**Board Meeting (held in public)**
**Friday 1 February 2019, 9.00am – 11.45**
**Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF**

| AGENDA | | | | |
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| **Time** | **Item no.** | **Item** | **Lead** | **Paper** |
| | | **Preliminary business** | | |
| 9.00 | 2018-19 (86) | Welcome, introductions and apologies: Brodie Clark | Neil Franklin | N |
| 9.05 | 2018-19 (87) | Declarations of interest | Neil Franklin | N |
| 9.10 | 2018-19 (88) | Questions from members of the public | Neil Franklin | N |
| 9.15 | 2018-19 (89) | Patient's story: Children's Services | Steph Lawrence | N |
| 9.30 | 2018-19 (90) | Minutes of previous meeting and matters arising:<br>a. Minutes of the meeting held on 7 December 2018<br>b. Actions' log | <br>Neil Franklin<br>Neil Franklin | <br>Y<br>Y |
| | | **Quality and delivery** | | |
| 9.40 | 2018-19 (91) | Chief Executive's report | Thea Stein | Y |
| 9.50 | 2018-19 (92) | Committees' assurance reports:<br>a. Charitable Funds Committee: 14 December 2018<br>b. Nominations and Remuneration Committee: 14 December 2018<br>c. Audit Committee: 14 December 2018<br>d. Quality Committee: 21 January 2019<br>e. Business Committee: 23 January 2019 | <br>Neil Franklin<br>Neil Franklin<br>Jane Madeley<br>Ian Lewis<br>Richard Gladman | <br>Y<br>Y<br>Y<br>Y<br>Y |
| 10.10 | 2018-19 (93) | Performance brief and domain reports | Bryan Machin | Y |
| 10.25 | 2018-19 (94) | Significant risks and assurance report | Thea Stein | Y |
| 10.35 | 2018-19 (95) | Serious incidents summary report | Steph Lawrence | Y |
| 10.40 | 2018-19 (96) | Mortality Report | Ruth Burnett | Y |
| 10.50 | 2018-19 (97) | Guardian for Safe Working Hours Report | Ruth Burnett | Y |
| 10.55 | 2018-19 (98) | Safe staffing report | Steph Lawrence | Y |
| | | **Strategy and planning** | | |
| 11.00 | 2018-19 (99) | Realising our strategic direction | Thea Stein | Y |
| 11.10 | 2018-19 (100) | Workforce strategy | Jenny Allen/Laura Smith | Y |
| 11.30 | 2018-19 (101) | Quality Strategy update report | Steph Lawrence | Y |
| | | **Governance** | | |
| 11.40 | 2018-19 (102) | Board work plan | Thea Stein | Y |
| | | **Minutes** | | |
| 11.40 | 2018-19 (103) | Approved minutes (for noting):<br>a. Quality Committee: 26 November 2018<br>b. Business Committee: 28 November 2018<br>c. Audit Committee: 19 October 2018<br>d. Charitable Funds Committee: 30 October 2018 | Neil Franklin | <br>Y<br>Y<br>Y<br>Y |
| 11.45 | 2018-19 (104) | Close of the public section of the Board | Neil Franklin | N |

**Date of next meeting (held in public) Friday 29 March 2019, 9.00am - 12noon**

Leeds Community Healthcare NHS Trust

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

**AGENDA ITEM 2018-19 (90a)**

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

**Friday 7 December 2018, 9.00am – 12.00pm**

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| **Present:** | Neil Franklin | Trust Chair |
| | Thea Stein | Chief Executive |
| | Brodie Clark | Non-Executive Director |
| | Dr Tony Dearden | Non-Executive Director |
| | Jane Madeley | Non-Executive Director |
| | Richard Gladman | Non-Executive Director |
| | Professor Ian Lewis | Non-Executive Director |
| | Bryan Machin | Executive Director of Finance and Resources |
| | Sam Prince | Executive Director of Operations |
| | Dr Ruth Burnett | Interim Executive Medical Director |
| | Steph Lawrence | Interim Executive Director of Nursing |
| | Jenny Allen | Director of Workforce, Organisational Development (OD) and System Development (JA) |
| | Laura Smith | Director of Workforce, Organisational Development (OD) and System Development (LS) |
| **Apologies:** | | |
| **In attendance:** | Diane Allison | Company Secretary |
| | Jo Brayshaw | Clinical Falls Specialist (Item 68) |
| | John Walsh | Freedom to Speak Up Guardian (Item 77) |
| | Dr Turlough Mills | Guardian of Safe Working Hours (Item 78) |
| **Minutes:** | Bridget Lockwood | Business Support Manager |
| **Observers:** | Roohi Collins | Insight Programme participant |
| **Members of the public:** | No members of the public in attendance | |

| Item | Discussion points | Action |
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| **2018-19 (65)** | **Welcome and introductions**<br>The Chair welcomed Board members and one observer to the meeting.<br><br>**Apologies**<br>None.<br><br>**Opening remarks**<br>The Chair opened the meeting by saying that he wished the meeting to retain a focus on performance issues and levels of assurance received at the Committee meetings. | |

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| **2018-19 (66)** | **Declarations of interest**<br>There were no declarations of interest made in relation to any items on the agenda. | |
| **2018-19 (67)** | **Questions from members of the public**<br>No members of the public were in attendance. No questions had been notified in advance of the meeting. | |
| **2018-19 (68)** | **A patient's story: Community Falls Service**<br>The Interim Executive Director of Nursing introduced the patient's story item and welcomed Jo Brayshaw, Clinical Falls Specialist to the meeting. The Clinical Falls Specialist informed the Board that the Community Falls Service was a therapy led team which predominantly treated people in their own homes.<br><br>The case of a patient who had initially been assessed at home and then attended an eight week group falls education programme was outlined to the Board. The individual was 77 years old, had been assessed by a GP in April 2018, had a history of falls and had reduced lower limb strength due to a stroke. The individual therefore had problems with their balance and this had affected their confidence in leaving their home.<br><br>The Clinical Falls Specialist outlined an eight week programme which consisted of a two hour session per week of strength, resistance and other circuit exercises, including table tennis, which aimed to strengthen limbs and improve balance. Each participant was assessed on a short falls efficacy scale at the start of the programme and the individual in the case scored 13 out of 28, and was felt to be high risk. Their objective was to be able to walk unaided round the local park with their partner.<br><br>At the end of the eighth week the individual had benefited from the programme, had found the games fun as well as strengthening muscles, and the exercises had helped with their posture. The individual scored 22 out of 28 when re-tested, moving from being high risk to moderate risk. They had managed to walk around their local park, had not fallen since the programme, had found their balance much improved, and wished to continue with a home exercise programme. Those who undertook the programme were asked to keep a 'falls diary' and were telephoned three months after the end of the programme to check on progress.<br><br>The Executive Director of Finance and Resources asked if transport was provided for participants and it was confirmed that this was arranged for them if required.<br><br>The Chief Executive asked if the team was well connected with local schemes. The Clinical Falls Specialist confirmed that all the programmes take place in Neighbourhood Network bases and they came in to the sessions to talk to individuals about any other assistance they may need and offered support with transportation.<br><br>The Chief Executive asked where referrals into this programme were from and the Specialist responded that referrals were received from the Community Falls Team. The programme was funded by iBCF funds non-recurrently so it was not possible for a waiting list to be held. The Interim Executive Director of Nursing asked if there were opportunities to link this with other schemes and the Specialist confirmed that the team was currently working with Leeds City Council (LCC) to explore further opportunities. | |

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| | The Executive Director of Operations informed the Board that the scheme had rated very well by the iBCF quarter two review panel due to clearly demonstrated outcomes. The Trust had been asked to attribute a financial value to these outcomes and if this was possible, the Executive Director of Operations was confident that recurrent funding could be secured.<br><br>A Non-Executive Director (IL) asked whether the cohort of participants was monitored to establish if major falls occurred subsequently, and how sustainable the programme was given that the population was growing older and living longer. The Clinical Falls Specialist responded that all participants were monitored for a year to see if they have a subsequent fall and none of the individuals had returned to the service. The Executive Director of Operations added that LCC Public Health were now monitoring this data.<br><br>A Non-Executive Director (RG) asked if there were other providers offering the same service in the city. The Clinical Falls Specialist responded that postural stability instructors were doing this work privately but there was variability in the quality of some of the classes.<br><br>The Trust Chair asked how practices could be embedded at an early stage to prevent a cohort of people at risk of falling from doing so. The Executive Director of Operations responded that the Neighbourhood Teams carry out a falls assessment and would monitor those felt to be at risk.<br><br>The Trust Chair thanked the Clinical Falls Specialist for outlining the programme to the Board and commented on its evident success in taking an engaging approach, provided in a social setting, and which had demonstrated its clinical effectiveness. The Board hoped that recurrent funding could be secured in order for such an important service to continue.<br><br>The Clinical Falls Specialist invited Board members to attend a session. | |
| **2018-19 (69)**<br><br>**(69a)**<br><br><br><br>**(69b)**<br><br><br><br><br>**(69c)** | **Minutes of the previous meetings held on 5 October 2018 and matters arising**<br><br>**Minutes of the meeting held on 5 October 2018**<br>The minutes were reviewed for accuracy and agreed to be a correct record of the meeting.<br><br>**Items from the actions' log**<br>The completed actions from previous meetings were noted. The Company Secretary informed the Trust Board that the Trust Chair and the Chair of Leeds GP Confederation had now signed the Committees in Common Memorandum of Understanding.<br><br>**Minutes from the Annual General Meeting held on 18 September 2018**<br>The minutes were reviewed for accuracy and agreed as a correct record of the meeting. | |
| **2018-19 (70)** | **Chief Executive's report**<br>The Chief Executive introduced the report, inclusions of which linked to the Board Assurance Framework Strategic Goals relating to working in partnership to deliver integrated care closer to home, and to recruiting, developing and retaining staff. The Chief Executive highlighted that the draft report on the Care Quality Commission's (CQC) Leeds system review of support offered to people over the age of 65 had now been received. The final report was expected the following week with the CQC Summit meeting taking place on 17 December 2018. The Chief Executive invited questions from Board members. | |

*Brexit*
A Non-Executive Director (RG) referred to the Secretary of State for Health's announcement that audits were going to be carried out in trusts regarding stocks of medication as part of contingency planning for Brexit. The Chief Executive responded that the Trust had received communications on actions to be taken, and added that the Trust did not hold significant quantities of drugs. The Chief Executive added that the main impact of Brexit for the Trust would be a potential reduction in care workers from the European Union.

*Overt and covert recording*
A Non-Executive Director (BC) queried the impact of overt and covert recording on staff employed by the Trust. The Chief Executive responded that this had emerged as an issue for some services and had led to concern and anxiety for some staff. The Chief Executive provided assurance that the issue had been properly escalated, concerned staff were aware that this had been responded to in a timely manner, and the Senior Management Team would be agreeing guidance for staff which would be followed by literature.

The Director of Workforce, OD and System Development (LS) commented that this demonstrated a good example of an issue being raised with the Freedom to Speak Up Guardian and the Chief Executive, and the Trust responding in early course, with teams working together, including Staffside representatives and the Information Governance team, in order to find a resolution.

*Winter pressures*
A Non-Executive Director (JM) queried the position in the city regarding the winter period. The Executive Director of Operations responded that the city was busy but there had been no specific outbreaks of viruses and the use of additional beds in the acute trust had been less than in the previous year. The Chair asked how the Trust would deal with any further pressures on services. The Executive Director of Operations responded that neighbourhood teams were consistently able to see patients within 24 hours of discharge from hospital. Further work was underway with acute colleagues to ensure that neighbourhood teams are given a clear notification when patients are due to be discharged from wards in order to maintain this position.

*Power outage*
The Board noted that a power outage had affected Leeds General Infirmary and Little Woodhouse Hall earlier in the week. The Executive Director of Operations confirmed that the response by the team at Little Woodhouse Hall had been excellent. A plan to maintain security and heating within four hours of the outage was put in place, with a further plan should the patients need to be moved to another site, although power was restored so this had not been necessary. Emergency generators were now on site in the event of another outage.

*Safety huddles*
A Non-Executive Director (IL) asked if safety huddles were now taking place across all Trust services and if they were place daily in the services taking this approach. The Interim Executive Director of Nursing responded that the huddles do not take place across all services but they are not exclusive to neighbourhood teams, huddles also take place at Little Woodhouse Hall and Hannah House. Most neighbourhood teams were holding safety huddles daily. The Board noted that the Trust had been accredited for its safety huddles, the only community trust in the country to receive the accreditation. The Interim Executive Director of Nursing added that the Trust had been asked to share best practice nationally with the Queens Nursing Institute. The Executive Director of Finance and Resources asked if it was felt that all services should hold safety huddles. The Interim

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| | Executive Director of Nursing responded that any teams that use a quality board should carry out safety huddles and teams were working to roll them out accordingly.<br><br>*Awards*<br>A Non-Executive Director (BC) said he was very pleased to note all the awards teams within the Trust had received recently. The Chair also referred to the Trust being named as one of the country's Top 50 inclusive organisations. The Director of Workforce, OD and System Development (JA) acknowledged the contribution Board members made in achieving this in terms of support and awareness.<br><br>**Outcome**: The Board noted the Chief Executive's report and the matters highlighted. | |
| **2018-19 (71)** | **Committees' assurance reports:**<br><br>**Item 71a – Charitable Funds Committee held 30 October 2018**<br>The report was presented by the Chair of the Committee and Non-Executive Director (BC) who highlighted the key issues, namely:<br>• **Charitable funds** – the Committee Chair highlighted that the Trust was at a point where it either needed to maintain existing funds, commit further resources in order to build on efforts, or enter into a constructive and positive partnership with Leeds Cares (who supported Leeds Teaching Hospitals NHS Trust (LTHT) in underpinning its charitable funds). Further discussion was taking place with Leeds Cares the following week. The Senior Management Team would then consider a proposal and make a recommendation to the Board. The Committee Chair suggested that Leeds Cares deliver a presentation to the Board.<br>• **Other workstreams** – it was noted that work was underway to explore the introduction of a staff lottery fund and the 'More than a welcome' project had now successfully migrated into business as usual within the Estates/Facilities team. Work needed to take place on the establishment of a Charitable Funds Development Group involving people external to the Trust to support.<br><br>**Action:** Senior Management Team to consider the Leeds Cares offer and put forward a recommendation to the Board<br><br>**Item 71b – Nominations and Remuneration Committee held 2 October 2018**<br>The report was presented by the Chair of the Committee, the Trust Chair, who highlighted that the Clinical Excellence Award panel had met since the last meeting of the Committee. The Interim Executive Medical Director highlighted that 40 percent of eligible staff who applied for an award were classified as BAME and there had also been a gender split.<br><br>**Item 71c – Audit Committee held 19 October 2018**<br>The report was presented by the Chair of the Committee and Non-Executive Director (JM) who highlighted the key issues, namely:<br>• **Audit reports** - reasonable assurance had been given regarding all audit reports considered<br>• **Audit plan for 2018/19** The Committee Chair expressed concern that not as many internal audit reports had been received as anticipated and requested assistance from the Executive Team in ensuring that all audits that remained outstanding were scheduled for completion by the end of the financial year<br>• **Payroll audit** - The Committee had been pleased to note that following a further audit of payroll practices, all actions had been confirmed as | **Chief Executive** |

complete

- **GDPR -** The Committee had noted that robust plans were in place and being delivered relating to compliance with General Data Protection Regulation (GDPR) legislation.

**Item 71d – Quality Committee held 22 October and 26 November 2018**

The report was presented by the Chair of the Committee and Non-Executive Director (IL) who highlighted the key issues, namely:

- **National Patient Safety Congress** – a group of staff who had attended the conference had presented to a Quality Committee workshop on the three themes from the conference: 'Just Culture' and how to move beyond blame; a National Early Warning Score (NEWS) to identify deteriorating patients; and how to capture good practice. It was agreed that the latter would be called 'Fabuleeds', led by the Clinical Governance Team.
- **Adult Business Unit** – the Committee had noted an update on all the good work being undertaken in response to challenges regarding recruitment and retention and winter pressures, initiatives such as the self-management programme and pain assessment in patients with cognitive impairment.
- **Electronic Staff Record (ESR) system** – The Committee Chair highlighted issues that had been raised previously regarding inaccurate training and appraisal information on ESR. The Chief Executive said the Senior Management Team had recently reflected that this was a significant issue for staff which impacted on morale and had agreed that a risk would be added to the risk register. The comprehensive amount of work being undertaken to address the issues would be articulated more fully. The Director of Workforce, OD and System Development (JA) confirmed that the Head of Workforce Systems and Intelligence was now in post and confident that the Trust could maximise the potential of ESR further. Work was also underway to address any data quality issues and a staff focus group was to be established. A Non Executive Director (JM) suggested that Internal Audit be asked to review the action plan. The Executive Director of Finance and Resources agreed to discuss with the Director of Workforce, OD and System Development and the Internal Audit Manager.
- **HR representation** – the Committee Chair felt that a gap had been identified, particularly in the conversation relating to ESR, and it would be useful to have HR representation on the Committee. The Trust Chair asked that further consideration be given to this
- **IAPT waiting times** – A Non Executive Director (JM) expressed concern regarding performance in this service. The Executive Director of Operations confirmed that the Business Committee had received a detailed paper which she would happy to circulate to Board members. The Board noted that the Trust had received additional funding to increase the number of Step 3 practitioners in the service, there was a national shortage of these trained clinicians however. The service was undertaking a data cleanse of waiting lists. The Interim Executive Director of Nursing informed the Board that it had been agreed at the CCG Clinical Quality Review meeting that a letter would be sent to patients who had been waiting eight weeks to establish if their needs had changed or indeed had escalated. The Executive Director of Operations advised the Board that she was unable to give a date for resolution at this time.
- **Virtual Respiratory Ward** – representatives from the team had presented a service spotlight at the November meeting of the Committee to provide context and background around the establishment of the virtual ward.
- **Hannah House improvement plan update** – the Committee Chair reflected on a very positive update report which had been presented to the Committee at its meeting in November.

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| | **Action:** Executive Director of Finance and Resources to speak with the Director of Workforce, OD and System Development and Internal Audit Manager regarding an internal audit review of the ESR action plan<br><br>**Action:** Chief Executive and Director of Workforce, OD and System Development to consider HR representation at the Quality Committee<br><br>**Item 71e – Business Committee held 24 October and 28 November 2018**<br>The report was presented by the Chair of the Committee and Non-Executive Director (BC) who highlighted the key issues, namely:<br>• **Service support session** – the Committee had received a good presentation from the Continence, Urology and Colorectal Service (CUCS) and had been impressed with the team's leadership, the reduction in the number of products handed out and the process around the revision to staffing structures<br>• **Digital Strategy** – a discussion had highlighted a number of new strategic priorities which would shape the next major revision of the Strategy. The Committee recommended that the developing strategy be brought to the Board in due course<br>• **Patient Admin Review** – the committee had been concerned regarding delays in delivering expected project outcomes, current challenges and the capacity of the project team to cope with the volume of work. The Chief Executive queried the limited assurance given when this was considered to be a good project with substantial engagement. The Executive Director of Operations responded that the reports to the Committee had not demonstrated the required level of assurance, however the conversation had provided further assurance to members. A Non-Executive Director (RG) added that the project was well run, more consensus was needed however on design visions and the outcomes to be achieved<br>• **Estates Strategy and Rationalisation Plan** – reasonable assurance had been provided and it was noted that the Committee and Trust Board would receive a revised strategy for consideration in early 2019<br>• **Performance Brief** – the Committee had noted concerns regarding the number of staff leaving the Trust within the first 12 months of employment, and IAPT waiting lists for which an improvement plan had been considered. Also noted was the positive news that commissioners had agreed to adjust the Neighbourhood Teams' activity levels profile<br>• **Learning and development** – following a service support session, the Committee had requested further clarification on the capacity and capability of the Trust to progress the development training alongside other initiatives, to review the generic offer for all levels of management, and to review the ambition to cover all training over a short series of events.<br><br>**Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted. | **Executive Director of Finance**<br><br>**Chief Executive** |
| **2018-19 (72)** | **Performance brief and domain reports**<br>The Executive Director of Finance and Resources presented the report which provided a high level performance summary for October 2018. Performance was noted as being good overall with a concern regarding the number of current vacancies. A strong financial position allowed for the impact of the vacancies to be mitigated through the use of bank and agency staff however.<br><br>***Safe and Caring domains***<br>The Board noted that vacancy levels were having no material impact on the | |

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| | quality and safety of care provided by the Trust. Further work was underway to understand a four percent increase in instances of moderate harm.<br><br>***Effective domain***<br>The measures were reported quarterly and there were no issues to report this month.<br><br>***Responsive domain***<br>The Trust was on target to achieve required activity levels following the CCG adjustment of Neighbourhood Team activity profiles. Concern regarding waiting times in the IAPT Service had been reviewed by the Business and Quality Committees.<br><br>***Well-led***<br>The Board noted that the overall trend of current key workforce indicators was positive, with further analysis required on staff leaving the organisation within 12 months of joining. Statutory and mandatory training compliance and appraisal rates were reported as below target.<br><br>The Director of Workforce, OD and System Development (JA) highlighted that staff leaving an organisation with less than 12 months' service was a trend being reported across all sectors. Work had been undertaken to establish which areas the trend was most prevalent (Band 5 Neighbourhood Team staff and clerical staff), and a number of retention initiatives were underway, including coaching, facilitating moves within the organisation and flexible working. The Chief Executive added that an update would be provided to the next meeting of the Trust Board.<br><br>***Financial position***<br>The Executive Director of Finance and Resources informed the Board that the Trust's performance remained good. The Trust's forecast outturn continued to be £4.0m and a significant income risk associated with the Leeds CCG contract had been resolved.<br><br>In response to a question from a Non-Executive Director (IL), the Interim Executive Medical Director confirmed that the data relating to the number of deaths attributable to incidents shown in the table on page six of the report was inaccurate. The Interim Executive Medical Director added that the Quality Committee had noted an update from the Mortality Surveillance Group that work was being progressed within the Clinical Governance Team and with the Clinical Leads in order to improve the data and supporting narrative presented. The Interim Executive Medical Director and Interim Executive Director of Nursing agreed to review the table under discussion and noted the request by a Non-Executive Director (IL) that the Board receive a separate report on mortality.<br><br>**Action:** Interim Executive Medical Director to submit a report on mortality to the January meeting of the Quality Committee and the Trust Board in February 2019<br><br>A Non-Executive Director (BC) queried the Friends and Family Test return rates. The Interim Executive Director of Nursing responded that the rates were not at the level the Trust would wish and provided an update on recruitment to two new Patient Engagement roles. The Board noted that Healthwatch Leeds had been commissioned to review patient engagement activity within the Trust. Initiatives underway within the Trust would be regularly reported going forward.<br><br>**Action:** Interim Executive Director of Nursing to provide update on patient engagement to the Quality Committee | **Interim Executive Medical Director**<br><br>**Interim Executive Director of Nursing** |

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| | The Director of Workforce, OD and System Development (LS) informed the Board that the opportunity to complete the Staff Survey had now closed and the response rate for the Trust was likely to be 52 percent, against a national average of 43 percent. The Chief Executive added that the Trust would receive the initial results in confidence later in the month, with further benchmarked data to follow at the end of February 2019. A verbal update would be provided to the Trust Board meeting in February 2019.<br><br>A Non-Executive Director (RG) queried the reporting of patient contacts for the year given the change in activity profile agreed mid-year. The Executive Director of Finance and Resources confirmed that a revised means of reporting this had been agreed as an action at the Business Committee.<br><br>A Non-Executive Director (JM) reflected on the positive meeting held with the CCG regarding the contracting income shortfall. The Executive Director of Finance and Resources agreed that this had been a very positive development and that any non-recurrent funding gaps were being managed.<br><br>**Outcome:** The Board noted the Trust's performance for October 2018. | |
| **2018-19 (73)** | **Significant risks and Board Assurance Framework (BAF) report**<br>The Chief Executive presented the report which showed little change from what had been reported previously, a position that the Senior Management Team were reflecting upon. The Board noted that two extreme risks remained on the Risk Register, there were no new risks scoring 15 or above, no de-escalated or closed risks which previously scored 15 or above, and one new risk scoring 12 (ID 954 – Diabetes Service waiting times).<br><br>The Chief Executive highlighted that the Senior Management Team regularly reviewed Risk ID 224 - reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust – and had not felt that the risk score could be reduced from extreme. The Chief Executive invited views from Board members as to whether the risk score and description were correct.<br><br>A Non-Executive Director (RG) felt that staffing issues resulting from sickness absence were being managed by the Trust, and suggested that the overarching extreme risk should relate to having sufficient staff in place, with the appropriate skills. The Trust Chair agreed.<br><br>A Non-Executive Director (BC) felt that sickness absence and staff shortages were being managed well, and added that the likelihood of any further staff shortages, with a potential impact on the level of care provided, was the risk that should be recorded. The Interim Executive Director of Nursing agreed that potential future staffing issues were a greater risk to the Trust than sickness.<br><br>A Non-Executive Director (JM) suggested that the initial risk score and mitigations relating to Risk ID 224 be reviewed to establish if the score could be reduced, and to determine if the risk description was correct.<br><br>The Director of Workforce, OD and System Development (JA) highlighted that Risk 3.2 on the Board Assurance Framework described the risk relating to sickness absence. The Executive Director of Finance and Resources agreed and felt that the operational risk no longer described the extreme risk which related to staffing levels rather than sickness.<br><br>A Non-Executive Director (IL) asked if the new risk relating to Diabetes waiting times also related to staffing levels. The Executive Director of Finance and Resources responded that the risk related to an increase in demand for the | |

