinical Commissioning Groups Partnership, which demonstrated how the Clinical Commissioning Group Annual Report has documented its contribution to the joint health and wellbeing strategy.

The report highlighted that information was previously submitted by the Leeds CCGs Partnership to the self-assessment workshop held for the HWB in January 2018. This submission provided an overview of how the organisation had contributed to each of the 12 priorities within the Leeds Health and Wellbeing Strategy 2016-21. It was proposed that this submission would be used for the Annual Report 2017-18 to evidence the extent that the Leeds CCGs Partnership has contributed to the delivery of the Leeds Health and Wellbeing Strategy.

RESOLVED

a) To support the process for developing the CCG annual report as outlined in para 3.6 to meet the statutory requirement outlined by NHS England.
b) To acknowledge the extent to which the NHS Leeds CCGs have contributed to the delivery of the Leeds Health and Wellbeing Strategy 2016-2021.
c) To agree to the formal recording of this acknowledgement in the NHS Leeds CCGs' annual reports according to statutory requirement.

59 For Information: iBCF (Spring Budget) Q3 2017/18 Return and BCF Performance Monitoring Q3 2017/18 Return

The Board received for information, a copy of the iBCF Spring Budget and the Better Care Fund 2017/18 Quarter 3 returns.

RESOLVED -

a) To note the contents of the report
b) To note the contents of the Leeds iBCF Quarter 3 return to the DCLG
c) To note the content of the Leeds HWB BCF Performance Monitoring return to NHSE for quarter 3 of 2017/18

60 For Information: Leeds Health and Care Quarterly Financial Reporting

The Board received, for information, a copy from Leeds Health and Care Partnership Executive Group (PEG) which provided an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report.

RESOLVED – To note the end of year forecast contained within the Leeds health & care quarterly financial report.

61 Any Other Business

No additional items of business were identified.

62 Date and Time of Next Meeting

RESOLVED – To note the following arrangements:

a) Board workshop – Thursday 19th April 2018 at 9.30 am
b) Formal Board meeting – Thursday 14th June 2018 at 12.30 pm