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| | service.<br><br>**Action:** Senior Management Team to review the risk score and description of Risk ID 224 and consider the addition of a risk relating to a potential reduced level of care if the Trust did not have sufficient staff in post with the appropriate skills. The Chief Executive and Company Secretary would then iterate this with risks on the BAF.<br><br>**Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided in the revised BAF summary. | **Chief Executive** |
| **2018-19 (74)** | **Neighbourhood Teams' activity**<br>The Executive Director of Operations introduced the report which explained how transformational change in neighbourhood teams had resulted in a reduction in face to face activity. The case study included as the appendix demonstrated how the changes had impacted on clinical practice and the reporting of activity.<br><br>A Non-Executive Director (BC) asked if there were any other areas of delivery which might influence future commissioning. The Executive Director of Operations responded that this had been a specific problem relating to neighbourhood teams. Work was underway with commissioners however, particularly in children's services, to ensure profiles continue to match activity.<br><br>The Executive Director of Finance and Resources suggested a review of activity levels against profiles be reported to the Business Committee and this was agreed as an action.<br><br>The Interim Executive Director of Nursing highlighted that there may be a further change in activity levels as further community focussed initiatives, including Leg Clubs, progress. The Executive Director of Operations commented that when future changes to practice are introduced, an impact assessment on activity and flow would be undertaken.<br><br>**Action:** Review of activity levels against profiles to be reported to Business Committee<br><br>**Outcome:** The Board received the narrative explaining the reduction in face to face activity in the Neighbourhood Teams. | **Executive Director of Finance and Resources** |
| **2018-19 (75)** | **Serious incidents summary report**<br>The Interim Executive Director of Nursing presented the Serious Incidents Report for the period July to September 2018 and informed the Board that future reports would include further narrative and triangulation of data.<br><br>The Chair requested that future reports demonstrate that lessons were being learned from incidents and include benchmarking data against other similar trusts. The Interim Executive Director of Nursing confirmed that the revised report to the Quality Committee in January 2019 would include this analysis.<br><br>In response to a question from a Non-Executive Director (BC) the Interim Executive Director of Nursing responded that there were no concerns to report regarding recent serious incidents.<br><br>A Non-Executive Director (JM) asked what support was available to staff when an avoidable incident occurred. The Interim Executive Director of Nursing responded that support was put in place for any staff members involved and they were included in the lessons learned process. The Trust was considering future serious incidents being investigated by a working group of frontline staff to ensure that a | |

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| | focus is placed on learning.<br><br>**Outcome:** The Board received assurance regarding the management of Serious Incidents and the handling of inquests, and noted the current position regarding action plans and learning. | |
| **2018-19 (76)** | **Patient experience report**<br>The Interim Executive Director of Nursing introduced a report which provided a six monthly update on complaints, concerns and feedback received from the Friends and Family Test. It was noted that the report included data regarding these themes but further analysis and narrative would be included in future reports. The Board once again noted that two new posts had been recruited to in order to support this workstream. The report that had been commissioned from Healthwatch would be completed to allow the Board to reflect on its findings at its meeting in April 2019. The Interim Executive Director of Nursing proposed that the updated report be titled the 'Patient Experience and Engagement Report' and this was agreed.<br><br>The Chief Executive acknowledged the work already underway and asked if there were any areas the Board should be concerned about. The Interim Executive Director of Nursing responded that response times for some complaints had not been met and the position was being monitored.<br><br>A Non-Executive Director (TD) queried the fact that data shown in 3.2.2 showed that 'clinical judgement' or 'poor treatment' had been the primary cause of complaints received by the Trust in 2017/18 which was not shown as a national theme. The Interim Executive Director of Nursing responded that the complaints may not have been coded correctly and further clarity would be provided on this. The Interim Executive Director of Nursing added that her sense from reviewing all complaints prior to sign off was that poor communication was the primary theme.<br><br>A Non-Executive Director (BC) requested further information on the 47 percent of complaints that had been either fully or partially upheld.<br><br>The Trust Chair highlighted that he had reviewed complaints quarterly with the previous Executive Director of Nursing and asked that this practice be reinstated with the Interim Executive Director of Nursing in order to provide further assurance regarding quality. The Chief Executive invited all Non-Executive Directors to review complaints if they wished to do so.<br><br>**Action:** Interim Executive Director of Nursing to provide further information in future reports on the primary themes of complaints and the number of complaints that had been fully or partially upheld.<br><br>**Action:** Interim Executive Director of Nursing and Trust Chair to arrange to meet quarterly to review a sample of complaint investigations and responses<br><br>**Outcome:** The Board noted the information included in the report and that work was in hand to review and revise the format of the report | **Interim Executive Director of Nursing** |
| **2018-19 (77)** | **Freedom to Speak Up Guardian Report**<br>The Chief Executive introduced the Freedom to Speak Up (FTSU) Guardian who presented an overview of basic activity data and information on the future direction of the role. In line with the most recent national guidance, the Board would receive an update twice a year.<br><br>The FTSU Guardian highlighted that in the two years since the role had been established, a strong culture of speaking up had been established in the Trust | |

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| | along with a strong developing vision. Activity had been reported in all business units from a range of occupations. Key themes were noted as follows: uncertainty of where a service is to be located, processes not taking into consideration the wellbeing of staff, issues around leadership and culture, and more recently, the use of CCTV in the homes of service users. Support was also requested by, and offered to managers.<br><br>The role had been developed to include involvement in any workstreams undergoing change, such as the 0-19 service development and the patient admin review. Further developments included extending the role to include support to the Leeds GP Confederation, and the establishment of a Speaking Up network in the City.<br><br>The Board noted that a Non-Executive Director (RG) was the Non-Executive Director Lead for the FTSU workstream and he and the FTSU Guardian were meeting monthly and would ensure that learning from elsewhere was adopted within the Trust.<br><br>A Non-Executive Director (JM) commented that the role appeared to be focussed on patient care, and yet, half the cases reported were from corporate services. The FTSU Guardian responded that initially issues raised related to patient care, however, nationally it had been found that the issues reported increasingly related to culture. The Chief Executive added that the role was increasingly a conduit for talking through issues with line managers which had assisted in identifying the need to further support managers.<br><br>The Chief Executive informed the Board that a recent Well-led Framework peer review exercise had identified that the FTSU Guardian's role was well embedded within the organisation and it had been recognised that the Board were open to listening to the issues raised. The Chief Executive added that the FTSU Guardian was also undertaking a peer review exercise on the FTSU Guardian role with a local provider organisation.<br><br>The Chair thanked the FTSU Guardian for a good report and for the way in which he had developed the role over the past two years.<br><br>**Outcome:** The Board noted the report and activity to date and supported the embedding of the work across the Trust | |
| **2018-19 (78 )** | **Guardian for Safe Working Hours Report**<br>The Guardian for Safe Working Hours attended the meeting to present the report which outlined issues such as working hours, quality of training and morale, which affected trainee doctors and dentists within the Trust.<br><br>The Board noted that the Guardian had attended the Health Education England Monitoring the Learning and Educational Environment meeting in September 2018 where feedback had been shared that the Trust was one of the best performing trusts in the region, with trainees reporting high levels of satisfaction with their training experience. The Guardian added that the trainees in CAMHS appeared to have engaged well with the Guardianship process. It was noted that Paediatric trainees had provided feedback that their training needs were being managed by their own training specialties.<br><br>The Interim Executive Medical Director commented that the Medical Lead Group would be considering why it was that CAMHS trainees felt engaged, and what could be done to ensure trainees in other areas felt more engaged.<br><br>A Non-Executive Director (IL) noted that the last two Joint Negotiating Committee | |

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| | (JNC) meetings (referred to in the report as the 'LNC') had been cancelled. The Interim Executive Medical Director highlighted that this was partly due to the British Medical Association representative taking some sickness absence leave. The Interim Executive Medical Director added that she was aware and would be ensuring the meetings take place in 2019.<br><br>**Outcome:** The Board noted the report and supported the further promotion of the interface between the Guardian and trainees. | |
| **2018-19 (79)** | **Health Education England self-assessment return**<br>The Interim Executive Medical Director presented the self-assessment report which required Board approval prior to submission to Health Education England.<br><br>**Outcome:** The Board approved the return for submission | |
| **2018-19 (80)** | **Professional Strategy**<br>The Interim Executive Director of Nursing provided a verbal update and informed the Board that further elements would be added to the Quality Strategy to create one strategy. A Non-Executive Director (IL) confirmed that the proposal had been discussed and supported at the Quality Committee.<br><br>**Outcome:** The Board noted the update | |
| **2018-19 (81)** | **Well Led Framework self-assessment update**<br>The Chief Executive introduced the update. A full self-assessment had been delayed pending the outcome of the recent peer review process undertaken by Cambridgeshire Community Services NHS Trust. Feedback reflected an emerging picture of an overall assessment of 'Good'. The Chief Executive added that the Executive Team were testing any areas where it was felt that the Trust may wish to self-assess as 'Outstanding'.<br><br>Key feedback received included: staff had a very good understanding of the role of the Chief Executive and the Executive Team; the majority of staff spoken with knew who the Executive Director of Operations was; there was a strong understanding of the organisation's culture with evidence of a culture of engagement and positivity; good feedback on embedding learning; Non-Executive Directors were less well known to frontline staff. The Chief Executive suggested that a Non-Executive Director write a guest blog in the weekly Community Talk e-bulletin.<br><br>The Chief Executive felt that the feedback reflected what was known by the Executive Team and would allow the team to focus on priority areas. The Executive Director of Operations informed the Board that Paul Morrin would be leading unannounced mock inspections of some services in order to ensure that concerns raised by the Care Quality Commission (CQC) in their last inspection of the Trust had been addressed.<br><br>The Trust Chair proposed that some time be used at the next Board workshop to discuss how Non-Executive Directors might be more visible in frontline services. It was noted that the Trust Chair would be attending the next meeting of the 50 Voices Group.<br><br>**Outcome:** The Board noted the development of the areas of focus for the action plan and were assured that the approach to preparing for the CQC Well-led Framework review was satisfactory. | |

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| **2018-19 (82)** | **Equality and diversity report**<br>The Director of Workforce, OD and System Development (JA) introduced the report which outlined progress made over the past 12 months in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED). Inclusions in the report demonstrating compliance with the NHS Standard Contract through the adoption of the NHS Equality Delivery System2 (EDS2) and Workplace Race Equality Standard (WRES) supported the Trust in meeting PSED.<br><br>The Director of Workforce, OD and System Development (JA) added that whilst the report demonstrated meeting the standards required, it did not illustrate all the work being undertaken, including; the Equality and Diversity Facilitator's role as a WRES Expert, the establishment of a BAME Network which was also working on awareness around dyslexia, the roll out of reverse mentoring in early 2019, and the work underway to identify talent that diversity in the workforce would enable.<br><br>The Trust Chair reflected on the need to continuously review the work in this area, particularly regarding race equality. The Trust Chair asked if the Freedom to Speak Up Guardian role provided adequate resource by which to raise any concerns. The Director of Workforce, OD and System Development (JA) responded that there were a number of avenues available to staff, including the BAME Network chair.<br><br>**Outcome:** The Board noted that the Trust was meeting the requirements of the PSED and the NHS Standard Contract in part, and recognised that there were areas for improvement. The Board was assured of the comprehensive plans and resources that had been put in place to advance equality of opportunity and would continue to be actively involved with promoting the equality and diversity agenda. | |
| **2018-19 (83)** | **Board work plan**<br>The Chief Executive presented the Board work plan (public business) for information.<br><br>**Outcome**: The Board noted the work plan. | |
| **2018-19 (84)** | **Approved minutes of Board committees**<br>The Board noted the following final approved committee meeting minutes and reports presented for information:<br>a) Quality Committee: 24 September 2018 and 22 October 2018<br>b) Business Committee: 26 September 2018 and 24 October 2018<br>c) Audit Committee: 19 July 2018<br>d) Charitable Funds Committee: 22 June 2018<br>e) Leeds Health and Wellbeing Board: 5 September 2018<br>f) Leeds Safeguarding Adults Board: 20 July 2018 | |
| **2018-19 (85)** | **Close of the public section of the Board**<br>The Chair thanked everyone for attending and concluded the public section of the Board meeting. | |
| **Date and time of next meeting<br>Friday 1 February 2019, 9.00am – 11.45am<br>Boardroom, Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF** | | |





Signed by the Trust Chair:
Date: 1 02 2019

AGENDA ITEM 2018-19 (90b)

# Leeds Community Healthcare NHS Trust
## Trust Board meeting (held in public) actions' log: 1 February 2019

| Agenda Number | Action Agreed | Lead | Timescale | Status |
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| **Meeting Friday 5 October 2018** | | | | |
| **2018-19** (51) | **Chief Executive's report:** *CQC Local System Review of Health and Social Care in Leeds*: a final copy of the CQC report to be circulated to Board members when available. | Executive Director of Operations | When the report is available Ongoing | |
| **2018-19** (56) | **Workforce strategy: framework document:** Further draft to be presented to the Board for approval in February 2019. | Director of Workforce, OD and System Development | Trust Board 1 February 2019 | On agenda |
| **Meeting 1 December 2018** | | | | |
| **Meeting Friday 5 October 2018** | **Committees' assurance reports** Senior Management Team to consider the Leeds Cares offer and put forward a recommendation to the Board | Chief Executive | Trust Board 29 March 2019 | |
| **2018-19** (71) | **Committees' assurance reports** Executive Director of Finance and Resources to speak with the Director of Workforce, OD and System Development and Internal Audit Manager regarding an internal audit review of the ESR action plan | Executive Director of Finance & Resources | Trust Board 29 March 2019 | |
| **2018-19** (71) | **Committees' assurance reports** Chief Executive and Director of Workforce, OD and System Development to consider HR representation at the Quality Committee | Chief Executive | Trust Board 29 March 2019 | To be reviewed at March 2019 Quality Committee |
| **2018-19 (71)** | **Committees' assurance reports** Interim Executive Medical Director to submit a report on mortality to the January meeting of the Quality Committee and the Trust Board in February 2019 | Interim Executive Medical Director | Trust Board 1 February 2019 | On agenda |
| **2018-19 (72)** | **Performance brief and domain reports** Interim Executive Director of Nursing to provide update on patient engagement to the Quality Committee | Interim Executive Director of Nursing | Trust Board 1 February 2019 | Completed |
| **2018-19 (73)** | **Significant risks and Board Assurance Framework (BAF) report** Senior Management Team to review the risk score and description of Risk ID 224 and consider the addition of a risk relating to a potential reduced level of care if the Trust did not have sufficient staff in post with the appropriate skills. The Chief Executive and Company Secretary would then iterate this with risks on the BAF. | Chief Executive | Trust Board 1 February 2019 | Risk 224 (Sickness absence) reviewed and score decreased. Risk register capacity risk to be added to |

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| | | | | risk register. |
| **2018-19 (74)** | **Neighbourhood Teams' activity**<br>Review of activity levels against profiles to be reported to Business Committee | Executive Director of Finance and Resources | Trust Board 1 February 2019 | Completed |
| **2018-19 (76** | **Patient experience report**<br>Interim Executive Director of Nursing to provide further information in future reports on the primary themes of complaints and the number of complaints that had been fully or partially upheld. | Interim Executive Director of Nursing | Trust Board 24 May 2019 | |
| **2018-19 (76** | **Patient experience report**<br>Interim Executive Director of Nursing and Trust Chair to arrange to meet quarterly to review a sample of complaint investigations and responses | Interim Executive Director of Nursing | Trust Board 1 February 2019 | |

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| Actions on log completed since last Board meeting | |
| Actions not due for completion before 1 February 2019; progressing to timescale | |
| Actions not due for completion before 1 February 2019; agreed timescales and/or requirements are at risk or have been delayed | |
| Actions outstanding as at 1 February 2019; not having met agreed timescales and/or requirements | |

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**AGENDA ITEM 2018-19 (91)**

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| **Meeting:** Trust Board 1 February 2019 | **Category of paper** | |
| **Report title:** Chief Executive's report | **For approval** | |
| **Responsible director:** Chief Executive<br>**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. The report, which aims to highlight areas where the CEO and senior team are involved in work to support the achievement of the Trust's strategic goals and priorities: delivering outstanding care in all our communities, staff engagement and support, using our resources efficiently and effectively, and ensuring we are working with key stakeholders both locally and nationally.

This month's report focusses on the key work being undertaken to support and develop our staff.

**Main issues for consideration**

The main features of the report are:

- Liaison and Diversion Service – new contract
- NHS long term plan – what this means for LCH
- Updates on collaborative working
- Reverse mentoring

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

**Recommendation**

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategic goals and particularly staff engagement and support

## Chief Executive's report

### 1. Trust business

### 1.1 Liaison and Diversion service – new contract

Liaison and Diversion (L and D) service Humberside – LCH, in partnership with Community Links, has been successful in securing this contract (£1.1m p/a) for 6 years starting 1 April 2019. The procurement follows a region-wide pilot of L and D services and LCH is the only non-incumbent provider who has been successful in securing a contract. The service will be a natural complement to our police custody healthcare services and provides an exciting opportunity to integrate care on the health and justice pathway.

### 1.2 Winter services

So far this winter services are coping well across the system however at the time of writing we have not had heavy snow or serious outbreaks of flue. Our services remain resilient and are managing across specialist and adult services to deal with flow and work well with both LTHT and Primary care services in meeting demand. System plans are having an impact but we remain to see how well we will all cope with further demand which need our surge plans to be operationalised.

### 1.3 Long term plan

The NHS Long Term plan was published in January 2019. The plan provides support for the direction of travel that LCH has been pursuing for several years now – namely closer working relationships with primary care, the importance of developing primary care networks (localities and LCPs in Leeds language), the importance of people taking control over their own health, the focus on population health, the need to invest in children's mental health services and shifting care to the community. The executive are parts of a wide range of conversations across the system looking at ways in which the plan will "come to life" across Leeds in the next 1-10 years.

### 1.4 OFSTED – Children's services are rated outstanding

Children's services provided by Leeds City Council and Leeds Community Healthcare were inspected by OFSTED recently and have been rated by as 'Outstanding'. Leeds is the first major city to achieve this standard. Health and social care colleagues involved in Children's Services across Leeds have been on a continuing journey of improvement since 2010. Partners across the city will continue working towards a shared ambition to make Leeds the best city for children to grow up in.

### 1.5 Trust Learning Disability Leads

Three lead contacts have been established within the Trust for patients with learning disabilities The Trust recognises the importance of staff being able to access expertise and support to ensure patients get the right level of care. The lead contacts will act in an advisory capacity for staff caring for patients with a learning disability**.** To date the details have been posted on ELSIE for all staff to see but there is work ongoing to produce posters for the organisation to ensure this is visible to all services and bases. The purpose of these roles is for staff to be able to make contact to seek advice or discuss any concerns in relation to caring for a patient

living with a learning disability to ensure we deliver high quality care for all our patients.

**1.6 Reverse mentoring**

We are delighted that the 12 month reverse mentoring programme (Cohort 1) was launched at the Trust Board workshop on the 4 January 2019. BAME staff are now mentoring a Board member with whom they will have opportunity to provide their experiences first hand. This is an exciting development and one that we hope will be another way in which we can tackle conscious and unconscious bias in Leeds Community Healthcare NHS Trust. The organisation is committed to its vision, values and behaviours and the reverse mentoring programme is a great way to bring many of them to life. Our second value is to treat everyone as an individual and two of our core behaviours are to care for one and another and to find solutions. Reverse mentoring gives us the opportunity to do all of that. We want Leeds Community Healthcare NHS Trust to be an outstanding organisation where everyone flourishes and everyone has the same experience and opportunity.

**1.7 Mental Health first-aiders**

We have been working in partnership with our Leeds City council colleagues who will deliver accredited Mental Health First Aid training for 12-15 of our staff. Mental Health First Aid is an internationally recognised training course, designed to teach people how to spot the signs and symptoms of mental health and provide help on a first aid basis.

**1.8 Sustainability Forum**

The Trust has established a Sustainability Forum which meets regularly to consider LCH's approach to environmental sustainability. The group is exploring topics such as recycling, car sharing, reducing single-use plastic, and skyping into meetings, all with a view to avoiding the depletion of natural resources.

**2. Working in partnership**

**2.1 Leeds Primary Healthcare Collaborative**

The Leeds Primary Healthcare Collaborative met on 22 January 2019 and discussed how the Leeds GP practices, the Trust, their wider partners and the people of Leeds can work together for improved outcomes for patients. The Collaborative received a presentation on current and future integrated working in the Holt Park and Woodsley area. The framework for this work was modelled on the Leeds Plan and the aim was to work together to achieve the outcomes that are important to the local population, avoid duplication and have the right care, at the right time in the right place. The Collaborative also considered the workforce priorities and challenges associated with increasingly integrated working across primary and community care. An update was received on a number of developing and emerging workstreams and the Collaborative considered the clinical governance processes needed to ensure good quality, safe care.

## 2.2 Leeds Providers' Integrated Care Collaborative

The second formal meeting of Leeds Providers' Integrated Care Collaborative was held on 22 January 2019. It was another really positive meeting where the collaborative discussed how it would take forward the work in frailty, ensuring service changes are driven by evidence. The collaborative also heard about some of the great that work that is already going on across primary, community, mental health and hospital services, for example work on respiratory, diabetes and outpatients more generally and heard about some of the barriers to this, and committed to support practical changes to enable further developments.

## 2.3 Integrated Care System (ICS)

All ICS partner organisations have now formally approved the Partnership's Memorandum of Understanding. A Partnership Board is being established to provide the formal leadership for the Partnership and to bring NHS, councils and communities closer together. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters. Cllr Tim Swift, Leader of Calderdale Council and Chair of Calderdale Health and Wellbeing Board, will be Chair of the Partnership Board for the first two years and Angela Schofield, Chair of Harrogate District NHS Foundation Trust, will be the Vice Chair. The first meeting in public will take place in June 2019.

# 3. News and awards

## 3.1 Admin celebratory event (conference)

The Trust hosted a conference for administrative staff on 11 December 2018. This was a full day event attended by 200 admin staff from across the organisation. The strap line was 'So much more than just admin' and the aim was to demonstrate that LCH values its admin staff. The programme involved a mixture of workshops and presentations on admin related topics ie career progression within LCH, health and wellbeing, development opportunities for admin from the Centre of Excellence, mindfulness and office design. The feedback was 100% positive, staff said they felt valued; they had a good day and felt that LCH was a great place to work. It is anticipated that will become a regular event.

## 3.2 Prestigious award win for new research

LCH Community Dietitian Jitesh Patel has recently won the British Dietetics Association's Research Symposium 1st prize for New Research for his research on Iodine screening for women of childbearing age.

# 4. Recommendations

4.1 The Board is recommended to:

- Note the contents of this report

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (92a)**

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| **Report to:** Trust Board: 1 February 2019 |
| **Report title:** Charitable Funds Committee 14 December 2018: Committee's Chair assurance report |
| **Responsible director:** Chair of Charitable Funds Committee<br>**Report author: Interim** 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 14 December 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

**Charitable development updates**
The Interim Director of Nursing updated the committee on the 4 key priority areas:

**More than a welcome programme**
A full report would be presented to the Committee at the next meeting to identify the work completed to date and the next steps as the new person is now in post.

**Charity Development Group**
There was not a Charitable Development Group operational in the organisation at that time. The Committee agreed this should be placed on hold until the future direction of travel for the work and governance of the Committee had been agreed.

**Liaison with Leeds Cares**
The Interim Executive Director of Nursing gave an overview of the meeting she had with the Chief Executive of Leeds Cares on 3 December 2018.

The Interim Executive Director of Nursing felt the conversation had been productive in terms of what the offer could be.

The Chief Executive of Leeds Cares had agreed the Hannah House fund could be kept as a separate entity.

There had been a discussion around 'what it would look like' if the Trust became part of Leeds Cares. The Chief Executive (Cares) had said there would be wider access to fund raising and also to additional funds.

The Chief Executive had confirmed that Leeds Cares were completely independent of Leeds Teaching Hospitals NHS Trust.

The Interim Executive Director of Nursing highlighted that Leeds and York Partnership Trust were in conversations with Leeds Cares around consolidation of their charitable funds.

The Interim Executive Director of Nursing stated that the Senior Management Team believed this was the right direction of travel.

The Chief Executive of Leeds Cares had offered to deliver a presentation to the Trust's Board around what they could offer. The Committee agreed the Trust Board Workshop in March 2019

would be a good opportunity to receive this presentation.

**In-house lottery scheme**
The Interim Executive Director of Nursing confirmed that the in-house lottery scheme had not been progressed since the last meeting.

In response to a query from the Trust Chair, the Deputy Director of Finance and Resources and the Interim Executive Director of Nursing said there had not been any 'testing the appetite of staff'. Deputy Director of Finance and Resources proposed talking to other Trusts about their in-house lottery schemes.

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

## Charitable funds: financial report

The Committee Chair raised two queries in relation to the report:

Income and Expenditure Account 31 October 2018: Overheads
In response to a query from the Committee Chair, the Deputy Director of Finance and Resources said the support costs for the telephone and computer charges were reasonable. She informed the Committee that the charges related to a fixed license fee for additional accounting software. The Charitable Funds required a separate system as it could not run on the Trusts Oracle system.

Detailed Expenditure Transactions: Hannah House TVs and radios
The Committee Chair queried the expenditure for TVs and radios at Hannah House. The Deputy Director of Finance and Resources responded that the expenditure had resulted from a CQC recommendation. The Committee Chair queried if the expenditure should have come out of the The Committee Chair queried if the expenditure should have come out of the Trust's funds rather than the Charitable Funds. The Deputy Director of Finance and resources agreed to look into this.

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

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (92b)**

**Report to:** Trust Board - 1 February 2019

**Report title:**
Nominations and Remuneration Committee - 14 December 2018
Committee Chair's 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 outlines the key issues for the Board arising from the Nominations and Remuneration Committee held on 14 December 2018.

**Appointment to Executive Director Roles:**
The Committee approved the substantive recruitment and selection processes to proceed for the Executive Medical Director and Executive Director of Nursing roles. Approval was given for the roles to be advertised and appointed to within VSM salary range from lower quartile up to and including median quartile salary. The involvement of NHS Improvement in the selection process was noted.

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

**Outcome of Clinical Excellence Awards:**
The Committee accepted the recommendations of the Clinical Excellence Awards panel in rewarding five Employer Based Clinical Excellence Awards for 2017/18 to the nominated Consultants. The Committee noted that the results, as set out in the paper, were encouraging with visible progress made in terms of gender equality and BAME diversity.

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

**Approval of Payment of Living Wage:**
The Committee confirmed support for the proposal that the Trust pay the new rate of the Real Living Wage from 1 November 2018. Approximately 200 staff would be in receipt of the uplift and it was felt that the impact on them would be significant with the resulting financial cost to the Trust c.£8K.

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

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**AGENDA ITEM 2018-19 (92c)**

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| **Report to:** Trust Board 1 February 2019 |
| **Report title:** Audit Committee 14 December 2018: Committee's Chair assurance report |
| **Responsible Director:** Chair of Audit Committee<br>**Report author:** Company Secretary |
| **Previously considered by:** Not applicable |


**Summary**
This paper identifies the key issues for the Board arising from the Audit Committee on 14 December 2018.


**Internal audit**
The Committee noted completion of a further five audits as part of the 2018/19 internal audit plan. The audits covered:

- Cyber Security
- Clinical Audit
- GDPR
- Collaborative Partnership Working
- Key Financial Systems

All had received reasonable assurance.

The Committee expressed some concern about the findings within the Clinical Audit report which prompted a question about whether the outcomes and learning from these audits are being shared widely enough across the Trust. Audit Committee suggested that the quality improvement aspect of clinical audits should be monitored by Quality Committee (QC) and the QC Chair agreed to discuss this at the next agenda setting meeting for the QC.

The Committee noted the recommendations for Collaborative Partnership Working. One of the findings had identified that, in several of the partnerships which had been reviewed, insufficient preparatory work was undertaken at the outset of the partnership and consequently the roles, responsibilities and governance arrangements for partnerships were therefore often unclear. The Committee requested that the Executive Director of Finances and Resources provide details of the actions to be taken in response to the Internal Audit recommendation 3. The Committee suggested this might include working with the Company Secretary to draft a set of governance standards for partnership working.

**General Data Protection Regulation (GDPR)**
The Committee received a progress report on the Trust's actions to achieve compliance with GDPR legislation, which provided reasonable assurance that the Trust's GDPR plans are robust and being delivered. This was supported by the internal auditor's opinion following their review of GDPR. The Committee was advised that data-mapping was 98% complete, with only two teams outstanding. The Committee noted the progress made on the implementation plan and recognised the achievements of the Data Protection Officer and her team. The Committee agreed that it should retain scrutiny of GDPR until it was confident that the plan was embedded and actions were sustained. The Data Protection Officer will continue to attend the Audit Committee meetings to provide further updates.

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

**Board Assurance Framework (BAF)**
The Committee reviewed the entire BAF as part of its 6 monthly review programme. The Committee queried the robustness of some of the controls and appropriateness of some sources of assurance and recommended a number of actions for individual executives and for the committees responsible for oversight of the BAF strategic risks, to be followed up by the Company Secretary.

At a previous review, the Committee had recommended that an additional strategic risk should be added concerning the threat of cyber security to the Trust's infrastructure. At the December 2018 meeting the Committee was provided with a draft risk description for proposed BAF Risk 2.6, along with controls and sources of assurance. The Committee reviewed this draft risk and recommended that the risk description should be extended to include risks associated with human behaviour in relation to cyber security and to add the controls provided by the National Cyber Security Centre. The Committee agreed to propose to the Board that this additional risk, once amended, is included in the current BAF.

**Standing Financial Instructions - breach**
The Committee was provided with information about a breach of standing financial instructions, concerning a celebration event in which staff were given gift vouchers. These are deemed to be "cash payments" as far as HMRC is concerned and as such they are liable to tax and national insurance; there is no exemption for small values of gift vouchers given to staff. This is the first time a breach of standing financial instructions has been reported and was picked up during routine scrutiny of re-imbursement of petty cash floats. The Committee was informed that the Executive Director of Finance and Resources would remind the organisation of the rules in respect of this and the tax and NI due will be paid to HMRC by the Trust.

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**AGENDA ITEM 2018-19 (92d)**

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| **Report to:** Trust Board 1 February 2019 |
| **Report title:** Quality Committee 21 January 2019: Committee's Chair assurance report |
| **Responsible Director:** Chair of Quality Committee<br>**Report author:** Company Secretary |
| **Previously considered by:** Not applicable |

**Purpose of the report**

This paper identifies the key issues for the Board from the Quality Committee meeting held on 21 January 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

The Committee holds six 'business' meetings aligned with Trust Board meetings and four 'focus based' workshop style meetings per year. The January 2019 Quality Committee meeting was a business meeting.

**Service spotlight: Police Custody Forensic Healthcare Service**

The Committee received a presentation from representatives from the Police Custody Forensic Healthcare Service. The representatives described the remodelling of the service's structure and its two main functions: which are forensic and healthcare. The service is moving away from reliance on forensic medical examiners towards an upskilled healthcare professional workforce. The service recognised that a lot of its staff have come from a number of other providers by a TUPE process, as well as having a large number of newly recruited staff, and is focussing on embedding the Trust's culture and values. This is a challenge as the service has a large geographic footprint spanning Yorkshire and the Humber. The Committee queried the variance in the numbers of patients being seen by the service in each of the four regions (West, South, North, Humber). The service representative explained that types of crime and patient needs were different in each region. The Committee learned that the service sees everyone who is referred and there are no gaps in provision. The awarding of the tender and the subsequent remodelling has meant the service is now moving forward in a positive way. The service is consistently meeting its key performance indicators set by the commissioners (the police) and are now able to focus more on clinical quality outcome indicators.

**Clinical Outcome Programme Update**

The Committee was advised that 75% of all services had completed a self-assessment on use of outcomes information, which rated them in terms of their current position and where they aspire to be in 12 months. This provided an objective overview of the Trust's position. Previously only anecdotal information had been available about clinical outcomes and services welcomed the prospect of have structured support and being able to demonstrate the true quality of their work. SMT are being provided with an options appraisal for additional resourcing. Whilst the Committee agreed that the report had provided them with a good understanding of the current position in relation to the Trust, there should ultimately be consideration for the Leeds system and public health outcomes for the City. The Committee will receive a further paper in March 2019 which will describe specific actions to progress the Clinical Outcomes Programme.

**'Winter Planning'**

The Committee was advised that whilst winter was now here, there hadn't as yet been a surge in local demand as had previously been experienced at this time of year. The hospitals were busy but not as stretched, our own services were busy, but mostly steady. There were a number of possible factors for this: the milder weather, that there hadn't been a major flu outbreak, an improvement in the ways of system working, partly as a result of the response by local trusts including LCH, to the Newton Europe and CQC system reviews. There had also been some improvements in social care, which was key for the flow of patients.

**Risk Register**
The Committee received an update on clinical and operational risks, including two new high scoring risks which were the increased demand for the Foot Protection Service and the increase in demand for the Adult Speech and Language Therapy Service. There was also one escalated high scoring risk regarding the IAPT service, which has seen an increase in demand and was experiencing capacity issues at the point of initial assessment. The Committee was advised that SMT had reviewed the risk register and there were a number of clinical risks currently being assessed with a view to adding these to the risk register.

**Quality Strategy Implementation Plan**
The Committee was presented with the quarter three position on progress with the Quality Strategy implementation plan and the overarching objective which is to strengthen the Trust's approach to quality improvement. There has been good progress made across all four quality improvement areas in the last quarter including the alignment of quality improvement work with other quality initiatives across the Trust. The update provided the Committee with reasonable assurance.

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

**Quality Account – quality improvement priorities quarter three position 2018/19**
The Committee was presented with the quarter three position on progress with the Quality Account Improvement priorities. The Committee was advised that at the end of Q3, nine indicators are progressing as planned, 14 indicators have a risk of delay or not being achieved and four indicators have not met the agreed timescale for achievement. The Committee expressed concern about the four areas not expected to be achieved. These were: Quality Challenge Plus visits to all services, waiting times in ICAN and autistic spectrum disorder assessment service, CAMHS waiting times, Friends and family test (FFT) equality data improvement. The Committee debated the level of assurance this report provided and felt that reasonable assurance was provided that the right actions were in place to support achievement of priorities; the Committee was less assured that all priorities would be achieved.

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

**Guardian for Safe Working Hours**
The Guardian for Safe Working Hours (GSWH) quarterly report described vacancies and rota gaps in the CAMHS service. The Committee was advised that currently not all services that had junior doctors and dentists were as engaged as the CAMHS service in reporting issues affecting their working hours, quality of training and morale. Work was taking place to consolidate an accurate database of junior doctors in training at LCH. The progress being made by the GSWH provided the Committee with reasonable assurance.

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

**Clinical Audit**
The Committee received an update on clinical audit activity for the period April to September 2018. The Committee was advised that progress of the rolling programme of audits was monitored through the Clinical Effectiveness Group. The Committee was content that sufficient progress was being made towards the completion of clinical audits. The Committee was advised that the next update on the 2018/19 programme would provide more information about the quality improvements achieved through clinical audit.

**Performance brief and domain reports**
The Committee reviewed the Performance Brief data, which is supplemented by additional clinical governance data in the Clinical Governance Report. The Committee recognised the improved format and richer narrative of this month's Performance Brief. The Committee queried the number of overdue incidents and was advised that an action plan to improve this was in place. In the Responsive section of the Brief, the Committee discussed IAPT's capacity and the quality implications of the increased waiting times for level 3 interventions. In the Effective domain, the Committee was advised that the targets set for Quality Challenge Plus programme of self-assessments and peer reviews are not currently sensitive

enough to provide useful data. The Committee also heard there were operational difficulties with the Quality Challenge Plus programme and that not many visits had been conducted recently. The Committee agreed that the programme was useful and helped services to think about quality in a particular way. The programme is being reviewed to ensure it is fit for purpose. The Committee discussed the learning achieved through pressure ulcer incident investigations and that there was a need for better holistic assessments of patients, rather than continuing the current linear approach. The Committee reviewed compliance with NICE guidance section, and recognised that the Trust had no control over some actions that were required.

The improved narrative and format of the Performance Brief provided the Committee with reasonable assurance.

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (92e)

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|---|
| **Report to:** Trust Board 1 February 2019 |
| **Report title:** Business Committee 23 January 2019: Committee's Chair assurance report |
| **Responsible Director:** Chair of Business Committee<br>**Report author:** Company Secretary |
| **Previously considered by:** Not applicable |

**Purpose of the report**
This paper identifies the key issues for the Board from the Business Committee held on 23 January 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

**Service Support Session:**
Representatives from Leeds Sexual Health Service attended Business Committee for the service support item, which was a shared problem-solving session. The service provided the Committee with a briefing paper in advance of the meeting, which provided background and contextual information about the service, including the integrated service model, and described the challenges around managing capacity and demand in a 'walk-in' service. The Committee was impressed by the collaborative approach that had been taken to the ambitious project to try reducing the number of people queuing for this service. Live data capture from more than 400 patients had provided useful intelligence and feedback about patient experience. Data analysis provided hard evidence to support negotiations with commissioners about the level of demand, the pattern of that demand during the opening hours and inefficiencies built in to the way of working to meet commissioner's specifications. The service provided the Committee with data to demonstrate how its approach to quality improvement had a positive impact on DNA rates and very significantly on the numbers of people who walk out when waiting too long a time to be seen at a clinic. The Committee congratulated the service on their approach to quality improvement, finding solutions, and combining excellent staff engagement with data collection and analysis.

**Operational Plan**
The Committee received an overview of progress towards achieving the Trust's 14 priorities set out in the 2018/19 operational plan and a forecast for year-end. The Committee was advised that 10 were currently on track, with the remainder having some risk of not being achieved. There are three priorities forecasting under performance at a year-end. These are: to reduce sickness absence, develop CAMHS T4 new build and service offer, and work on productivity within agreed services.

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

**Change Board (Projects)**
The Committee received an overview of the Trust's major change projects. The Committee was advised that an options appraisal paper on the Admin Review Project was to be considered by SMT regarding next steps, project support and timescales for completion. The Committee was reasonably assured by the information about individual projects but requested that future reports should include information about cross-cutting dependencies for the six major change projects.

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

**Draft Estates Strategy Transformation 2019-2024**
The Committee received a report describing proposals for an Estates strategy refresh. The Committee had previously reviewed the existing estates strategy and found that it did not provide sufficient vision. This paper set out the vision and the key proposals and targets which would shape the revised strategy. The Committee was advised of the opportunities this strategy provided for rationalising and utilising space in a different way and for working more closely with partners across the City. The Committee reflected that the paper did not say enough about the change in the ways that staff work and whether the strategy should drive or facilitate the change. The Committee's comments and concerns will be used to shape the revised strategy, which will be presented to the Committee later in the year.

**Performance Brief**
The Committee agreed that the new format and improved narrative provided the Committee with a much clearer picture of performance. The Committee reviewed the IAPT waiting times information and were advised that a recovery plan is being worked on with the commissioners, to improve access and flow. In the meantime, additional funding had been provided. The Committee noted that statutory and mandatory training figures were down in December 2018; this is in part because of a national issue with e-learning, which has since been resolved. The Committee discussed sickness absence figures and was advised that the Trust is not statistically an 'outlier' when compared to other trusts. It is however higher than average. The Committee was advised that the Trust is likely to achieve its financial control total.

NHS
Leeds Community Healthcare
NHS Trust

**AGENDA ITEM**
2018-19
(93i)

| | | |
|---|---|---|
| **Meeting:** Trust Board, 1 February, 2019 | **Category of paper** *(please tick)* | |
| **Report title** Performance Brief and Domain Reports | **For approval** | |
| **Responsible director:** Executive Director of Finance and Resources<br>**Report author:** Head of Business Intelligence | **For assurance** | ✓ |
| **Previously considered by:**<br>Senior Management Team, 16 January 2019<br>Quality Committee, 21January 2019<br>Business Committee, 23 January 2019 | **For information** | |

**Purpose of the report**

This report provides a high level summary of performance within the Trust during December 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**

A particular highlight this month is a significant reduction in the turnover of staff with less than 12 months' service, which has been subject to close analysis and support from the Workforce team following an unexpected rise earlier in the year. Overall turnover continues to be significantly lower than peer organisations.

Within the Trust and across all partners in the city, winter preparations are high on the agenda. Overall staffing levels, including banks and agency resourcing, remain under continuing review as we approach the months where the greatest demand on our neighbourhood teams and other services can be expected.

In recent weeks, since late December 2018, a national ESR issue has led to NHS employees being unable to effectively undertake e-learning. This is expected to have a negative impact on statutory and mandatory training compliance until the issue is resolved. We continue to press the national ESR team for a resolution timeframe; as yet none is forthcoming although we have been given assurance that the issue is being worked on as a high priority.

A summary narrative for each domain is provided in section 1 of the Performance Brief.

**Recommendations**
**The Committee is recommended to:**

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

# Performance Brief – December 2018

Leeds Community Healthcare NHS Trust

**Purpose of the report**

This report seeks to provide assurance to the Senior Management Team, Business Committee, the Quality Committee and the Trust Board on quality, performance, compliance and financial matters.

It is structured in line with the Care Quality Commission (CQC) domains with the addition of Finance.

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.

**Committee Dates**
Senior Management Team – 16th January 2019
Quality Committee – 21st January 2019
Business Committee – 23rd January 2019
Trust Board – 1st February 2019

**Recommendations**

Committees and the Board are recommended to:

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

**Main issues for Consideration**

Overall performance remains ***good***.

Within the Trust and across all partners in the city, potential pressure over the next couple of months remain a focus. Pressure on hospital services has been reported but this has not translated into increased demand on our Neighbourhood teams and other services. At the time of writing this report (17 January) a change to a colder period of weather is expected and Trust services are remaining vigilant with regard to the potential impact on demand. Overall staffing levels, including banks and agency resourcing, remain under continuing review. On 23 January the Business Committee received a detailed update on Neighbourhood team key performance indicators. This report noted that vacancies are at a level consistent with the average over the past two years, sickness and maternity leave absence slightly above a two year average and bank and agency use slightly below average. Teams continue to maintain delivery of revised standards for timely response to new referrals from community and acute partners. All referrals before 12:00 from hospital or community beds requiring an immediate support response on discharge will be seen the next day.

Across the domains in this Performance Brief, the summary position is as follows:

In the **Safe and Caring** domain, all KPIs were at or above target in December with the exception of a marginal (0.5%) under achievement on percentage of respondents recommending community care. This Performance Brief provides more detail behind the KPIs and associated safe and caring measures. There will be a particular focus over the coming month on ensuring that information is provided to Committees and Boards to provide greater assurance over the process to investigate close and learn from incidents.

The Board may have noted good news tweeted during December by the Recovery Hub North West provided by Leeds City Council and the Trust in partnership; they were delighted to report 65 days free from pressure harm in their care and showed off some pictures of the recently completed refurbishment.

In the Responsive domain the Trust continues to perform well against nationally reported waiting lists indicators, with all rated as green for December. There were no patients waiting more than 52 weeks for consultant led services which is a consistent picture for the last 21 months. Since the beginning of the current financial year, the measure of patients waiting less than 6 weeks for a diagnostic test has remained within control limits and subject only to normal variation. For the last 3 months this measure is reported at 100%.

The Trust will continue to focus on all waiting times for all patients across all our services. For example, in the reporting period, the ICAN Service received over 100 new referrals in one week from the CAHMS service for paediatric input for autism assessments. This was as a result of batching referrals and on closer inspection it was found that a) half of the referrals were unnecessary as the young people were known to ICAN and b) the timing of the referrals could be smoothed out over the month to flatten flow. However it did identify the steady increase in referrals from CAMHS to ICAN as a result of an increase in referrals for assessment for autistic spectrum disorders. A multi-disciplinary team drawn from CAMHS and ICAN is now working on a clear pathway between the two services.

There has been a reduction in performance against the 6-week waiting target in IAPT over quarter 3. The expectation is that 75% of referrals should be seen within 6 weeks and the overall quarter performance was 69.9%. It should be noted that the target to see 95% of all referrals within 18 weeks has not been impacted by this deterioration in performance against the 6-week target where quarter 3 was 99.2%.

The service is also commissioned to provide 15% access to the prevalent population; the service is currently achieving access of 13.6%. The national target for 2018/19 is 19% and the perceived underperformance against the national expectation has attracted attention from NHS England.

Joint work with commissioners to address the access target has resulted in a recent increase in the number of patients being referred to the service. In October the service received 1806 referrals which was an 18% increase on the September figure (1536) and a 37% increase on the summer months' average of 1319. This was in line with seasonal trends but is 11% higher than October 2017 and the highest number of monthly referrals received since 2013/14. In November 2018 the service received 1271 referrals (8.2% higher than November 2017) and in December a further 967 referrals were received (8.2% more than December 2017).

This significant increase in referrals in the quarter had a resulting impact on the waiting time for treatment. The longest wait for screening is 7 weeks (at end of December), an increase of 3 days since end of November. Joint work on an action plan to improve performance on the 6-week wait has resulted in new funding from commissioners. A combination of recruitment of new starters, staff completing training and staff returning from sickness absence will create additional capacity of 6.4WTE from February 2019.

Demand, capacity and the impact of the agreed actions are all being closely monitored

The measures in the **Effective** domain are reported quarterly. There is detailed information in this report about the Trust's compliance with NICE Guidelines. The report also brings to the Board's attention the need for a review of our Quality Challenge + process whilst ensuring any reasons why a peer review process may have assessed a service as requires improvement are consistently highlighted and monitored to ensure adequate support is provided.

Good news in the **Well led** domain is a significant reduction in the turnover of staff with less than 12 months' service, which has been subject to close analysis and support from the Workforce team following an unexpected rise earlier in the year. Overall turnover continues to be significantly lower than peer organisations.

In recent weeks, since late December 2018, a national ESR issue has led to NHS employees being unable to effectively undertake e-learning. This is expected to have a negative impact on statutory and mandatory training compliance until the issue is resolved. We continue to press the national ESR team for a resolution timeframe; as yet none is forthcoming although we have been given assurance that the issue is being worked on as a high priority.

Sickness absence continues to track the expected annual trend seen in LCH and other NHS organisations, showing in this report the yearly rise in absence associated with the winter months. Whilst this rise results in December's sickness absence rate being, at 6.37%, the first time this financial year the organisation has been above its target outturn figure of 5.8%,

The 2018 NHS Staff Survey has concluded. Initial results received from Capita on 24 December 2018 are embargoed until after the end of February 2019 and will be shared widely as soon as possible. Internally, work has commenced to engage Business Units and Corporate Directorates in understanding their results and formulating this year's actions in response to them.

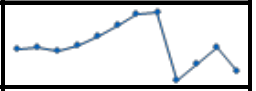
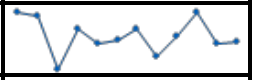
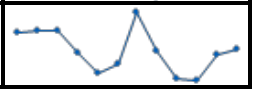
Further Workforce information is shared this month in the Quarterly Workforce report; whilst the new Workforce Strategy will be put before the Board in early February.

In the **Finance** domain, the Trust's financial position at the end of Quarter 3 is a small underspending of £0.3m against the revised plan and Trust fully expects to meet its increased control total for the year. As was noted above, there is a continuing level of vacancies in Neighbourhood Teams, as there is in some other services. To a large extent this has been mitigated with the financial savings from vacancies being utilised on bank or agency staff and providing additional resilience for winter. The Trust's careful management of its finances has meant that there has been no restriction placed on the employment of staff to vacant posts, it is the supply that is the restrictor. The Resourcing Group continues to look at short term and longer term actions to improve our position, which, as Board members know, is a national issue across many professions.

# Safe – December 2018

**By safe, we mean that people are protected from abuse and avoidable harm**

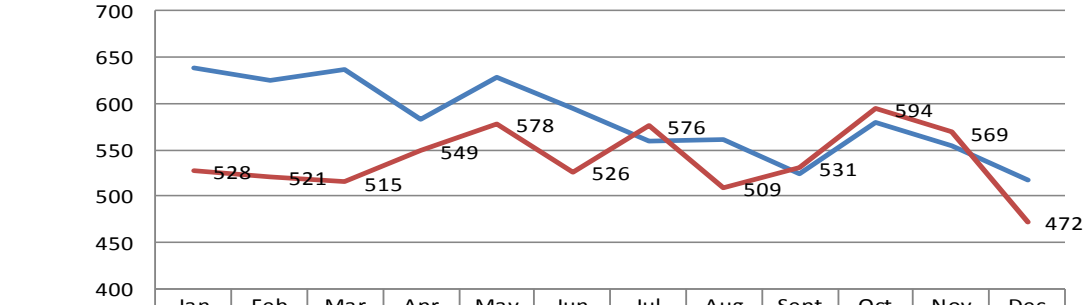
Leeds Community Healthcare NHS Trust

| Safe - people are protected from abuse and avoidable harm | | Target | YTD | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast | Rolling 12 Month Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall Safe Staffing Fill Rate - Inpatients | 2018/19 | >=97% | - | 101.1% | 101.1% | 97.5% | 99.5% | 96.3% | 97.8% | ● |  |
| | 2017/18 | | - | 97.7% | 98.7% | 94.2% | 99.8% | 100.4% | 98.1% | | |
| Patient Safety Incidents Reported in Month Reported as Harmful | 2018/19 | 0.56 to 1.1 | 0.90 | 0.86 | 0.85 | 1.01 | 0.83 | 0.84 | 0.89 | ● |  |
| | 2017/18 | | | 0.92 | 0.86 | 0.84 | 0.74 | 0.89 | 0.82 | | |
| Potential Under Reporting of Patient Safety Incidents | 2018/19 | 1.17 to 2.74 | 1.91 | 1.85 | 1.82 | 2.31 | 2.05 | 1.80 | 2.06 | ● |  |
| | 2017/18 | | | 2.22 | 2.20 | 2.22 | 1.72 | 2.12 | 2.01 | | |
| Serious Incident Rate | 2018/19 | 0 to 1.85 | 0.05 | 0.04 | 0.05 | 0.02 | 0.05 | 0.05 | 0.04 | ● |  |
| | 2017/18 | | | 0.05 | 0.05 | 0.07 | 0.03 | 0.02 | 0.04 | | |
| Percentage VTE Risk Assessment Completed* | 2018/19 | >=95% | 93.2% | 79.2% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | ● |  |
| | 2017/18 | | | - | - | - | 100.0% | 100.0% | 98.3% | | |
| 20% Reduction in Avoidable Category 3 Pressure Ulcers | 2018/19 | 10 | 8 | 3 | 5 | 0 | 0 | 0 | 0 | ● |  |
| | 2017/18 | | | 2 | 6 | 1 | 0 | 0 | 1 | | |
| 0 Avoidable Category 4 Pressure Ulcers | 2018/19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ● |  |
| | 2017/18 | | 12 | 0 | 0 | 1 | 0 | 2 | 3 | | |
| Percentage of Incidents Applicable for DoC Dealt with Appropriately | 2018/19 | 100% | 92.0% | 100.0% | 100% | 75% | 100% | 100% | 92% | ● |  |
| | 2017/18 | | 100.0% | 100% | 100% | 100% | 100% | 100% | 100% | | |

**Performance in December against all the Safe KPIs was good. Further detail is provided for some key areas below.**

**All Incidents – Year on Year Comparison December 2016, 2017 and 2018**

In December, 472 incidents were reported. This is significantly (16.5%) less than November. Whilst it would be easy to conclude that the Christmas period will have impacted on reporting, indeed the graph below shows a reduction in December 2016 and 2017, this would need to be seen in the context of the overall trend over the longer period. Further, analysis of the different types of incidents follows below.



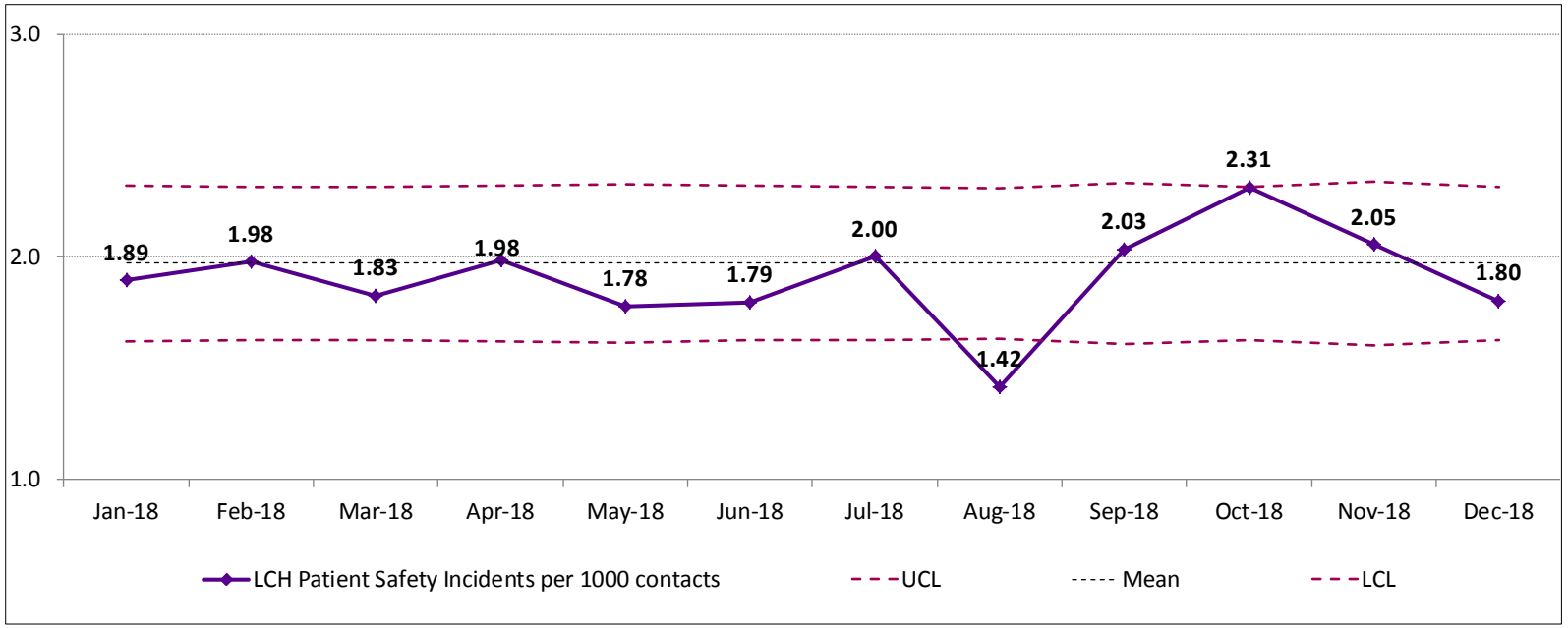

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2016/17 | 639 | 625 | 637 | 583 | 629 | 594 | 560 | 561 | 524 | 579 | 555 | 518 |
| 2017/18 | 528 | 521 | 515 | 549 | 578 | 526 | 576 | 509 | 531 | 594 | 569 | 472 |

**Staff Incidents**

There were 49 staff incidents reported in the month. This is consistent with November figures and accounts for approximately 10% of all incidents reported.

**Patient Safety Incidents (PSIs) (LCH only)**

There were a total of 210 LCH PSIs reported in December 2018, a reduction on the previous month. In absolute terms this is the lowest number of patient incidents reported. Relative to the number of contacts, only August had a lower figure as shown in the SPC chart below but as the chart shows this is within normal variation.




**Incidents causing harm (LCH only)**

Incidents causing harm in November have been updated as a result of checks by Clinical Governance and the general investigation processes. Therefore the November ratio has dropped from 1:6.3 to 1:5.2. December ratio is at 1:4.1 which is comparable with earlier months.

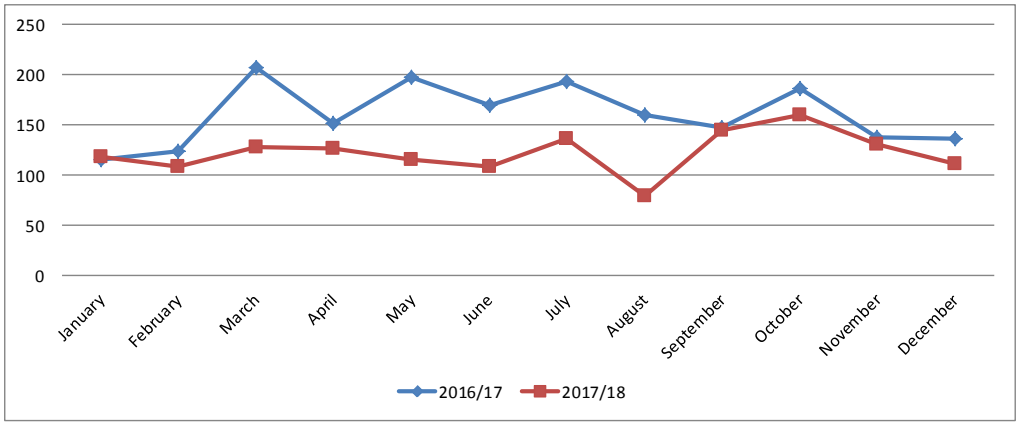
| | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No Injury Sustained | 119 | 113 | 133 | 126 | 116 | 108 | 135 | 78 | 126 | 161 | 146 | 111 |
| Minimal Harm | 82 | 62 | 45 | 66 | 75 | 70 | 83 | 58 | 67 | 84 | 66 | 57 |
| Moderate Harm | 51 | 45 | 32 | 43 | 33 | 37 | 31 | 26 | 30 | 49 | 33 | 37 |
| Major Harm | 4 | 9 | 7 | 5 | 6 | 4 | 5 | 8 | 9 | 2 | 8 | 4 |
| Total | 256 | 229 | 217 | 240 | 230 | 219 | 254 | 170 | 232 | 296 | 253 | 209 |
| Ratio | 1:3.7 | 1:3.2 | 1:4.6 | 1:4 | 1:4.9 | 1:4.3 | 1:6.1 | 1:4 | 1:4.9 | 1:4.8 | 1:5.2 | 1:4.1 |

**Moderate & Major Harm Incidents**

The decrease in moderate/major harms reported last month has been reviewed and, as investigations have progressed, this figure has returned to a level consistent with previous months in the year. Numbers in December are consistent with the general experience over the year.

## No Harm Incidents

Internal reporting in November suggested a 21% decrease of no harm incidents in November over October. Continuing review and investigation has revised that reduction down to 9.3%. As the graph below shows the November and December reductions are in line with reductions experienced in the previous two years. Continued refinement of our statistical analysis will take place. Ongoing assessment of all harm reporting to identify potential trends and to ensure that learning can take place will be the focus of the Trust's approach.




## Overdue Incidents

There are 378 live incidents as of 03/01/2019. Of these, 123 have breached the 15 or 30 day investigation time. The Clinical Governance team has committed to support Business Unit staff to improve this position whilst being cognisant of likely increased service pressures over the next couple of months.

## Never Events

As at the end of December 2018, the Trust has never reported a Never Event to commissioners.

## Safety Alerts (CAS)

There were five new alerts issued in December; all of which have been sent to relevant staff for review and/or action. There have been four alerts which were due to be closed by December 2018. Three of these were notices of medication supply disruption that were actioned by the Medcines Management team in the month they were reported, distributed to services identified and closed at that point. One alert concerned medical devices alert HeartStart Monitor/Defibrillators. These are not used in LCH so not applicable and closed at that point.

## Duty of Candour

Four incidents were closed that were attributable to LCH of moderate harm or above. All have been offered an apology and given the option of receiving further information about the completed investigation. Therefore we are 100% compliant.

**Serious Incidents**

There were 6 SI's reported to the CCG in December 2018; 5 pressure ulcers (3 unstageable, 1 category 3 and 1 category 4) and 1 fall resulting in a fractured neck of femur.

Five Serious Incident investigations were signed off/ closed in December. Four were identified as being avoidable to the Trust, occurring in the Morley, Middleton and Holt Park neighbourhoods and the Cardiac Service.

| | Avoidable incident attributable to LCH Care | Unavoidable incident or accident | Total |
|---|---|---|---|
| Pressure sore / decubitus ulcer | 1 | 1 | 2 |
| Assessment - other | 1 | 0 | 1 |
| Slips, trips, falls and collisions | 2 | 0 | 2 |
| Total | 4 | 1 | 5 |

The most common themes from these investigations appear to be

- Poor quality of record keeping
- Poor quality of assessments
- Missing information.

Action plans from the SI investigations have been added to Datix from which an automated reminder of overdue actions is issued . The Clinical Governance team will monitor completion of the individual actions.

| **Total SI's Closed** | **2016/17** | **2017/18** | **2018/19** |
|---|---|---|---|
| | **92** | **97** | **36(to date)** |
| Total number of actions generated (from closed SI's) | 221 | 373 | 145 |
| Actions closed within timescale | 88 | 106 | 62 |
| Actions closed outside of timescale | 133 | 202 | 26 |
| **Total actions closed** | **221** | **308** | **88** |
| **Number of SI's with current open action plans** | **0** | **17** | **12** |
| Total number of actions currently open | 0 | 65 | 57 |
| Number of actions over deadline | 0 | 65 | 56 |

The figures for 2017/18 action plans have not changed this month. A renewed drive by the Clinical Governance Team with action owners has taken place. A bottleneck in the final sign off process has been identified and is being addressed. The Senior Management Team has asked for an in depth update on the position and the actions being taken to improve it before the end of January.

## Pressure Ulcer Focus

### New Pressure Ulcers in December

40 pressure ulcers incidents (LCH PSI) (47 individual ulcers) were reported. There were also a further 4 pressure ulcer incidents reported that were quickly identified as moisture and updated to reflect this. No category 4 ulcers were reported in December. There have been no avoidable category 4 pressure ulcer incidents in this financial year. The Board is advised that one is still being investigated and due to review panel in January.

| Total Pressure Ulcers and Categories | Number of Pressure ulcers | Pressure ulcer Severity |
|---|---|---|
| Category 2 | 17 | Minimum Harm |
| Category 3 | 9 | |
| Unstageable | 21 | Moderate Harm |
| Category 4 | 0 | Major harm |
| **Total** | 47 | |

### Closed Pressure Ulcers in December

46 (57 individual ulcers) LCH pressure ulcer incidents (all reported categories) were investigated and closed. Three were found to be avoidable to LCH, two of these were reports of category 2 ulcers, the third was unstageable.

### Table of Pressure Ulcers investigated and closed in December

| | Category 2 | Category 3 | Category 4 | Unstageable | Total |
|---|---|---|---|---|---|
| Avoidable incident attributable to LCH Care | 2 | 0 | 0 | 1 | 3 |
| Avoidable incident attributable to patient or other care provider | 4 | 0 | 0 | 0 | 4 |
| Unavoidable incident or accident | 22 | 10 | 1 | 17 | 50 |
| Total | 28 | 10 | 1 | 18 | 57 |

The category 2 avoidable pressure ulcer investigation highlights a delay updating documentation, assessments not being completed and delays/lack of documentation regarding equipment ordered or otherwise.

The unstageable ulcer serious incident investigation conclued that a more holistic assessment of the patient could have identified the risks and changes to the patients condition earlier. This appears to be a recurring theme.

# Caring – December 2018

**By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect**

Leeds Community Healthcare NHS Trust

| Caring - staff involve and treat people with compassion, kindness, dignity and respect | | Target | YTD | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|
| Percentage of Staff Recommending Care (Staff FFT) | 2018/19 | >=73% | - | 83.0% | 82.4% | | | | | ● |
| | 2017/18 | | - | 81.0% | 75.0% | | | | | |
| Percentage of Respondents Recommending Inpatient Care (FFT) | 2018/19 | >=95% | - | 91.7% | 100.0% | 100.0% | 100.0% | 95.0% | 98.3% | ● |
| | 2017/18 | | - | 100.0% | 96.7% | 100.0% | 100.0% | 71.4% | 90.5% | |
| Percentage of Respondents Recommending Community Care (FFT) | 2018/19 | >=95% | - | 95.9% | 96.9% | 96.0% | 94.4% | 94.5% | 95.0% | ● |
| | 2017/18 | | - | 95.3% | 95.5% | 96.2% | 95.3% | 96.3% | 96.0% | |
| Written Complaints - Received | 2018/19 | <211 | 121 | 44 | 40 | 22 | 11 | 4 | 37 | ● |
| | 2017/18 | | | 50 | 57 | 21 | 18 | 13 | 52 | |
| Mixed Sex Accommodation Breaches | 2018/19 | 0 | | | | | | | | |
| | 2017/18 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

**Friends and Family Test**

Responses from patients to the December Friends and Family Test show a positive attitude to the care they recieve. Those words highlighted in red are percieved as negative by the system used to analyse the responses but they may not be negative when placed in context of the sentence they are in.

Overall, 94.5% of Community patients would recommend the service to family and friends. Of inpatients, 91.7% would recommend. A further breakdown by Business Unit is provided below.

| December 2018 | Number of responses received | % recommend | % not recommend | Comments received | Overall response rate |
|---|---|---|---|---|---|
| Adult Community Services | 128 | 92.97% | 2.34% | 103 | 3.51% |
| Children's Community Services | 489 | 93.87% | 2.25% | 611 | 6.5% |
| Children's Inpatients | 4 | 100% | 0% | 7 | 100% |
| Specialist Community Services | 560 | 95.36% | 2.32% | 569 | 5.14% |
| Specialist Inpatients | 20 | 90% | 5% | 22 | 117.65% |

**Complaints, Concerns, PALS and Claims**

| Feedback | December 2018 Received | Notable trends |
|---|---|---|
| Complaints | **4** | No themes emerging at present. Closer links with the new patient experience team will support teams to look at any highlighted problem areas through complaints to be reviewed and acted upon. |
| Concerns | **25** | |
| Clinical Claims | **0** | |
| Non-clinical Claims | **0** | |

| Complaints KPI Performance | Status | Comment |
|---|---|---|
| Acknowledged within 3 days | **100%** Compliance | Good performance against compliance targets.<br><br>It was highlighted at the end of November that a number of complaints had been delayed from the original agreed timeframe of 40 working days and/or the renegotiated timeframes. A process review including new checks and balances has been undertaken in order to ensure that a similar situation does not occur in the future. |
| Responded to within 180 days | **100%** Compliance (closed complaints) | |
| Active PET Caseload | **23** open complaints, **7** open concerns | |
| PHSO requests | **0** | |

# Effective – December 2018

**By effective, we mean that care, treatment and support received by people achieve good outcomes and helps people maintain quality of life and is based on the best available evidence.**

Leeds Community Healthcare NHS Trust

| 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 | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|
| Compliance with Other NICE Guidance Within 2016 | 2018/19 | | | | | | | | | |
| | Full Compliance | 38 | 21 | 6 | 12 | | | | 21 | |
| | Action Plan in Place | | 1 | - | 1 | | | | 1 | |
| | Not yet due | | 16 | 32 | 25 | | | | 16 | |
| Number of Mandatory Audits | Due to start in Q | All audits started | | 6 | 0 | | | | 6 | |
| | Started in Q | | | 18 | 1 | | | | 4 | |
| Number of LCH Generated Audits Started (as a percentage of all LCH generated audits) | 2018/19 | >=80% | - | 31.2% | 9.2% | | | | 6.4% | |
| | 2017/18 | | - | | | | | | | |
| Compliance with Clinical Supervision | 2018/19 | >=80% | - | 81.9% | 83.0% | | | | 85.6% | |
| | 2017/18 | | - | 80.0% | 61.0% | | 70.0% | | 70.0% | |
| Number of Unexpected Deaths in Bed Bases | 2018/19 | No Target | | 0 | 0 | | 1 | | 1 | |
| | 2017/18 | | - | 0 | 2 | | 1 | | 1 | |
| Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload | 2018/19 | No Target | | 5 | 4 | | 5 | | 5 | |
| | 2017/18 | | - | 1 | 1 | | 2 | | 2 | |
| Percentage of services rated good or outstanding following the Quality Challenge+ Peer Review | 2018/19 | >=70% | | 100.0% | 0.0% | | | | 50.0% | |
| | 2017/18 | | - | - | - | | - | | - | |
| Percentage of services rating themselves as good/outstanding through the Quality Challenge+ Self Assessment | 2018/19 | >=80% | | 82.0% | 88.0% | | | | 100.0% | |
| | 2017/18 | | - | - | - | | - | | - | |

Since the Q2 report, NG 51 Sepsis has been fully implemented by all services. The Health Visiting Service is working with the Midwifery Service to ensure appropriate post-partum follow up. Advice has been provided by the LTHT Chemotherapy Nursing Team to support Neighbourhood Teams recognise sepsis in patients undergoing chemotherapy.

**Technology appraisals published July – September 2018**

None of the 16 Technology Appraisals published by NICE between July and September 2018 were relevant to LCH

**Other NICE guidance published October to December 2016 (exception report)**

NG 57 Physical health of people in prison:

- Published in November 2016, the 73 recommendations in this guideline cover assessing, diagnosing and managing physical health problems of people in prison. It aims to improve health and wellbeing in the prison population by promoting more coordinated care and more effective approaches to prescribing, dispensing and supervising medicines.
- 65 of the recommendations are applicable to HMYOI Wetherby, with 63 recommendations fully met.
- Of the two recommendations not currently being met:
    - Recommendation 1.4.6 provision of lockable in-cell storage for in-possession medication – will not be implemented by the Prison Service (who are responsible for infrastructure within the prison) as all the young people occupy single cells. Partial non-compliance accepted
    - Recommendation 1.7.13 medication review for people who need extra support – work to implement this recommendation is part of the wider personalised transition and discharge process, a service CQUIN for 2018/19.

**Other outstanding guidance:**

NG 43 Transition from children's to adult's services for young people using health or social care services

- Published in February 2016. Applies to all of Children's Services.
- A detailed review of the current position against the 56 recommendations was undertaken in December 2018.
- 23 of the recommendations are applicable to LCH, with 18 recommendations fully met.
- Of the five recommendations not currently being met, plans are in place to address these:
    - Recommendation 1.1.1 involvement of young people in service design – this is being taken forward on a city-wide basis with health and social care partners;
    - Recommendation 1.1.5 development of joint health and social care mission statements and protocols – city-wide work has commenced, but there is still more work to do to agree a joint framework;
    - Recommendation 1.2.4 undertake an annual transition planning meeting for each young person – within CAMHS and the Community Nursing Service, transition planning meetings start when the young person is 17 and a half. Routine annual transition planning meetings are not held. This has been flagged to commissioners.
    - Recommendation 1.2.5 a named practitioner should coordinate transition care and support – each service has a named practitioner coordinating transition for the young person from that service. Ongoing discussions with partners about whether the single practitioner model will be adopted in Leeds; and
    - Recommendation 1.3.1 joint transition appointments with adult and children's services prior to transfer – to be developed with commissioners are part of the pathway work within the Children and Young People's Strategy.

NG 11 challenging behaviour and learning disabilities

- First published in May 2015, the 59 recommendations in this guideline cover interventions and support for children, young people and adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges, and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and intervention for family members or carers
- 35 of the recommendations are applicable to LCH, with 31 recommendations fully met.
- Of the four recommendations not currently being met, three are partially in place :
    - guidance on restrictive practice is being developed;
    - training for staff in CAMHS around proactive strategies for managing challenging behaviour is being planned; and
    - additional training for staff in CAMHS carrying out assessments and delivering interventions is underway.
    - One of the recommendations is not currently met:
    - Recommendation 1.5.8 for severe and or complex cases, further assessment to be undertaken by a specialist MDT service – this has only recently been commissioned (as Intensive Positive Parenting – to be fully operational from April 2019)

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 51 recommendations cover how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of line managers.
- A detailed review of the current position is being undertaken with the Assistant Director of Workforce on 23 January 2019.

**Mandatory Audits**

Of the 6 due to start in this period (Quarter 3), 2 were started in Q3 and 1 had previously been started. There were 2 further mandatory audits which started in Q3 but were not due to have begun during this quarter. The other 3 that should have started in this quarter have been slightly delayed but are due to start early in Q4 and this will be monitored by the team.

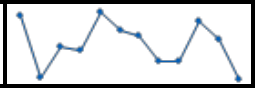
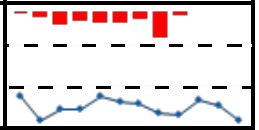
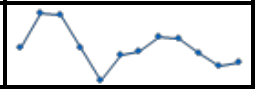
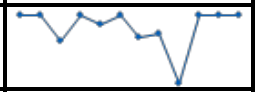
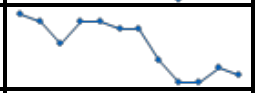
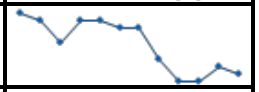
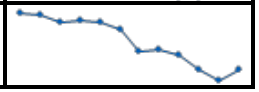
**Quality Challenge +**

Data on the outcomes of the Quality Challenge + self-assessment and peer review process are presented in the KPI table above. The Senior Management Team has reviewed the peer review target and data and believes that they are not sensitive enough to the different services provided by the Trust. Nevertheless, the Director of Nursing will report to the Senior Management Team before the end of January on the actions being undertaken if the peer review process has identified that a service was, for whatever reason, assessed as requires improvement.

# Responsive – December 2018

**By responsive, we mean that services are organised so that they meet people's needs**

Leeds Community Healthcare NHS Trust

| 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 | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast | Rolling 12 Month Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Patient Contacts - Variance from Profile* | 2018/19 | 0 to ± 5% | -4.3% | -3.0% | -6.5% | 0.6% | -0.3% | -10.5% | -3.4% | ● |  |
| | 2017/18 | | | -5.9% | -7.5% | -1.1% | 10.2% | -15.8% | -1.5% | | |
| Patient Contacts - Variance from 2017/2018 | 2018/19 | - | - | -4.2% | -7.1% | -5.1% | -15.9% | -3.3% | -8.5% | ● |  |
| | 2018/19 | | - | 392,700 | 373,589 | 133,727 | 128,575 | 116,485 | 378,787 | | |
| | 2017/18 | | - | 409,858 | 402,291 | 140,896 | 152,819 | 120,442 | 414,157 | | |
| Percentage of patients currently waiting under 18 weeks (Consultant-Led) | 2018/19 | >=92% | - | 97.0% | 97.8% | 96.8% | 96.9% | 96.4% | 96.7% | ● |  |
| | 2017/18 | | - | 99.6% | 99.5% | 99.5% | 99.4% | 97.6% | 98.8% | | |
| Number of patients waiting more than 52 Weeks (Consultant-Led) | 2018/19 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ● |  |
| | 2017/18 | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01) | 2018/19 | >=99% | - | 99.7% | 97.0% | 100.0% | 100.0% | 100.0% | 100.0% | ● |  |
| | 2017/18 | | - | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | |
| % Patients waiting under 18 weeks (non reportable) | 2018/19 | >=95% | - | 98.9% | 98.4% | 98.1% | 98.3% | 98.2% | 98.2% | ● |  |
| | 2017/18 | | - | 98.8% | 98.8% | 98.9% | 99.1% | 98.7% | 98.9% | | |
| IAPT - Percentage of people treated within 18 weeks of referral | 2018/19 | >=95% | - | 98.9% | 99.6% | 99.5% | 99.6% | 99.0% | 99.4% | ● |  |
| | 2017/18 | | - | 100.0% | 98.6% | 99.6% | 98.8% | 99.3% | 99.2% | | |
| IAPT - Percentage of people treated within 6 weeks of referral | 2018/19 | >=75% | - | 98.9% | 78.8% | 71.2% | 66.8% | 71.6% | 69.9% | ● |  |
| | 2017/18 | | - | 96.1% | 94.4% | 95.5% | 96.9% | 96.0% | 96.2% | | |

**Patient Contacts**

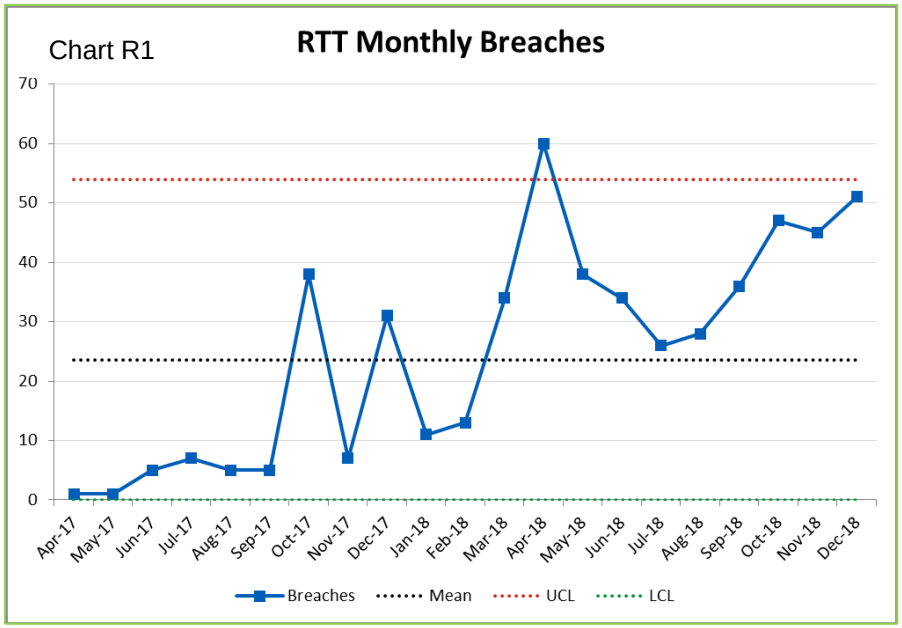
The Christmas and New Year period, containing 4 Bank Holidays, 2 weekends and school holidays have all had an impact upon patient contacts. Overall performance in December, when measured as Face to Face contacts is 10.5% below profile The Adult Business Unit reported 0.1% below profile (reflecting the new profile agreed with the CCG for neighbourhood teams), the Children's' Business Unit reported 18.6% below profile and the Specialist Business Unit reported 21.1% below profile.

**Statutory Breaches and Waiting Lists**

The Trust is currently performing within all nationally set targets and at the end of December 2018, 51 patients had waited more than 18 weeks for treatment in consultant-led services; increase of 6 from the previous month.

This financial year to date there have been a total of 593 breaches compared with 158 for the whole of FY 2017/18 but the Trust remains well above the target of 95.0% of patients waiting less than 18 weeks.

Chart R1 below shows a 21 month Statistical Process Control Chart (SPC) for RTT Breaches. Since March 2018 there have been 10 points above the mean denoting special cause variation in the process. This is statistically significant and, whilst stressing that Trust performance is within nationally prescribed performance, is of concern and work has commenced to understand it further,



There were 44 waiters in Child Development Centre (CDC) in December. 1 waiter in Community Paediatric Clinics (CPC CHICS) and 6 in Paediatric Neuro Disability Clinics (PND) but all now have a scheduled appointment or have been seen.  Analysis shows that most breaches and long waiters are found in the CDC service.

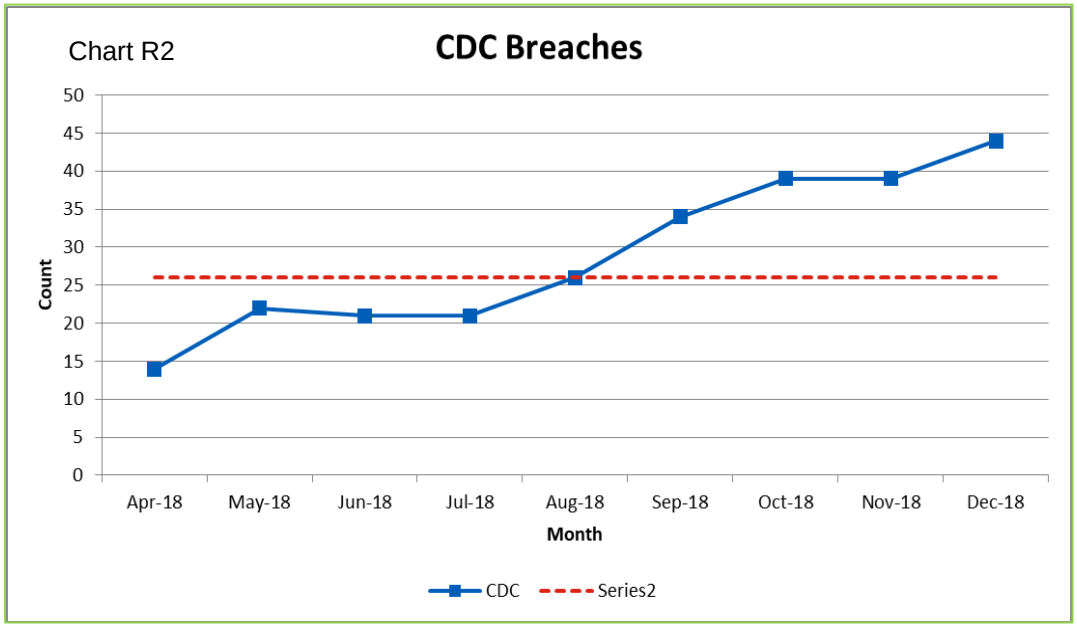


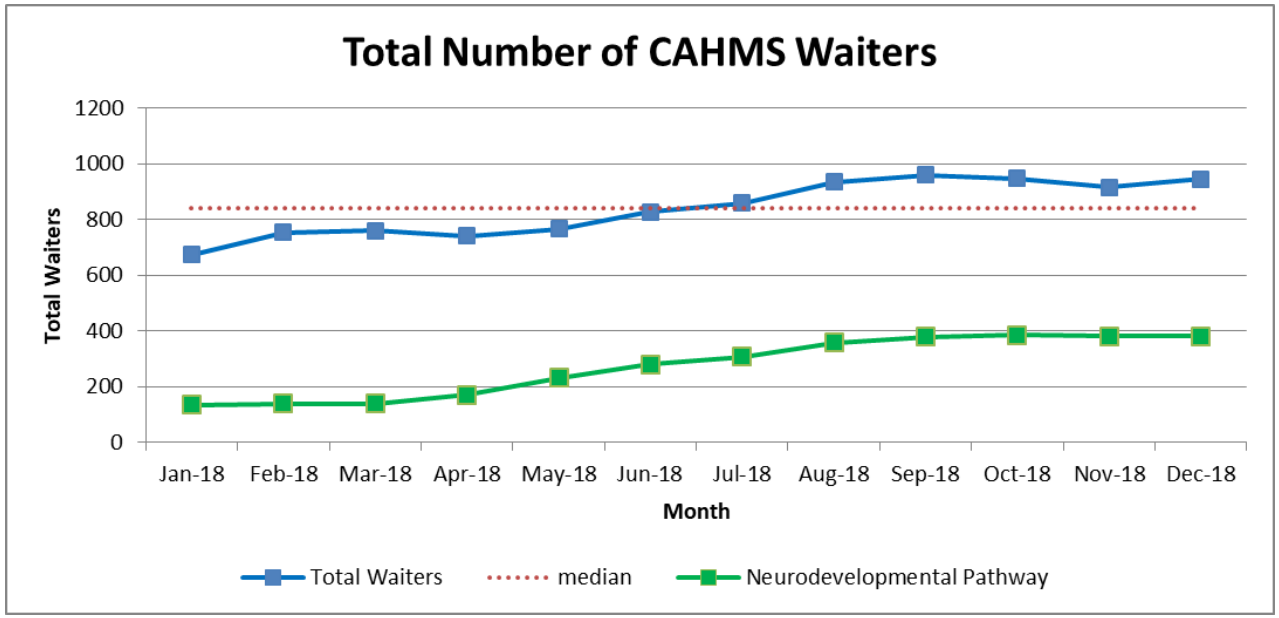

Chart R2 shows that although there is no statistical significance, yet, of points about the median line, but there remains a clear upward trend this financial year.  The reason for the significant increase in the CDC line is due to the increase in Complex Communication Assessment (CCA) referrals (essentially the autistic spectrum disorder assessment for under-5s) which is a national issue. 41 children are waiting more than 18 weeks; the longest wait is 31 weeks but all waiters have an appointment booked.  Commissioners are aware and have provided funding for a waiting list initiative, which aims to bring waits to 12-weeks by April.

In CAMHS it is worth noting that waiters who were previously on the ASC, ADHD and Complex Assessment waiting lists and new ‘Neurodevelopmental Pathway’ waiters are included in this Neurodevelopmental waiting list summary.  For information, wait times are measured from Referral Received Date (date CAMHS receive the referral) to either the month end date (for current waiters) or the start date for the episode of care (for completed waits).

The total number of waiters in the CAHMS Service at the end of December is 946. For the 12 months of 2018, the median number of waiters is 843. Since July the number of waiters has increased and is reported above the mean.

The overall increase in the number of CAMHS waiters can be attributed to the Neurodevelopmental Pathway.

We have seen Neurodevelopmental Pathway referral rates increase throughout the year which has had an impact. The service was recently successful with a bid to secure some additional funding to have approximately 100 of these cases assessed by an external provider (Clinical Partners). Work is also ongoing to free up capacity in the service.

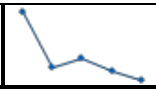
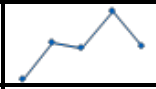
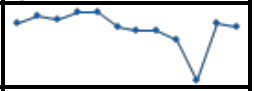
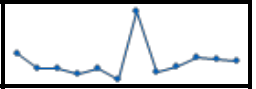


# Well-Led – December 2018

**By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high quality person-centred care, encourages learning and innovation, and promotes an open and fair culture.**

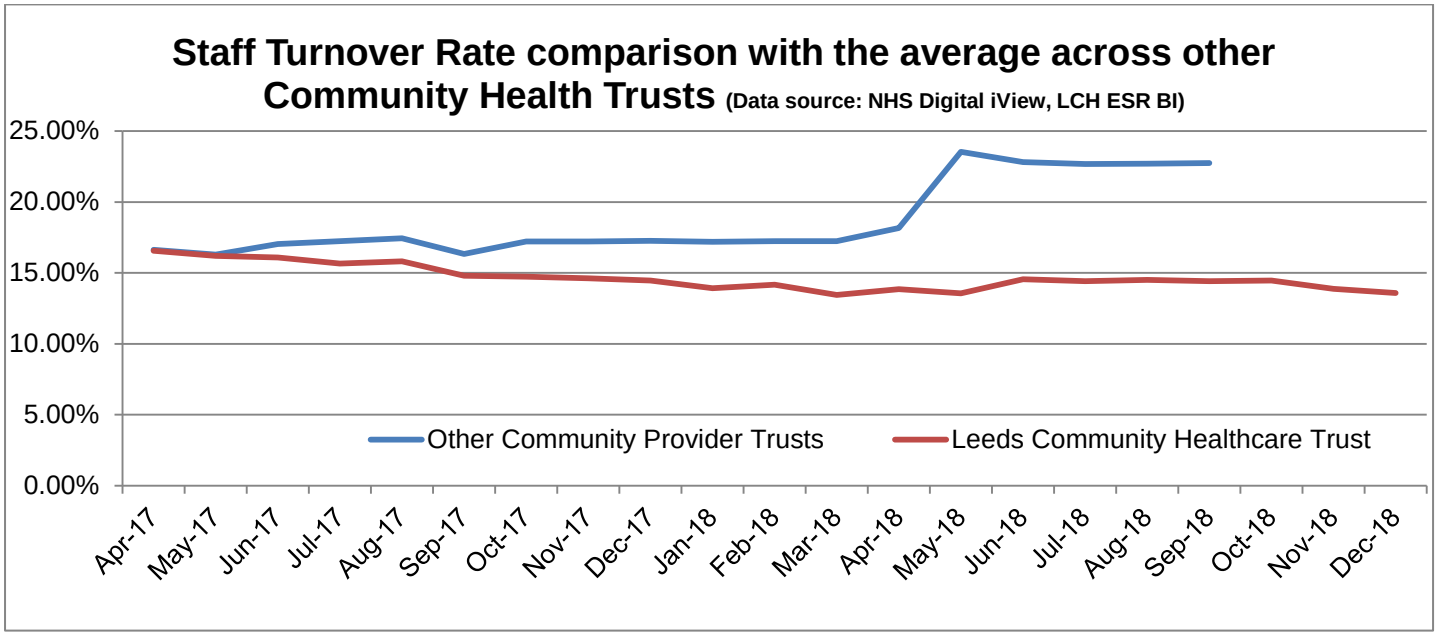
Leeds Community Healthcare NHS Trust

| 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 | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast | Rolling 12 Month Trend |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Staff Turnover | 2018/19 | <=15.0% | - | 14.0% | 14.5% | 14.5% | 13.9% | 13.6% | 14.0% | ● | |
| | 2017/18 | | - | 15.2% | 14.4% | 14.1% | 14.1% | 14.8% | 14.8% | | |
| Reduce the number of staff leaving the organisation within 12 months | 2018/19 | <=20.0% | - | 13.1% | 14.4% | 15.7% | 15.5% | 13.4% | 14.9% | ● | |
| | 2017/18 | | - | 16.3% | 12.0% | 12.0% | 12.0% | 11.0% | 11.0% | | |
| Executive Team Turnover | 2018/19 | <=14.5% | - | 0.0% | 2.1% | 0.0% | 0.0% | 0.0% | 0.0% | ● | |
| | 2017/18 | | - | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | | |
| Stability Index | 2018/19 | >=85% | - | 85.5% | 86.0% | 86.0% | 86.3% | 86.7% | 86.3% | ● | |
| | 2017/18 | | - | 83.8% | 82.5% | 84.9% | 84.9% | 85.3% | 85.3% | | |
| Short term sickness absence rate (%) | 2018/19 | <2.2% | - | 1.9% | 1.6% | 1.9% | 2.2% | 2.3% | 2.1% | ● | |
| | 2017/18 | | - | 1.8% | 1.9% | 2.3% | 2.5% | 2.5% | 2.5% | | |
| Long term sickness absence rate (%) | 2018/19 | <3.6% | - | 3.5% | 3.8% | 3.6% | 3.4% | 4.0% | 3.8% | ● | |
| | 2017/18 | | - | 3.5% | 3.4% | 3.5% | 3.5% | 4.0% | 4.0% | | |
| Total sickness absence rate (%) | 2018/19 | <5.8% | - | 5.3% | 5.4% | 5.5% | 5.6% | 6.4% | 5.8% | ● | |
| | 2017/18 | | - | 5.2% | 5.4% | 5.8% | 6.0% | 6.5% | 6.5% | | |
| AfC Staff Appraisal Rate (12 Month Rolling - %) | 2018/19 | >=95% | - | 80.7% | 82.3% | 87.5% | 88.2% | 86.3% | 87.3% | ● | |
| | 2017/18 | | - | 86.6% | 82.5% | 81.3% | 87.6% | 78.3% | 78.3% | | |
| Medical staff appraisal rate (%) | 2018/19 | 100% | - | 100.0% | 100.0% | | | | 78.0% | ● | |
| | 2017/18 | | - | 100.0% | 100.0% | 100.0% | | | 100.0% | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| WRES indicator 1 - Percentage of BME staff in the overall workforce | 2018/19 | No Target | - | | | 9.8% | 9.7% | 9.6% | 9.7% | |  |
| | - | | - | | | 91.5% | 90.4% | 90.2% | 90.2% | | |
| WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM | 2018/19 | No Target | - | | | 3.2% | 3.3% | 3.2% | 3.2% | |  |
| | - | | - | | | 91.5% | 95.0% | 90.2% | 90.2% | | |
| 6 universal Statutory and Mandatory training requirements | 2018/19 | >=95% | - | 90.3% | 88.9% | 90.3% | 90.0% | 90.6% | 90.3% | |  |
| | 2017/18 | | - | 91.0% | 90.5% | 91.5% | 95.0% | 90.2% | 90.2% | | |
| Percentage of Staff that would recommend LCH as a place of work (Staff FFT) | 2018/19 | >52.0% | - | 63.0% | 60.3% | Staff | | | | | |
| | 2017/18 | | - | 54.0% | 53.9% | Survey | | | | | |
| Percentage of staff who are satisfied with the support they received from their immediate line manager | 2018/19 | >52.0% | - | 64.0% | 65.1% | Staff | | | | | |
| | 2017/18 | | - | 62.0% | 60.0% | Survey | | | | | |
| Sustain the time between placing adverts | | | | | | | | | | | |
| | Qualified Nurses | <= 112 Days | - | | | | | | | | |
| | Administration | <=83 Days | - | | | | | | | | |
| | Police Custody | <=145 Days | - | | | | | | | | |
| Response Rate for Staff FFT | 2018/19 | >22.0% | - | 24.0% | 23.5% | Staff | | | | | |
| | 2017/18 | | - | 22.2% | 21.0% | Survey | | | | | |
| Response Rate for Inpatient FFT | 2018/19 | 23.1% | - | 38.9% | 96.1% | 100.0% | no data | | | |  |
| | 2017/18 | | - | 15.4% | 11.8% | 8.4% | 88.9% | 175.0% | 175.0% | | |
| Response Rate for Community FFT | 2018/19 | 6.8% | - | 7.4% | 6.2% | 6.8% | 6.6% | | | |  |
| | 2017/18 | | - | 6.9% | 4.6% | 5.5% | 5.7% | 7.4% | 7.4% | | |
| Total agency cap | 2018/19 | £534k | £4045k | £1,403k | £2,766 | £387k | £450k | £442k | £4045k | | |
| | 2017/18 | | £6,089 | £1,544k | £3,123k | £509k | £476k | £423k | £4532k | | |
| Percentage Spend on Temporary Staff | 2018/19 | | 6.9% | 7.8% | 7.1% | 6.1% | 6.3% | 7.5% | 6.9% | | |
| | 2017/18 | | 8.0% | 8.1% | 8.1% | 8.0% | 7.7% | 7.5% | 7.7% | | |

**Retention**

The overall trend continues to be a positive one, with the stability rate increasing to 86.66% which is above trust target of 85% and turnover continuing to reduce further to 13.58% which is below the 2018/19 outturn target of 14.5%. This continues to benchmark favourably against LCH's Community Trust peers whose most recent data shows 22.7% turnover as at September 2018 (LCH's September 2018 turnover was 14.4%). This is visually presented in the graph below:




Staff leaving the Trust within the first 12 months of employment (based on a rolling 12 month period) was 13.37% in December which remains below the 20% target. This has significantly reduced since November's 15.48% figure. A more detailed analysis has been provided within the Quarterly Workforce report (Quarter 3).

The distribution of leavers across the Trust's Business Units and professional groups in December 2018 remains consistent with the month-on-month pattern seen throughout Quarter 1, 2 and 3. Nursing staff continue to be the professional group with the highest number of leavers each month but this is proportionate to the composition of the workforce (nursing staff account for 35% of the workforce).

Work life balance continues to be the highest reason for leaving with 28% of leavers reporting this as their reason for leaving the trust in December, compared with 23% in November. Further analysis will be undertaken to understand this and will be reported in next month's report.

Work is progressing on talent management, leadership and management development, health and wellbeing which will support the trust in further reducing turnover and keeping within target during 2018/19.

Background detail associated with turnover and retention can be found in Appendix 1.

**Health and Wellbeing**

The sickness absence rate for December is 6.37% (consisting of 2.34% short term and 4.03% long term). This increase in absence is aligned with the trend of previous years, which sees increased absence over winter months.

Of note is the long term sickness absence within Children's Business Unit which has been steadily increasing since October and currently stands at over 5%. The HR rep is working pro-actively with the management team to look at ways to address this.

Sickness absence due to stress, anxiety and depression, continues to be our highest reason for long term absence. Whilst the Trust currently provides a range of HWB support for staffs mental health and wellbeing, there is more we plan to do. The month of January is being promoted as the "spotlight on mental health and wellbeing". Further detail is contained within the Quarterly Workforce Report.

Over the coming months the focus will be on looking at ways to support staff with their physical health and wellbeing, as MSK and related absences is the second highest reason for sickness absence.

This work is being driven through the HWB Engagement group which consists of members of staff with lived experience of a health condition or has a passion for improving health and wellbeing.

**Appraisal**

Appraisal rates stand at 86.27% for December, indicating a slight overall decline in comparison to November.

| | Target | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Overall** | **Imp Traj to 95%** | **81.88%** | **80.23%** | **79.89%** | **78.53%** | **83.26%** | **84.91%** | **87.51%** | **88.20%** | **86.27%** |
| Adult Business Unit | | 85.71% | 82.02% | 80.83% | 78.64% | 82.14% | 86.31% | 90.70% | 93.27% | 90.61% |
| Children's Business Unit | | 83.38% | 84.91% | 83.57% | 79.12% | 83.42% | 84.39% | 84.25% | 82.58% | 79.86% |
| Corporate Directorate | | 56.40% | 57.35% | 64.76% | 69.03% | 81.63% | 84.25% | 85.11% | 83.21% | 77.86% |
| Operations | | 88.46% | 90.82% | 90.24% | 87.89% | 89.16% | 88.00% | 90.53% | 89.01% | 88.95% |
| Specialist Business Unit | | 80.70% | 77.14% | 76.65% | 77.58% | 84.31% | 82.89% | 86.36% | 88.44% | 88.47% |

The following actions will be continued, with a view to sustaining the rate of improvement:

- There will be a continuing focus on appraisal rates at performance panels for Adults, Children's and Specialist Business Units.
- Workforce Information weekly update reports for SMT around compliance rates – for circulation to senior managers.
- Team level performance reports are being developed to be sent to senior managers with expectations of local actions to increase compliance.

**Statutory and Mandatory training**

The overall level of compliance for the universal statutory and mandatory training requirements currently stands at 90.55%. Whilst remaining relatively stable over the last four months, this remains consistently below the target of 95%.

| | Target | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 | Nov-18 | Dec-18 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Overall** | **Imp Traj to 95%** | **91.44%** | **89.89%** | **89.60%** | **89.57%** | **88.66%** | **88.36%** | **90.33%** | **90.04%** | **90.55%** |
| Adult Business Unit | | 89.43% | 87.94% | 88.80% | 89.43% | 88.50% | 87.48% | 90.57% | 89.76% | 90.98% |
| Children's Business Unit | | 93.35% | 92.58% | 92.21% | 91.71% | 89.72% | 89.64% | 91.52% | 90.55% | 91.31% |
| Corporate Directorate | | 86.06% | 92.55% | 92.32% | 92.56% | 91.15% | 91.25% | 94.07% | 92.81% | 92.17% |
| Operations | | 82.93% | 86.99% | 84.20% | 82.39% | 83.48% | 81.58% | 83.74% | 87.52% | 88.41% |
| Specialist Business Unit | | 92.74% | 90.32% | 89.24% | 89.91% | 89.67% | 90.37% | 90.63% | 90.61% | 90.03% |

A focussed initiative has been launched by ODI to support the improvement of statutory and mandatory compliance, initially focussing on the Universal six, plus five other priority areas, with a view to a phased approach to supporting all training in achieving the required 95% compliance. Weekly reports on statutory & mandatory compliance are being sent to SMT, to ensure close scrutiny of the situation.

**Staff Survey**

Staff Survey 2018 data was collected between October and November 2018, but remains under embargo until March 2019.

Although response rates were down slightly on 2017 (52% compared to 54% 2017), preliminary results show significantly higher response rates at LCH compared with the NHS National average response rate, which has been provisionally released as 43%. Work has commenced on engagement around the survey results since the first set of data was released by Capita on 24/12/18. This includes:

- Senior business unit and corporate directorate leadership share of results and plan for cascading the results to their teams, and work with engagement
- Communication plan for central share of feedback, next steps and involvement
- Blogs in Community Talk by key influencers: Thea, Staff Side, Chair of BAME network
- ELSIE page to showcase findings, themes and trends (subject to embargo on data being lifted in March 2019)
- Presentation and discussion at Leaders Network on 30 January

The National Staff Survey and Staff FFT have been realigned to one another as part of a broader initiative in the Trust to create data series offering greater ongoing insight into engagement.

**Friends and Family Test (FFT)**

Q3's Staff FFT will be launched in March 2019 to offer a 'pulse' on the National Survey data, which by that point should be out of embargo. Data from FFT will be used to support trend analysis in line with the National Staff Survey and reported as a whole to the Business Units and Corporate Services.

# Finance – December 2018

**By finance, we mean the Trust's financial position is well managed. This is not a CQC Domain.**

Leeds Community Healthcare NHS Trust

| Finance | | Target | YTD | Q1 | Q2 | Oct | Nov | Dec | Q3 | Forecast |
|---|---|---|---|---|---|---|---|---|---|---|
| Net surplus (-)/Deficit (+) (£m) - YTD | 2018/19 | £3.4m | £3.7m | £0.3m | £1.6m | £1.6m | £1.8m | £3.7m | £3.7m | ● |
| | 2017/18 | | -£3.3m | -£0.9m | -£2.1m | -£2.4m | -£2.5m | -£2.9m | -£2.9m | |
| Net surplus (-)/Deficit (+) (£m) - Forecast | 2018/19 | £4.0m | £4.0m | £2.5m | £4.0m | £4.0m | £4.0m | £4.0m | £4.0m | ● |
| | 2017/18 | | -£3.3m | -£3.0m | -£3.0m | -£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 | -£1.4m | -£1.4m | |
| Capital expenditure in comparison to plan (£k) - YTD | 2018/19 | £381k | £1,348k | £303k | £574k | £415k | £323k | £36k | £1348k | ● |
| | 2017/18 | | £1.4k | £0.2m | £0.3m | £0.4k | £0.5k | £0.6k | £0.6k | |
| Capital expenditure in comparison to plan (£m) - Forecast | 2018/19 | £3.4m | £3.4m | £3.2m | £3.4m | £3.4m | £3.4m | £3.4m | £3.4m | ● |
| | 2017/18 | | £1.4m | £1.8m | £1.8m | £1.8m | £1.5m | £1.6m | £1.6m | |
| CIP delivery (£m) - YTD | 2018/19 | £0.5m | £3.2m | £1.0m | £1.9m | £0.5m | £0.4m | £0.4m | £3.2m | ● |
| | 2017/18 | | £2.8m | £0.6m | £1.2m | £1.6m | £1.8m | £2.1m | £2.1m | |
| CIP delivery (£m) - Forecast | 2018/19 | £4.7m | £4.5m | £4.7m | £4.7m | £4.5m | £4.5m | £4.5m | £4.5m | ● |
| | 2017/18 | | £2.8m | £3.4m | £2.9m | £2.9m | £2.9m | £2.9m | £2.9m | |
| Use of Resources Risk Rating (from Oct 2016) | 2018/19 | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | ● |
| | 2017/18 | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |

## Income & Expenditure Summary

The Trust's overall financial position remains consistent with previous months. The year to date surplus is running £0.3m ahead of plan. The Trust's forecast outturn continues to be our revised control total of £4.0m which includes £1.2m original control total, £0.5m additional surplus from the release of a redundancy provision no longer required and £2.3m of Provider Sustainability Funding (PSF) from NHS Improvement. The budget (planned position) has been updated this month to reflect the agreed position.

**Income**

Year to date contract income continues to run slightly less than plan due to penalties for the police custody and community care beds contracts. Non-contract income continues to be as planned. Receipt of all CQUIN and PSF has been assumed. Based on current performance there is a delivery risk in respect of 2 CQUINs; this totals £155k and in this scenario the shortfall will be manged so as not to impact on the control total delivery.

Forecast income is £0.2m less than planned as a result of the penalties above; this will be mitigated by underspending on reserves expenditure.

**Pay and Non-pay Expenditure and Vacancies**

Year to date

Pay expenditure is £0.5m underspent at the end of December, this is £0.1m more than last month. The main driver for the underspending is the level of vacancies which are 87 wte (same as Nov), or 3.2% of establishment; this is after the budgeted vacancy factor reduction. Temporary staffing costs were £651k for the month (£611k at Nov).

Agency staffing expenditure is 15.7% below the cap and not a concern.

Non-pay is overspent £0.4m for the year to date; the overspending is 1.6% of expenditure and is not a risk to the overall financial position and is being driven by the cost saving requirement. The “Other Non-pay” costs include the as yet un-identified corporate and Trust-wide CIPs which are resulting in the year to date overspending of £0.5m. Given the Trust’s overall financial position it is not intended to pursue these this year but they do need to be delivered recurrently.

Forecast Outturn

The pay forecast underspending is £0.4m which is the same as last month, it includes additional recruitment planned for the second half of the year in police custody, YOI, foot protection and neurology services in the Specialist business unit and neighbourhood team services, with an anticipated reduction in pay costs within the Children’s Business Unit.

The non-pay forecast overspend is £0.8m including a £0.2m overspending on interpreting services work continues on addressing this cost pressure. The forecast includes the cost of additional clinical contracts to increase capacity in the neighbourhood teams for winter, this utilises some of the pay underspending for the Adult’s Business Unit.

**Delivery of Cost Improvement Plans**

CIP delivery remains consistent with last month; there is a 3.7% (£125k) shortfall in respect of the procurement savings at the end of December. Specific corporate support savings have not been identified however corporate pay continues to be underspent at the end of December so these savings are being made non-recurrently.

The forecast delivery of the Cost Improvement Plans is consistent with last month. There are no further procurement savings identified this year, the shortfall is factored into the reported position.

Continued delivery of efficiency savings is essential to avoid impacting on the financial performance and deterioration of the underlying position.

**Business Unit Budget Performance**

The Business Units have a total of 31 wte vacancies for December with 29 of these being in the Adult's business unit; Specialist services are marginal overstaffed by 2.7 wte and Children's have 2.7 wte vacancies.

Specialist services are £0.6m underspent at December and forecast to be £0.7m under at the end of March. Pay underspending is £0.4m year to date the biggest drivers of this is £188k from reserves, CRU (£124k), police custody (£98k), YOI (£126k) and dental (£65k). Non pay underspending are £0.2m overall at the end of quarter 3 and are in the following services YOI (£88k), dental (£85k), MSK (£54k) and dietetics (£47k).

Children's Business Unit is a net £0.8m overspent at the end of December being £0.9m over on pay which is offset by an underspending on non-pay. The overspending on pay is being driven by CAMHS medical staff £426k, Paediatric medical staff £355k; both of these primarily relate to the cost of locum cover. There are further pay overspendings for Speech and Language therapy (£180k), Hannah House (£91k) and ICAN (£74k) services. Hannah House staffing has been increase as a result of the CQC inspection. Non-pay underspending is in Speech and Language therapy services £52k and Children's Continuing Care £39k.

Adult Business Unit is a net £0.5m underspent at December and forecast to be £0.4m under at the end of March as the services address winter pressures. The December underspending is in respect of pay and is driven by the level of vacancies across the services. Services with the largest underspending on pay include Neighbourhood teams (£303k), Health Case Management (£113k) Community Geriatricians (£130k) and the Night service (£49k).

**Capital Expenditure**

The Trust had planned for capital expenditure of £3.2m plus £127k adjusted in year for public access to WiFi. The Trust expects to spend the full £3.5m less write offs of £0.13m giving a net £3.4m charge against the CRL. £1.5m of this is in respect of the CAMHs Tier 4 inpatient new build which is not reflected in the CRL. It is anticipated the CAMHS expenditure will transfer to Leeds and York Partnerships NHS FT.

There is an overspending of £0.3m for the year to date in respect of IT equipment and the CAMHS inpatient new build. These are not cost overruns but represent earlier than anticipated outlay. It is not a concern in respect of the overall position.

**Cash**

The Trust's cash position remains very strong at £25.6m, £1.0m less than planned as a result of net adverse payables and receivables variances.

**Better Payment Practice Code**

The Trust continues to exceed the 95% target for paying invoices for all measures.

**Use of Resources Risk Rating**

The Trust's risk rating at the end of December continues to be 1 overall, which is the lowest risk. All measures are rated as 1 for the year to date.

# Appendix 1 – December 2018

Leeds Community Healthcare NHS Trust

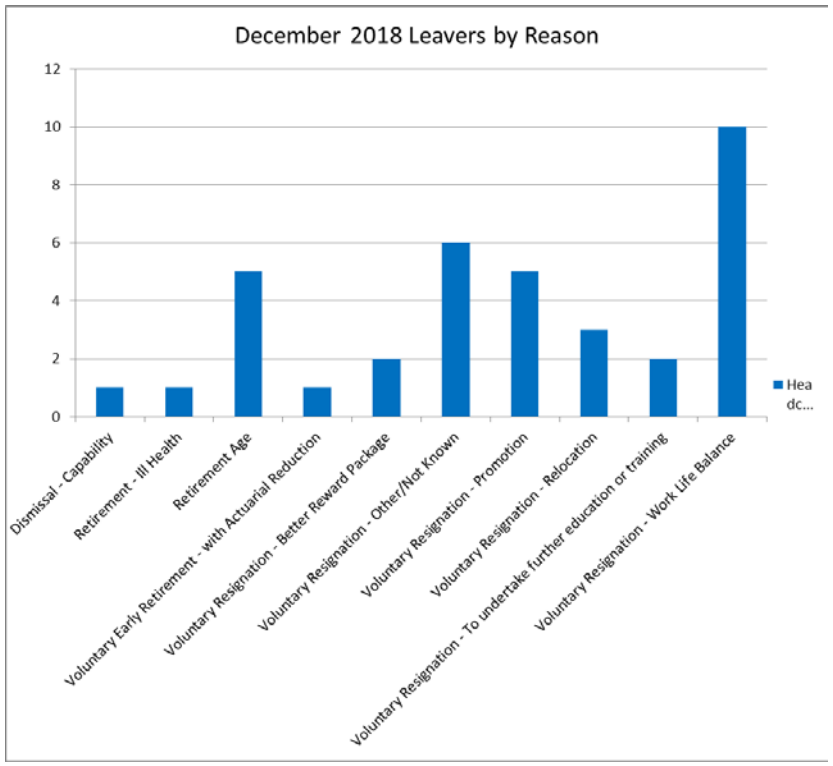
## Well- Led Additional Information

**Retention background data**

In December 2018 there were 36 leavers across the Trust. There distribution by Business Unit, staff group and reason for leaving is set out below:

| Business Unit | December 18 Leavers |
|---|---|
| Adult Business unit | 15 |
| Children's Business Unit | 7 |
| Corporate / Operations | 5 |
| Specialist Business Unit | 9 |
| **Grand Total** | **36** |

| Staff Group | December 18 Leavers |
|---|---|
| Clinical Services and Scientific/medical | 2 |
| Administrative and Clerical | 9 |
| Allied Health Professionals | 4 |
| Nursing and Midwifery Registered | 13 |
| Additional Clinical Services | 8 |
| **Grand Total** | **36** |



# Appendix 2 – December 2018

## Detailed Financial Tables

Leeds Community Healthcare NHS Trust

| Table 1<br>Key Financial Data<br>Statutory Duties | Year to Date | Variance from plan | Forecast Outturn | Performance |
|---|---|---|---|---|
| Income & Expenditure retained surplus | £3.7m | £0.3m | £3.0m | G |
| Remain with EFL of (£3.708m) | | | -£3.7m | G |
| Remain within CRL of £2.039m | £1.3m | -£0.3m | £3.4m | G |
| Capital Cost Absorption Duty 3.5% | | | 3.5% | G |
| BPPC NHS Invoices Number 95% | 98% | 3% | 95% | G |
| BPPC NHS Invoices Value 95% | 98% | 3% | 95% | G |
| BPPC Non NHS Invoices Number 95% | 96% | 1% | 95% | G |
| BPPC Non NHS Invoices Value 95% | 97% | 2% | 95% | G |
| | | | | |
| **Trust Specific Financial Objectives** | | | | |
| Use of Resources Risk Rating | 1 | - | 1 | G |
| CIP Savings £3.2m recurrent in year | £2.3m | -5% | £3.2m | R |
| CIP Savings £1.5m planned non recurrent in year | £1.0m | - | £1.5m | G |

| Table 2<br>Income & Expenditure Summary | December Plan WTE | December 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 | | | (104.4) | (104.2) | 0.2 | (139.2) | (138.9) | 0.2 | 0.2 |
| Other Income | | | (9.3) | (9.2) | 0.1 | (12.6) | (12.5) | 0.1 | 0.0 |
| ***Total Income*** | | | ***(113.7)*** | ***(113.4)*** | ***0.3*** | ***(151.8)*** | ***(151.4)*** | ***0.3*** | ***0.3*** |
| **Expenditure** | | | | | | | | | |
| Pay | 2,691.8 | 2,604.4 | 80.5 | 80.0 | (0.5) | 107.6 | 107.2 | (0.4) | (0.4) |
| Non pay | | | 27.4 | 27.9 | 0.4 | 36.9 | 37.8 | 0.8 | 0.7 |
| Reserves & Non Recurrent | | | 0.5 | (0.2) | (0.7) | 0.7 | (0.3) | (1.0) | (1.3) |
| ***Total Expenditure*** | ***2,691.8*** | ***2,604.4*** | ***108.4*** | ***107.7*** | ***(0.8)*** | ***145.2*** | ***144.7*** | ***(0.5)*** | ***(1.0)*** |
| **EBITDA** | **2,691.8** | **2,604.4** | **(5.3)** | **(5.7)** | **(0.5)** | **(6.5)** | **(6.8)** | **(0.2)** | **(0.7)** |
| Depreciation | | | 1.4 | 1.5 | 0.1 | 1.9 | 2.0 | 0.1 | 0.1 |
| Public Dividend Capital | | | 0.5 | 0.6 | 0.0 | 0.7 | 0.7 | 0.0 | 0.1 |
| Profit/Loss on Asset Disp | | | 0.0 | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.1 |
| Interest Received | | | (0.1) | (0.1) | (0.0) | (0.1) | (0.1) | (0.0) | (0.0) |
| **Retained Net Surplus** | **2,691.8** | **2,604.4** | **(3.4)** | **(3.7)** | **(0.3)** | **(4.0)** | **(4.0)** | **(0.0)** | **(0.5)** |
| | **Variance =** | **(87.4)** | | | | | | | |

| Table 3<br>Month on Month Pay Costs by Category | April<br>£k | May<br>£k | June<br>£k | July<br>£k | August<br>£k | Sept<br>£k | Oct<br>£k | Nov<br>£k | Dec<br>£k | YTD Actuals<br>£k |
|---|---|---|---|---|---|---|---|---|---|---|
| Directly employed staff | 7,886 | 7,829 | 7,898 | 8,247 | 8,688 | 8,344 | 8,340 | 8,276 | 8,300 | 73,810 |
| Seconded staff costs | 88 | 51 | 109 | 86 | 83 | 12 | 72 | 72 | 104 | 677 |
| Bank staff | 176 | 218 | 224 | 45 | 163 | 166 | 138 | 161 | 209 | 1,500 |
| Agency staff | 438 | 417 | 549 | 394 | 462 | 507 | 386 | 450 | 442 | 4,045 |
| **Total Pay Costs** | **8,588** | **8,515** | **8,781** | **8,772** | **9,396** | **9,029** | **8,936** | **8,960** | **9,056** | **80,032** |

| Table 4<br>Year to Date Non Pay Costs by Category | YTD Plan<br>£k | YTD Actual<br>£k | YTD Variance<br>£k | Last Month YTD Variance<br>£k | Forecast Outturn Variance<br>£k |
|---|---|---|---|---|---|
| Drugs | 606 | 678 | 72 | 62 | |
| Clinical Supplies & Services | 7,836 | 7,532 | (304) | (308) | |
| General Supplies & Services | 3,851 | 3,752 | (99) | (98) | |
| Establishment Expenses | 5,040 | 4,969 | (71) | (60) | |
| Premises | 9,337 | 9,488 | 151 | 140 | |
| Other non pay | 777 | 1,467 | 690 | 560 | |
| **Total Non Pay Costs** | **27,447** | **27,886** | **439** | **296** | **834** |

| Table 5<br>Savings Scheme | 2018/19 YTD Plan<br>£k | 2018/19 YTD Actual<br>£k | 2018/19 YTD Variance<br>£k | 2018/19 Annual Plan<br>£k | 2018/19 Forecast Outturn<br>£k | 2018/19 Forecast Variance<br>£k | 2018/19 Forecast Variance<br>% |
|---|---|---|---|---|---|---|---|
| Estates | 525 | 525 | 0 | 700 | 700 | 0 | 0% |
| Admin Review | 188 | 188 | 0 | 250 | 250 | 0 | 0% |
| Corporate Support | 225 | 225 | 0 | 300 | 300 | 0 | 0% |
| Procurement | 135 | 10 | (125) | 180 | 10 | (170) | -94% |
| Non Pay Inflation | 330 | 330 | 0 | 440 | 440 | 0 | 0% |
| CQUIN | 339 | 339 | 0 | 452 | 452 | 0 | 0% |
| Contribution to overheads / fixed costs | 623 | 623 | 0 | 831 | 831 | 0 | 0% |
| Release of Reserves | 56 | 56 | 0 | 75 | 75 | 0 | 0% |
| IT Kit | 225 | 225 | 0 | 300 | 300 | 0 | 0% |
| Discretionary spending | 375 | 375 | 0 | 500 | 500 | 0 | 0% |
| Decommissioning cost reduction | 350 | 350 | 0 | 700 | 700 | 0 | 0% |
| **Total Efficiency Savings Delivery** | **3,371** | **3,246** | **(125)** | **4,728** | **4,558** | **(170)** | **-4%** |

| Table 6<br>Service Line | Annual Budget £m | Budget WTE | Actual Contract WTE | Variance WTE | YTD Budget £m | YTD Actual £m | YTD Variance £m |
|---|---|---|---|---|---|---|---|
| Specialist Services | 39.1 | 674.7 | 677.4 | 2.7 | 29.1 | 28.6 | (0.6) |
| Childrens Services | 29.0 | 705.3 | 702.6 | (2.7) | 21.6 | 22.3 | 0.8 |
| Adults Services | 41.2 | 881.3 | 851.9 | (29.4) | 31.0 | 30.5 | (0.5) |
| Ops Management & Equipment | 1.7 | 52.8 | 51.1 | (1.6) | 1.2 | 1.3 | 0.0 |
| **Service Line Totals** | **111.0** | **2,314.0** | **2,283.1** | **(31.0)** | **83.0** | **82.7** | **(0.3)** |
| Corporate Support & Estates | 28.5 | 377.7 | 321.3 | (56.4) | 21.3 | 21.6 | 0.3 |
| **Total All Services** | **139.4** | **2,691.8** | **2,604.4** | **(87.4)** | **104.2** | **104.2** | **(0.0)** |

| Table 7<br>Scheme | YTD Plan £m | YTD Actual £m | YTD Variance £m | Annual Plan £m | Forecast Outturn £m | Forecast Variance £m |
|---|---|---|---|---|---|---|
| Estate maintenance | 0.5 | 0.2 | (0.3) | 0.7 | 0.7 | 0.0 |
| Equipment/IT | 0.1 | 0.3 | 0.2 | 0.5 | 0.6 | 0.1 |
| Electronic Patient Records | 0.3 | 0.3 | (0.1) | 0.5 | 0.5 | 0.0 |
| CAMHS Tier 4 | 0.0 | 0.5 | 0.5 | 1.5 | 1.5 | 0.0 |
| Public WiFi | 0.1 | 0.1 | 0.0 | 0.1 | 0.1 | 0.0 |
| Disposals | 0.0 | (0.1) | (0.1) | 0.0 | (0.1) | (0.1) |
| **Totals** | **1.0** | **1.3** | **0.3** | **3.4** | **3.4** | **0.0** |

| Table 8<br>Statement of Financial Position | Plan 31/12/2018 £m | Actual 31/12/2018 £m | Variance 31/12/2018 £m | *Opening 01/04/18 £m* | Planned Outturn 31/03/19 £m | Forecast Outturn 31/03/19 £m | Forecast Variance 31/03/19 £m |
|---|---|---|---|---|---|---|---|
| Property, Plant and Equipment | 28.8 | 29.0 | 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*** | **28.9** | **29.0** | **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 | 8.7 | 1.7 | *8.8* | 7.9 | 7.9 | 0.0 |
| Cash and Cash Equivalents | 26.7 | 25.6 | (1.0) | *23.2* | 25.8 | 27.4 | 1.7 |
| ***Total Current Assets*** | **33.6** | **34.3** | **0.7** | *32.1* | **33.7** | **35.3** | **1.7** |
| **TOTAL ASSETS** | **62.5** | **63.4** | **0.9** | *61.5* | **64.3** | **66.1** | **1.7** |
| **Current Liabilities** | | | | | | | |
| Trade and Other Payables | (11.2) | (11.4) | (0.2) | *(12.1)* | (13.4) | (13.4) | (0.0) |
| Provisions | (0.4) | (0.7) | (0.3) | *(1.4)* | (0.4) | (0.4) | 0.0 |
| ***Total Current Liabilities*** | **(11.6)** | **(12.1)** | **(0.5)** | *(13.4)* | **(13.8)** | **(13.8)** | **(0.0)** |
| **Net Current Assets/(Liabilities)** | **22.0** | **22.2** | **0.2** | *18.7* | **19.9** | **21.5** | **1.7** |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **50.9** | **51.3** | **0.4** | *48.0* | **50.6** | **52.3** | **1.7** |
| 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** | **50.9** | **51.3** | **0.4** | **48.0** | **50.6** | **52.3** | **1.7** |
| **TAXPAYERS EQUITY** | | | | | | | |
| Public Dividend Capital | 0.3 | 0.4 | 0.1 | *0.3* | 0.3 | 0.4 | 0.1 |
| Retained Earnings Reserve | 20.1 | 20.3 | 0.3 | *17.2* | 19.7 | 21.3 | 1.6 |
| 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** | **50.9** | **51.3** | **0.4** | **48.0** | **50.6** | **52.3** | **1.7** |

| Table 9<br>Measure | Performance This Month | Target | RAG |
|---|---|---|---|
| NHS Invoices | | | |
| *By Number* | 98% | 95% | G |
| *By Value* | 98% | 95% | G |
| Non NHS Invoices | | | |
| *By Number* | 96% | 95% | G |
| *By Value* | 97% | 95% | G |

| Table 10<br>Criteria | Metric | Performance | Rating | Weighting | Score |
|---|---|---|---|---|---|
| Liquidity | Liquidity ratio (days without WCF) | 57 | 1 | 20% | 0.2 |
| Balance Sheet sustainability | Capital servicing capacity (times) | 9.5 | 1 | 20% | 0.2 |
| Underlying performance | I&E margin | 3% | 1 | 20% | 0.2 |
| Variance from plan | Distance from plan | 0 | 1 | 20% | 0.2 |
| Agency spend above ceiling | Agency | -16% | 1 | 20% | 0.2 |
| **Overall Use of Resources Risk Rating** | | | | | **1** |

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (94)**

| **Meeting:** Trust Board 01 February 2019 | **Category of paper** *(please tick)* | |
|---|---|---|
| **Report title:** Significant risks and Board Assurance Framework (BAF) report | **For approval** | |
| **Responsible director:** Chief Executive<br>**Report author:** Risk Manager / Company Secretary | **For assurance** | ✓ |
| **Previously considered by:** N/A | **For information** | |

**Purpose of the report:**

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

The report provides the Board with the current risk profile. It details the Trust's risks currently scoring 15 or above, after the application of controls and mitigation measures. It provides an analysis of all risk movement, presents the risk profile, identifies themes, and links these material risks to the strategic risks on the Board Assurance Framework (BAF).

The Board Assurance Framework (BAF) summary advises the Board of the current assurance level determined for each of the Trust's strategic risks.

**Main issues for consideration:**

There are no risks scored as an 'extreme' risk.

Two risks previously scored as 'extreme' have been deescalated

The risks on the risk register (both clinical and non-clinical risks) have been interrogated for this report. The two strongest themes are:

- Staff sickness absence, vacancies, retention of staff
- An increased demand for services resulting in waiting times rising above 18 weeks

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by SMT, committees, and the Board. BAF risk scores have recently been reviewed and BAF risk 2.2 (delivery of contracted activity requirements) is reduced from 9 (high) to 6 (medium). BAF risk 3.2 (scale of sickness absence) has been reduced from 16 (extreme) to 12 (high). Audit Committee are recommending that the Board agree to include an additional BAF. This is (proposed) BAF Risk 2.6 and is attached as appendix 2.

**Recommendations**

The Board is recommended to**:**

- Note the contents of the risk register
- Note the themes identified in this report
- Note the revised BAF risk scores and the current assurance levels provided in the revised BAF summary
- Agree to additional BAF risk 2.6

## SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

## 1.0 Introduction

1.1 This report, which is presented at Senior Management Team (SMT) monthly, and every two months to the Board provides an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures. The report also provides a description of risk movement since the last risk register report was presented to SMT in November 2018.

1.2 The paper also provides a section detailing risks scoring 12. Whilst these do not meet the definition for inclusion in the risk register extract reported to SMT and the Board, they have been detailed as they evidence those matters of high risk and are scrutinised closely by SMT and the Board. In addition, there is a short summary of those risks scoring 8 or above, which are reported at the Quality Committee or Business Committee at each meeting.

1.3 The Board has previously agreed to the reduction in the number of in-depth risk register reports. Summary reports are received on a frequent basis, which alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report (such as this one) is received on a less frequent basis, and describes and analyses all risk movement, the risk profile, themes and risk activity.

1.4 The risk register has been analysed for this in-depth report and themes have been identified, which link these material risks to the strategic risks on the Board Assurance Framework (BAF).

1.5 This paper provides a summary of the current BAF and an indication of the assurance level that has been determined for each strategic risk.

## 2.0 Background

2.1 Risks showing a current score of 15 or above (extreme) are reported to the Trust's Board at each meeting. Prior to Board scrutiny, the Senior Management Team (SMT) consider and moderate the risks at 15 and above (monthly). SMT also receives a summary of risks graded 12. In exceptional circumstances, a director can request inclusion of any risk onto the register received by the Board.

2.2 The Board Assurance Framework (BAF) is a significant tool in helping the Board hold itself to account, understand the implementation of strategy and the risks that might impede delivery of its strategy and brings together:

- The Trust's strategic goals as set out in the Trust's longer term plans, its annual operational plan and the strategic priorities of business units
- Strategic risks that might prevent the Trust from meeting its strategic goals and corporate objectives; their causes and effects
- Controls and sources of assurance in place to manage risk and so support the delivery of those goals and objectives
- Actions to remedy gaps in controls or assurances

## 3.0 Summary of current risks scoring 15 or above

3.1 There are no risks with a current score of 15 (extreme) or above on the Trust risk register as at 7 January 2019.

## 4.0 New or escalated risks scoring 15+

4.1 Since the last report to the Board in December 2018, there have been no new risks scoring 15 or more.

4.2 There have been no risks escalated to 15 or more.

## 5.0 Closures, consolidation and de-escalation of risks scoring 15+

5.1 Since the December 2018 report, there have been no closed risks previously recorded at 15 or above.

5.2 Two risks have been deescalated below 15 since December 2018. These are:

| **Risk 939** | **Current risk score**<br>12 (high) | **Previous risk score**<br>16 (extreme) |
|---|---|---|
| **Title: New CAMHS Tier 4 building**<br><br>Reason for de-escalation:<br>• There have been productive discussions between LCH and LYPFT to identify solutions to the capital shortfall<br>• Work continues to secure the best possible building within the resources that can be made available in as short a timescale as possible | | |
| **Risk 224** | **Current risk score**<br>12 (high) | **Previous risk score**<br>16 (extreme) |
| **Title: Prevalence of staff sickness:**<br>Risk description in full: Due to current high levels of staff sickness absence across the Trust, there is a risk of greater reliance on agency cover and a risk of remaining staff being under pressure to manage an additional workload. The impacts are the financial cost of agency cover and an effect on staff morale and wellbeing<br><br>Reason for de-escalation:<br>• The risks associated with this risk register entry are a greater reliance on agency cover, and remaining staff being under pressure. Staffing issues resulting from sickness absence are being managed by the Trust in a multi-faceted approach to health and wellbeing. Agency spend is closely monitored.<br>• New appointments, including a senior leader with significant strategic workforce analytics experience within the directorate will enhance the functions capability and potential to deliver the proactive analytics aspired to. | | |

## 6.0 Summary of risks scoring 12 (high)

*6.1 High risks (scoring 12)*

6.1.2 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

6.1.3 The table below details risks currently scoring 12 (high risk).

**Table 2 High risks (scoring 12)**

| ID | Description | Rating (initial) | Rating (current) | Rating (Target) |
|---|---|---|---|---|
| 939 | New CAMHS Tier 4 Building | **16** | **12** | **4** |
| 954 | Diabetes Service waiting times | **15** | **12** | **3** |
| 949 | High Turnover of Staff in Neighbourhood Teams | **15** | **12** | **2** |
| 913 | Increasing numbers of referrals for complex communication assessments in ICAN service | **15** | **12** | **3** |
| 224 | Prevalence of staff sickness | **16** | **12** | **6** |

## 7.0 Summary of all risks currently scoring 8 or above

7.1 The following sections aim to apprise the Board of risks with a current score of 8 or above (after the application of controls and mitigations).

7.2 At present, the Trust's risk register comprises of 26 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate and headquarters functions. This is a lower number of risks when compared with 30 risks on the previous report.

### 7.3 Risks scoring 8 or above

7.3.1 The chart below shows the number of risks by area of the business, logged on the Trust's risk management database (Datix) as at 7 January 2019.

**Table 4 risks by area of the business**

| Directorate | Risks scored 8-12 High | Risks scored 15+ Extreme | Totals by directorate |
|---|---|---|---|
| Adult Services | 8 | 0 | 8 |
| Children's Services | 6 | 0 | 6 |
| Specialist Services | 5 | 0 | 5 |
| Operational Support Services | 1 | 0 | 1 |
| Corporate & HQ functions | 6 | 0 | 6 |
| **Totals by risk severity** | **26** | **0** | **26** |

## 8.0 Current risks scoring 8 or above by theme

8.1 For this report, the current material (the 'here and now') risks have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a more holistic view of the higher level risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

8.2 The emergence of material risks could mean that the controls in place on the Board Assurance Framework to manage strategic risks are not sufficiently robust. Themes within the current risk register, and their links to BAF strategic risks are as follows:

| **Theme /** *BAF Risk(s)* |
|---|
| **Risk register theme: Shortages of staff due to vacancies, recruitment issues and the high turnover of staff**<br>*BAF Risk 3.1 having suitable and sufficient staff capacity and capability* |
| **Risk register theme: Increase in demand for services (increased numbers of referrals, complex referrals, and subsequent follow-on appointments)**<br>*BAF Risk 2.4 retaining existing viable business and/or win new financially beneficial business tenders*<br>*BAF Risk 3.1 having suitable and sufficient staff capacity and capability* |
| **Risk register theme: Staff safety (violence, aggression and inadequate equipment storage)**<br>*RISK 3.2 the scale of sickness absence*<br>*RISK 3.3 engaging with and involving staff* |
| **Risk register theme: Processes and systems (lack of integrated systems with other service providers, inconsistent criteria)**<br>*RISK 4.2 maintaining relationships with stakeholders*<br>*RISK 4.4 having sufficient capacity across the Trust to deliver the key workstreams* |

*of system change programmes*
*Risk 4.5 ensuring there are robust agreements and clear governance arrangements for partnership arrangements*

## 9.0 Risk profile - all risks

9.1 There are 11 open clinical risks on the Trust's risk register and 36 open non-clinical risks. The total number of risks on the risk register is currently 47. This is a decrease compared to the 59 risks reported in the previous in-depth risk register report. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

**Table 7 Risk profile across the Trust.**

| | 1 - Rare | 2 - Unlikely | 3 - Possible | 4 - Likely | 5 - Almost Certain | Total |
|---|---|---|---|---|---|---|
| 5 - Catastrophic | 0 | 1 | 0 | 0 | 0 | 1 |
| 4 - Major | 1 | 2 | 1 | 0 | 0 | 4 |
| 3 - Moderate | 3 | 7 | 15 | 4 | 0 | 29 |
| 2 - Minor | 0 | 1 | 9 | 2 | 1 | 13 |
| 1 - Negligible | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 4 | 11 | 25 | 6 | 1 | 47 |

## 10.0 Board Assurance Framework Summary

10.1 The purpose of the BAF is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively.

10.2 Definitions:

- Strategic risks are those that might prevent the Trust from meeting its strategic goals and corporate objectives
- A control is an activity that eliminates, prevents, or reduces the risk
- Sources of assurance are reliable sources of information informing the Committee or Board that the risk is being mitigated ie success is been realised (or not)

10.3 Directors maintain oversight of the strategic risks assigned to them and review these risks regularly. They also continually evaluate the controls in place that are managing the risk and any gaps that require further action.

10.4 SMT, the Quality and Business Committees, and the Board review the sources of assurance presented to them and provide the Board (through the BAF process) with positive or negative assurance.

10.5 The BAF summary **(appendix 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).

10.6 There has been very little movement in levels of assurance as the committees were not scheduled to meet in December 2018. Since the last BAF summary report to SMT in November 2018 and Trust Board in December 2018, the current level of assurance for the following BAF risks has been adjusted as follows:

10.6.1 ***Positive movement (indicating an improved situation)***

- BAF risk 1.1 (effective systems and process for assessing quality) Quality Challenge+ visit to Hannah House provided the Quality Committee with reasonable assurance.
  BAF risk 2.2 (delivery of contracted activity requirements) Business Committee received reasonable assurance that Neighbourhood Team activity issues have been addressed with commissioners. The Trust is still working through the anomalies in children's activity levels. In recognition that the risk is being mitigated, the risk score has been reviewed and lowered from 9 (high) to 6 (moderate).

10.6.2 ***Negative movement (indicating a worsening situation)***

No negative movement has occurred since the last BAF report to the Board in December 2018.

10.7 Two BAF risks have revised risk scores (decreased scores). These are BAF risk 2.2 (delivery of contracted activity requirements), which is reduced from 9 (high) to 6 (medium) as the commissioners have agreed to a revised profile. BAF risk 3.2 (scale of sickness absence) has been reduced from 16 (extreme) to 12 (high) as a number of substantial controls are in place to manage this risk.

10.8 ***Addition of BAF Risk 2.6***

Audit Committee conducted a review of the BAF in July 2018 and recommended that an additional strategic risk should be added concerning the threat of cyber security. The Assistant Director of BI, Clinical Systems and IT provided a draft risk description, and identified controls and sources of assurance for Risk 2.6. Audit Committee reviewed this draft risk in December 2018 and recommends that Trust Board approves its addition to the current BAF. This draft BAF risk is included in **appendix 3**

10.9 If approved, the risk will be assigned to Audit Committee in order that the Committee can determine assurance levels from the sources of assurance it receives and report these to Trust Board.

## 11.0 Risk management activity

11.1 A bespoke training session was provided to CAMHS team managers to provide them with an understanding of how risk management works within the business. The course covered topics of risk terminology, risk assessments including 'bowtie' methodology, the risk appetite statement, the role of the risk register, and the need to include risk as an agenda item at team meetings.

11.2 A programme of risk assessment workshops is due to be completed during 2019 for services to ensure that all locally held statutory risk assessments are in place and current.

11.3 Support in completing risk assessments continues to be provided to staff and new staff receive an overview of the organisation's approach to risk management at the induction sessions.

11.4 The winter edition of Risky Business was published in January 2019. A message was sent out to staff via Community Talk to advise staff that they can subscribe to get the newsletter via email. Articles in the winter 2019 edition included:

- Reducing the risk of flu
- The escalation process for raising a concern
- Look alike and sound alike drug names
- Recording faults with medical devices
- Feedback on slips, trips and falls incidents

## 12.0 Impact

### 12.1 *Quality*

12.1.1 Risks recorded on the Trust's risk register are regularly scrutinised to ensure they remain current. Risk owners are encouraged to devise action plans to mitigate the risk and to review the actions, risk scores and provide a succinct and timely update statement. There are no known quality issues regarding this report.

### *12.2 Resources*

12.2.1 Any financial or other resource implications are identified and managed by the risk owner/lead director responsible for individual risks.

### *12.3 Risk and assurance*

12.3.1 This paper seeks to advise the Board that there is a robust process in place in the Trust for managing risk. Evidence that risks are proactively identified and managed in the Trust can be seen in the shifting profile of the risk register, with new risks being added and subsequently updated, risk scores amended and risks being closed.

## 13 Next steps

13.1 A number of developments are planned to ensure that the Trust's risk management framework continues to mature.

13.2 A Health, Safety and Risk training course is currently being developed to ensure that managers understand their roles and responsibilities with regards to risk management in relation to the safety and wellbeing of their direct reports and other persons affected by LCH work activities. This will form part of the essential management training which is to launch in February 2019. It is anticipated that all managers of staff will eventually receive this training.

13.3 The Risk Manager will continue to monitor risk review dates and remind risk owners of their responsibility to review and update risks appropriately.

13.4 The improvement plan formulated to address the risk management comments and recommendations made by the CQC in their inspection report continues to be actioned.

## 14.0 Reporting schedule

14.1 Set out below is the risk register and BAF reporting schedules to which this report conforms:

14.2 **Risk register reporting schedule**

| | | Month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Meeting | RRG | FULL | | | FULL | | | FULL | | | FULL | | |
| | AC | | | | | | | Report | | | | | Report |
| | SMT | FULL | SUM | SUM | SUM | FULL | SUM | SUM | | FULL | SUM | SUM | |
| | QC | FULL | | SUM | | FULL | | SUM | | FULL | | SUM | |
| | BC | FULL | SUM | SUM | SUM | FULL | SUM | SUM | | FULL | SUM | SUM | |
| | Board | | FULL | SUM | | | FULL | | SUM | | FULL | | SUM |

| Key | |
|---|---|
| FULL | = In-depth report |
| SUM | = Snapshot report |
| | = Information flow |

14.3 **BAF reporting schedule**

| | | Month | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| Meeting | SMT | Summary | | Summary | | Full | | Summary | | Summary | Mid-year review | Summary | |
| | QC/BC | | | | | Full (extract) | | | | | Mid-year revised | | |
| | AC | | | | Summary | | | Full | | | | | Full |
| | Board | | Summary | | Summary | | Summary | | Summary | | Summary | | Summary |

| | |
|---|---|
| Full | = Complete BAF |
| Summary | = BAF overview |
| Mid-year review | = Mid-year review |
| | = Information flow |

## 15.0 Recommendations

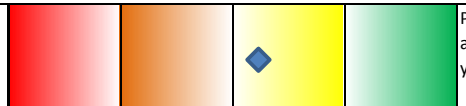
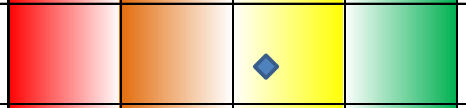
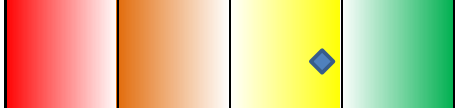
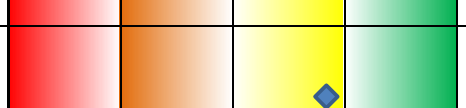
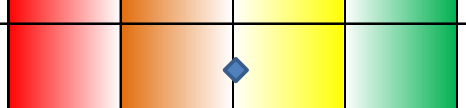
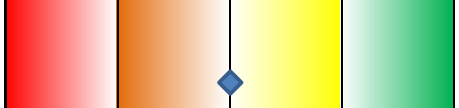
15.1 The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the revised BAF risk scores and the current assurance levels provided in the revised BAF summary
- Agree to additional BAF risk 2.6

# Board Assurance Framework (summary) 2018-19

**Appendix 1**

| 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. | SL | QC | 3 | 4 | 12 | | | | ◆ | | Quality Challenge+ visit to Hannah House provided reasonable 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. | SL | QC | 2 | 4 | 8 | | | | ◆ | | | |
| | **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 | SL | QC | 2 | 3 | 6 | | | | ◆ | | Action plan for CQC report into looked after childrens services provided reasonable assurance. Compliance with safeguarding training has improved. | |
| | **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. | SL | QC | 3 | 2 | 6 | | | | ◆ | | | |
| Provide sustainable services | **RISK 2.1** If the Trust does not achieve principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised. | SP | BC | 2 | 3 | 6 | | | | ◆ | | Change Board report and Estates Utilisation plan provided reasonable assurance. Admin Review update provided limited assurance. | |
| | **RISK 2.2** If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability. | SP | BC | 2 | 3 | 6 | ↓ | | | ◆ | | Risk score has been lowered. Business Committee received reasonable assurance that Neighbourhood team activity issues have been addressed with commissioners. Trust is still working through the anomalies in children's activity levels . | → |
| | **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 | 3 | 9 | | | | | ◆ | Digital strategy provided reasonable assurance. | |
| | **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 | |  | | Performance Brief highlighted concerns about number of staff leaving in first year. | |
| | **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. | JA/LS | BC | 4 | 3 | 12 |  |  | | Risk score has decreased. | |
| | **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 . | JA/LS | 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 (ex STP) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc. | TS | 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. | SL | QC | 3 | 3 | 9 | |  | | | |
| | **RISK 4.4** If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered. | TS | BC | 3 | 3 | 9 | |  | | | |
| | **Risk 4.5** If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships | BM | BC | 3 | 3 | 9 | |  | | | |

## Proposed new BAF risk 2.6

## Appendix 2

| | |
|---|---|
| Strategic Goal | Provide sustainable services |
| Strategic Risk 2.6 | *Description of risk:* ***(2.6) If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.*** |
| Lead Director | Bryan Machin |

| Risk score | Likelihood | Consequence | Score |
|---|---|---|---|
| Initial | 3 | 5 | 15 |
| Current | 2 | 4 | 8 |
| Target | 1 | 4 | 4 |

| Responsible committee |
|---|
| Audit Committee |

**Key controls** (lead director)

| Control Ref | Control (what are we doing already to manage the risk?) | Lead director | Adequacy of control |
|---|---|---|---|
| 2.6.1 c | Technical Control - software patching regime. Microsoft monthly updates, last Wednesday of the month. Others software released as required by the vendor | B Machin | Adequate |
| 2.6.2c | Technical Control - firewalls - to prevent intrusion and to monitor unexpected and suspect traffic | B Machin | Adequate |
| 2.6.3c | Technical Control - Smooth Wall (filtering) & prevention | B Machin | Adequate |
| 2.6.4c | Technical Control - NHS Digital Advance Threat Protection Service | B Machin | Adequate |
| 2.6.5c | Technical Control - Anti Virus Software - scanning and threat detection | B Machin | Adequate |
| 2.6.6c | Annual penetration test - testing network perimeter defences | B Machin | Adequate |
| 2.6.7.c | CareCert Weekly for up to date alerts from NHS Digital to highlight risks | B Machin | Adequate |
| 2.6.8.c | Business Continuity Plan | B Machin | Adequate |
| 2.6.8.d | Specific Cyber SOPs and Cyber Incident Response plans | B Machin | 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 |
|---|---|---|---|---|
| Create a specific cyber security management resource (in addition to the Head of IT post) | Build case of need to secure additional resources | B Machin | Mar-19 | |
| | | | | |
| | | | | |
| | | | | |

**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 |
|---|---|---|---|
| 2.6.1a | IG update (Audit Committee) | 1 | AC |
| 2.6.2a | Cyber security submission (assessment) | 1 | AC |
| 2.6.3a | Data Security & Protection Toolkit | 2 | AC |
| 2.6.4a | Internal audit - cyber security (Audit and Business Committees) | 3 | AC/BC |
| 2.6.5a | External scrutiny (Penetration Test) | 3 | AC |

**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 3**

## Glossary- BAF risk assurance levels

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

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**AGENDA ITEM 2018-19 (95)**

| | | |
|---|---|---|
| **Meeting** Trust Board 1 February 2019 | **Category of paper** *(please tick)* | |
| **Report title**<br>Serious Incident Summary Report | **For approval** | |
| **Responsible director** Executive Director of Nursing<br><br>**Report author** Incident and Risk 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 (SI's). It summarises the outcomes, themes, actions and learning from SI investigations closed within the organisation during 1 October to 31st December 2018.

**Main issues for consideration**

A total of fifteen Serious Incidents were reported and verified in October through to December 2018. Ten of the SIs in this reporting period related to pressure ulcers and four were serious falls. The remaining one SI was an unexpected death in one of the Recovery Hubs.

Outcomes of serious incident investigations completed in this reporting period are included along with any themes identified through investigations.

The main body of the report will consider the quarters reported incidents, learning and any other pertinent issues to bring to the Boards attention. The data and explanation of this in terms of statutory reporting etc. can be found in the appendix of the report.

**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 New Serious Incidents in Quarter 3

Fifteen SI's were reported to the commissioners via STEIS between 1st October and 31st December 2018.

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

| | Oct 2018 | Nov 2018 | Dec 2018 | Total |
|---|---|---|---|---|
| Pressure ulcer - Category 4 | 0 | 0 | 1 | 1 |
| Pressure ulcer - Category 3 | 1 | 1 | 1 | 3 |
| Pressure ulcer - Unstageable | 1 | 2 | 3 | 6 |
| Unexpected Death in Bed Base | 0 | 1 | 0 | 1 |
| Slips, trips, falls and collisions | 1 | 2 | 1 | 4 |
| Total | 3 | 6 | 6 | 15 |

The unexpected death details are:
Patient complained of pain at 1.30am, Catheter expelled, found to be in retention of urine following bladder scan. No attempt to re-catheterise and GP called who advised to call for ambulance. As this was not classed as an emergency the ambulance was booked to arrive within 2-4 hours. The ambulance was chased and staff were informed they would get to the patient as soon as possible. Patient's condition deteriorated at 06:30. Patient passed away before ambulance arrived at 06.52. DNACPR in place so no resus attempted.
At the review meeting for this incident it became apparent there were potential lapses of care in this case. In terms of the patient's death, the coroner has accepted the cause of death and there is no inquest planned and it would appear the cause of death was unrelated to the catheter concerns and retention of urine. However, there is further investigation ongoing and conversations with the staff involved as to whether more timely care could have been instigated on the unit rather than waiting for an ambulance. Once these have been concluded, appropriate actions will be taken where necessary.

## 2.0 Completed Investigations

2.1 Eighteen SI's were signed off by the Director of Nursing or deputy in quarter 3. Twelve were signed off before the due date. Six were subject to delays which resulted in the due date being passed.

These delays were due to staffing levels within the Clinical Governance Team; this has now been resolved with vacancies being filled. Further review of the investigation process has been put in place

to ensure that closer monitoring of due dates and progress is undertaken and if similar delays are noted in the future the CCG will be contacted and an extension sought and the Director of Nursing updated.

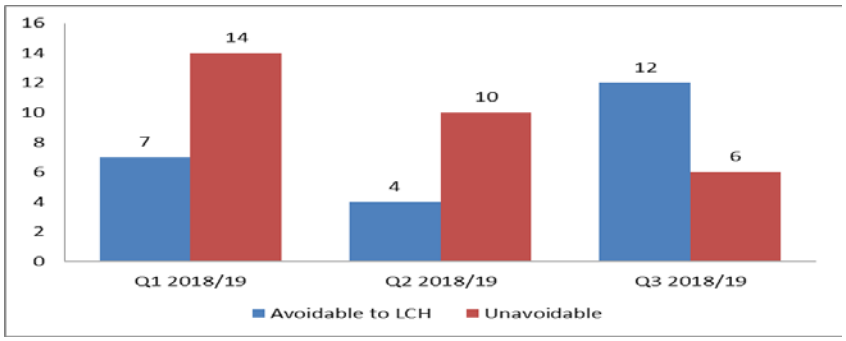
2.2 There were no category 4 pressure ulcers closed in quarter 3.

2.3 A breakdown in process occurred in quarter 3:

Four reports were not sent directly to the commissioners. The error was found in the production of this report and these documents have now been sent.
The cause has been identified as a breakdown in the process for completing SI investigation documentation by the Clinical Governance Team once the document had been signed off. New staff within the Clinical Governance Team will be familiarised with the process as part of their induction and a flowchart will be produced for use within the team for the SI process to ensure all staff are aware of the correct process.

## 3.0 Outcomes and Themes

3.1 Of the eighteen SI records closed in the quarter, twelve were found to be avoidable with only six being found to be unavoidable. Compared to previous quarters it is clear that the number of avoidable incidents is higher this quarter than in any other quarter this year. Due to this and




to ensure we understand the reason for this the emerging themes and actions to be taken are stated below.

3.2 Themes emerging from all the Serious Incident investigation reports completed in October to December identify documentation and poor standard of assessments in the top three areas of concern. Although individual action plans have been developed in each Serious Incident report; similar themes continue to be highlighted.

The recurring themes identified below have been escalated to the Deputy Director of Nursing who will be supporting individual teams in identifying methods of ensuring non recurrence. Further discussion

will be held at PSEG to ensure a robust process is in place to support services and that learning is shared across the organisation.

| Themes from SI Investigations | Number |
|---|---|
| Documentation not updated/reviewed | 3 |
| Documentation Standards - missing information | 3 |
| Assessments - Poor Quality | 2 |
| Communication - Breakdown with external services | 2 |
| Poor Care/Case Management | 1 |
| Assessments - Delay | 1 |
| No Holistic Assessment | 1 |
| Communication - Breakdown within the Team | 1 |
| Communication breakdown with patient or carer | 1 |
| Delay in Reporting Incident | 1 |
| Failure to Identify Risks | 1 |
| Staff - Capacity Issues | 1 |
| Patient - Concordance | 1 |

3.3 The Clinical Governance Manager has met with the Quality Improvement (QI) Team to facilitate the support of the team on the completion of action plans for both the tracking of actions, identifying themes to completion and also provide assistance and support for the clinical teams on effective action planning and QI methodology. Further work will be undertaken on how we build a stronger relationship with the QI team to support this crucial work to ensure sustainability of changes made through action plans and ensure that these are robust, achievable and completed. In addition actions from these types of incidents could and should inform future QI projects

## 4.0 Inquests

4.1 There was no inquest registered with LCH as an interested party in quarter 3**.**

**APPENDIX 1**

**Serious incident summary report**

## 1. Purpose of report

1.1 The purpose of the report is to provide the trust board with an overview of serious incidents (SI's) managed within lch in the period 1 October to 31st December 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 (DH March 2015), via the LEEDS CCG strategic executive information system (Steis).

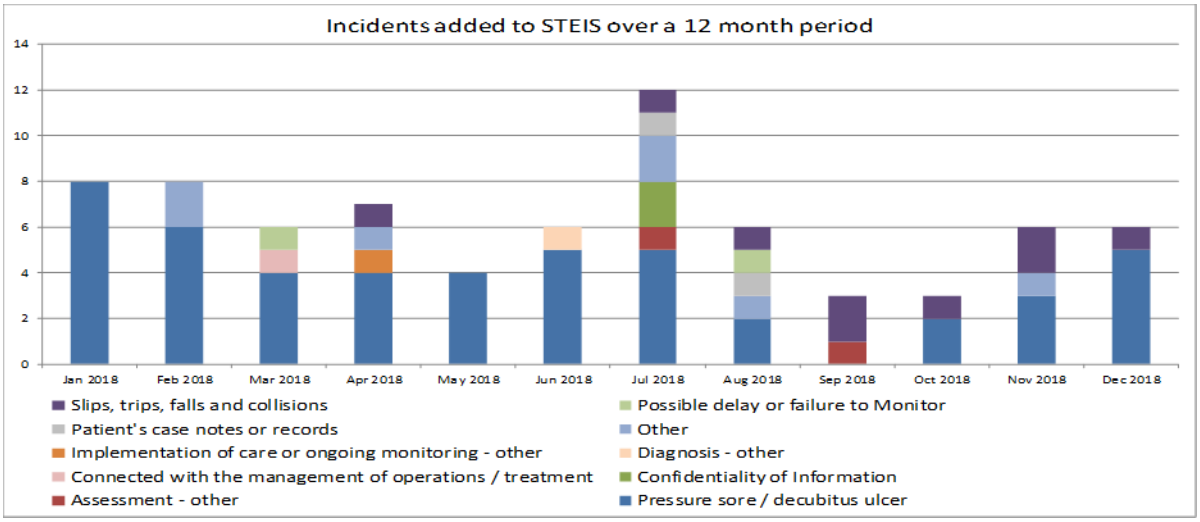
2.2 Serious incidents should be reported on Steis within 2 working days of the incident being confirmed as a serious incident. They are allocated to the relevant commissioner via the Steis report.

2.3 An SI occurring in services with additional commissioning arrangements (for example HMP Wetherby YOI, police custody) 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 Total Number of SIs

3.1 Total SI's taken forward for investigations for the year are in the table




3.2 Of the Eighteen reports, fourteen were sent directly to the CCG for review, the remaining four related to category 3 and unstageable pressure ulcer and a quarterly thematic report and review is sent to commissioners. A synopsis of the 14 individual submissions sent directly to the CCG is provided below:

| ID | Type | Avoidable / Unavoidable | Synopsis of findings |
|---|---|---|---|
| 51754 | Slips, trips & falls | Avoidable | Tier 2 falls risk assessment should have been completed after the patient had an unwitnessed fall at home on 09.03.18. Patient scored 2 on Tier 1 and did not trigger a Tier 2 . This should have been completed due to the recent fall resulting in injury. |
| 52104 | Slips, trips & falls | Unavoidable | Medical staff identified cause of fall to be over medication for blood pressure causing hypotension. Importance of recording baseline and ongoing clinical observations. Importance of Tier 2 assessment following falls and any onward referral. The importance of completing observations as part of the tier 2 after a fall. |
| 51867 | Slips, trips & falls | Avoidable | No full assessment including FRAT when the patient was discharged back to NHT post elective femoral popliteal bypass surgery. |
| 50558 | Unexpected Death | Unavoidable | Rapid onset of necrotising fasciitis and subsequent death. Pressure Ulcer was a possible entry point for the bacteria |
| 50909 | Unexpected Death | Unavoidable | Actions taken by the clinician were appropriate and in line with service protocols and identified risks |
| 49335 | Slips, trips & falls | Avoidable | Relevant assessment and interventions were not completed after the patient had two falls, Concerns/incidents were not always reported to the appropriate Clinician/s therefore timely review/actions were not completed. |
| 50985 | Assessment - other | Avoidable | Hospital and GP investigations ongoing - a joint meeting is going to be arranged to share learning. Indications are that there are multiple factors and missed opportunities, the majority around communication between care providers and with the patient. |
| 50918 | Confidentiality of Information | Avoidable | Complexity of communication in LAC cases to all who are involved with the child and the high emotions with LAC. There was no single 'gate keeper' identified in this case who had responsibility for passing on information from professionals involved to the biological parents |
| 52112 | Assessment - other | Unavoidable | The pin of the metal work inserted to support the repairing of the fractured ankle in 2012 had worked itself to the skin surface. It was estimated by WPMS that the protruding pin would have caused unpreventable damage eventually, as the skin and area remained vulnerable. In time, the wound would break down, as the protruding pin / wire would inhibit the full healing process until being removed. |

| | | | |
|---|---|---|---|
| 52385 | Slips, trips & falls | Avoidable | Patient has dementia, often declines interventions. Discrepancies highlighted when completing Tier 1 and 2 between individual agency nurses. No care plan added to complete lying and standing blood pressure.<br>Missed opportunity to commence bone protection in March as no evidence GP contacted. Poor attendance at safety huddles and handover by some agency staff, which reduced opportunity to discuss face to face concerns. |
| 51816 | Slips, trips & falls | Avoidable | There were a number of missed opportunities to undertake falls prevention activities. |
| 51769 | Slips, trips & falls | Avoidable | Missed opportunities for accurate completion of FRAT and tier 2 assessments but patient may still have fallen. |
| 51503 | Delay or failure to Monitor | Unavoidable | Alleged communication issues between the patient and staff around leg swelling. Formation of DVT following recent knee surgery. Patient mobility affected post-surgery which was a factor contributing to development of the DVT and consequential bi-lateral Pulmonary Embolism. |
| 50948 | Patient's records | Avoidable | Failure to follow policies and procedure |

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**AGENDA ITEM 2018-19 (96)**

| | | |
|---|---|---|
| **Meeting:** Trust Board 1st February 2019 | **Category of paper** *(please tick)* | |
| **Report title: Mortality Report** | **For approval** | |
| **Responsible director: Dr Ruth Burnett, Interim Executive Medical Director**<br>**Report author: Dr Ruth Burnett, Interim Executive Medical Director** | **For assurance** | √ |
| **Previously considered by: Quality Committee 21 January 2019** | **For information** | |

**Purpose of the report**:

To provide the Board with assurance regarding the Mortality figures and process within LCH NHS Trust in Quarter 3.

**Main issues for consideration**

Mortality data is now more accurately reported across the Trust, encompassing data from both Datix® and EPaCCs (Electronic Palliative Care Coordination Systems). We are now also able to report on the number of Level 1 and Level 2 investigations completed.

Mortality data from Quarter 3 shows no significant variation from previous data and trends.

Children's' Business Unit Mortality Review meetings have not been quorate during Quarter 3 and there has been an absence of data flow and narrative up to the Mortality Surveillance Group. Individual cases have still been reviewed and assurance has been provided that the process has been reinstated successfully for the start of Quarter 4. Additionally there are established robust processes within Children's services around unexpected deaths via the sudden unexpected death in children (SUDIC) process and Child death overview panel (CDOP).

Whilst data reporting has significantly improved in consistency during 2018 /19 and we are now able to determine the number of Level 1 and Level 2 reviews completed, the next step is to work towards a dataset for both local and central meetings that enables us to provide assurance regarding whether those cases undergoing Level 2 investigation are for the correct patient groups e.g. patients with a mental health condition or learning disability.

At present there is no comparable Community Trust dataset available for us to benchmark our mortality data against. We continue to explore this with NHS Benchmarking and hope to resolve this for 2019/20.

**Recommendations**

**The Board is recommended to:**

- Receive the assurance made regarding mortality reporting and review in the Trust
- Confirm that they wish to receive specific quarterly Mortality Reports to maintain focussed oversight regarding the mortality within the Trust

# Mortality Report

## 1.0 Purpose of this report

1.1 To provide the Board with assurance regarding the Mortality figures and process within LCH NHS Trust in Quarter 3.

## 2.0 Background

2.1 Leeds Community Healthcare NHS Trust has contact with a significant number of patients within the city, with very few in an inpatient environment. For many of the people who die under the care of the NHS this is an inevitable outcome particularly given we provide a lot of end of life care in peoples own homes, and many receive excellent care in the time leading up to their death.

2.2 The Francis inquiry report[1] into the care failings identified at Mid Staffordshire Hospital Trust, identified one of the significant measures that was not acted on appropriately was a mortality rate significantly higher than expected for the Trust. The NHSE National Guidance on Learning from Deaths, 2017[2] provides the underpinning for the framework that NHS Trusts now follow. Within this it emphasises that "Community NHS Trusts should carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach".

2.3 Our responsibility as a Trust encompasses the following requirements:

- Ensure we have adequate governance arrangements and processes that include, facilitate and give due focus to the review, investigation and reporting of deaths.
- Ensure that we share and act upon any learning derived from these processes.
- Ensure adequate training and support is provided to staff to support this agenda
- Have a clear policy for engagement with bereaved families, or carers, including giving them the opportunity to raise questions or share concerns and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage of the process
- Have a clear Mortality and Learning from Deaths Policy that details how we respond to, and learn from, deaths who die under our management and care
- Collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting in each quarter

2.4 Leeds Community Healthcare NHS Trust Mortality and Learning from Deaths Policy, 2017 details our Trust response to both of these and clearly articulates our assurance process and governance surrounding mortality reviews and shared learning throughout the Trust and the wider system.

2.5 Deaths can broadly be categorised into unexpected and expected deaths, where an expected death results from an acute or gradual deterioration in a patient's health status, usually due to an advanced progressive incurable disease. The death is anticipated, expected and predicted.

2.6 Within Leeds Community Healthcare NHS Trust all deaths, whether expected or unexpected, whilst a patient is under the care of LCH services and on an active caseload are reported via Datix®. Exceptions to this are noted in the policy, the main one being if the death is already recorded in the Electronic Palliative Care Coordination Systems (EPaCCs).

2.7 All deaths are reviewed using the Level 1 assessment tool, whether unexpected or expected. If this identifies that a more in depth review is required the Level 2 mortality review tool must be completed and the case reviewed at the local Mortality Governance meeting.

2.8 Any deaths that fall under the Trust's Serious Incident policy (e.g. Death in Custody) will be investigated using the Serious Incident Investigation framework and policy.

2.9 Where the unexpected death is a child the death will be reported via the sudden unexpected death in infants and children (SUDIC) route and follow that process.

2.10 Leeds Community NHS Trust is committed to ensuring any learning from deaths is shared appropriately, as widely across the organisation as required and using a variety of methods.

2.11 We are committed to ensuring the Trust's Duty of Candour policy is followed, and that families are involved in both any investigation that takes place and any subsequent learning as appropriate, including from any lapses in care.

## 3.0 Current position

3.1 The Mortality Surveillance Group met twice as scheduled in Quarter 3, in October and December 2018. The group was quorate both times. The Terms of Reference (Appendix 1) were reviewed by the group in October 2018 and approved by Quality Committee in November 2018. An agreed minimum dataset has been standardised for Business Unit reports into the Mortality Surveillance Group to ensure that sufficient information is available for robust discussion.

3.2 Business Unit Mortality Governance meetings have taken place regularly in Adult and Specialist Business Units, but the Children's Business Unit has experienced some challenges in terms of quoracy over Quarter 3. During this time deaths have continued to be reviewed within the Children's Business Unit and assurance provided that the meetings will be successfully reinstated from the beginning of Quarter 4.

3.3 Data integrity due to the use of different recording systems (Datix® and EPaCCs) has previously provided a challenge in regards to obtaining an accurate picture of deaths reported across the Trust until recently. It has also previously not been possible to accurately report the number of deaths undergoing Level 1 and Level 2 reviews.

3.4 We are now in a position to report these reliably, in order to provide the Board with greater assurance regarding the integrity of the Trust mortality

data and the number of Level 1 and Level 2 reviews that are being undertaken within the Trust.

3.5 Further work is underway to ensure that the dataset available can provide the Trust with assurance that the deaths we are conducting more detailed reviews on are the correct ones.

3.6 The Trust is compliant with the Learning Disabilities Review Programme (LeDeR) system for reporting any deaths in a patient with Learning Disabilities whilst under the Trust's care. There have been no deaths that fall into this criteria within Quarter 3.

3.7 Adult Business Unit

3.7.1 **Mortality Data**

| 2018 -19 | | Total number of deaths in month | | | | Total |
|---|---|---|---|---|---|---|
| Total Reported Adult deaths | Q1 | Q2 | Q3 | Running Total | Q4 | |
| | | | | | | |
| | | | | | | |
| EPaCCS deaths | 435 | 426 | 344 | **1205** | | |
| Datix reported Unexpected deaths | 81 | 111 | 84 | **276** | | |
| Datix reported Expected deaths | 13 | 42 | 13 | **68** | | |
| **Total of deaths** | **529** | **579** | **441** | **1549** | | |
| Level 1 reviews | 168 | 234 | 314 | **716** | | |
| Level 2 reviews | 36 | 39 | 60 | **135** | | |
| Serious Incidents | | | 1 | **1** | | |

3.7.2 Due to the smaller number of deaths recorded in Q3 2018, this was reviewed against the Q3 2017 data; this period detailed a total of 512 overall deaths reported. Analysis of the 2018 data shows this reduction is mainly due to the smaller number of deaths reported on EPaCCS in December and this figure may change when the December data is validated by the End of Life Team.

3.7.3 In Q1 and Q2 the Neighbourhood Teams were embedding the new Mortality review process for completing the Level 1 and Level 2 Mortality review forms, which explains the difference in the numbers of deaths reviewed and reflects the introduction of a new process with increased confidence in Q3 reported numbers.

3.7.4 In addition, a 75% change in the clinical leadership within the Neighbourhood Teams required a focused support programme in Q2 to develop the knowledge and skills required to oversee the process.

3.7.5 Learning from the initial Mortality Review Pilot demonstrated that between 20-25% of Level 1 reviews require a Level 2 investigation. This has been consistently observed from Q1 to Q3 as the process embeds.

3.7.6 A recent but short term increase in the number of under 65 year old deaths reported on an active ABU Team caseload was noted, but does not appear to be an ongoing trend. The findings have been shared with the Hospice Clinical Leads at a recent team to team meeting in Q3. It was acknowledged by both parties that this situation can occur and is within the normal variation of mortality data.

3.7.7 A reduction in the overall number of Q3 unexpected deaths is due to the low number reported in December 2018. Neighbourhood Teams experience variability in the number of fast track patients on caseloads at any one time, which in turn leads to a variation in the number of palliative deaths from one month to another. Work is ongoing to explore what is the acceptable range.

3.7.8 Information gained from reporting of deaths on EPaCCs shows that over the past quarter there has been a short term increase in the number of patients dying in hospital. This is not thought to be long term trend and is being monitored by the Palliative Care Leads (PCLs) and the Neighbourhood Team Clinical Leads. Early analysis indicates that this most probably reflects a cohort of patients requiring specialist medical support at the end of life.

## 3.8 **Childrens Business Unit**

3.8.1 Mortality Data

Deaths within Children's Business Unit, with 2017-18 data for comparison

| 2018 -19 (2017-18 data for comparison) | Total number of mortality reported incidents | | | | Total |
|---|---|---|---|---|---|
| Total Reported Children's deaths | Q1 (17-18) | Q2 (17-18) | Q3 (17-18) | Q4 (17-18) | (17-18) |
| | 10 (7) | 5 (9) | 6 (9) | (11) | 21 (36) |
| | | | | | |
| Unexpected deaths [SUDIC] | 3 (4) | 5 (6) | 4 (7) | (8) | 12 (25) |
| Expected Deaths [CDOP] | 7 (3) | 0 (3) | 2 (2) | (2) | 9 (11) |

3.8.2 There are established robust processes within Children's services around unexpected deaths via the sudden unexpected death in children (SUDIC) process and Child death overview panel (CDOP).

3.8.3 No learning from Child Death Overview Panels (CDOPs) or completed SUDIC reviews have been available for presentation at the Mortality Surveillance Group in Quarter 3.

## 3.9 **Specialist Business Unit**

3.9.1 Mortality Data

| 2018 -19 | Total number of deaths in month | | | | Total |
|---|---|---|---|---|---|
| Total Reported Adult deaths | Q1 | Q2 | Q3 | Q4 | |
| | 10 | 4 | 8 | | 22 |
| | | | | | |
| Unexpected deaths | 8 | 3 | 4 | | 15 |
| Expected deaths | 2 | 1 | 4 | | 7 |
| Level 1 reviews | 4 | 2 | 4 | | 10 |
| Level 2 reviews | 5 | 2 | 3 | | 10 |
| SI | 1 | | 1 | | 2 |

Source: Datix®

3.9.2 Breakdown of services reporting deaths on Datix® Q3 2018/19
a. Long term conditions = 4
b. Community Neuro Rehab service = 1
c. Nutrition and Dietetics = 1
d. CIVAS = 1
e. IAPT = 1

3.9.3 The Specialist Business Unit mortality review process has been aligned with that of the Adult Business Unit over Quarter 3, resulting in greater consistency and reduced duplication of deaths reported on Datix®. Where both Business Units have been involved with a patient a joint review of the death is undertaken.

3.9.4 The apparent reduction in deaths reflects a clarification of reporting process and review of the definition of an unexpected death within the Cardiac service, rather than a decreasing trend.

## 4.0 Impact

### 4.1 Quality

4.1.1 There has been a significant improvement in the consistency of data reporting on both Datix® and EPaCCs, and of recording the number of Level 1 and Level 2 investigations completed.

4.1.2 Ongoing work is underway to ensure all staff are aware of the correct system and criteria for reporting a death onto Datix® or EPaCCS. Whilst much improved, there have still been a small number of identified cases where this has not been followed correctly, and ongoing work continues in this regard.

4.1.3 At present it is not possible to centrally report the number of Level 1 and Level 2 reviews undertaken against the type of death reported as this is currently a narrative process.

4.1.4 All deaths, expected or unexpected, are reviewed by the local Quality Lead to ensure that the correct level of investigation is undertaken.

### 4.2 Resources

4.2.1 The number of deaths investigated by the Adult Business Unit, and the relatively stable 20-25% requiring Level 2 review requires a substantial amount of work by the senior clinical leadership team in the Business Unit.

4.2.2 In Q4 the Adult Business Unit, on behalf of Leeds Community Trust, will begin to report deaths reviewed within the ABU Mortality Review process on behalf of the Leeds CCG following a death in a non LCH/LCC Community Care Beds following an agreement reached in Q3.

4.2.3 The capacity within the team conducting the mortality reviews in the Adult Business Unit will need to be carefully monitored to ensure that they can continue to conduct the number of reviews required to a sufficient quality and consistency.

## 5 Next steps

5.1 Accuracy of reporting continues to improve, as does recording of the level 1 and 2 data and we are gaining a more informed understanding of a normal range of data. The Trust continues to work hard to ensure benchmarking and normal range are understood, and to ensure accuracy of our dataset.

5.2 Now the integrity of the data centrally reported is significantly improved, we aim to move to a greater detail of central reporting to allow us to provide assurance in regards to the fact those deaths investigated in greater depth are the correct ones. This would include the number of deaths in patients with a mental health condition or learning disability that underwent Level 2 reviews and the number of deaths reported on EPaCCs or Datix® that underwent Level 1 or Level 2 reviews.

5.3 Business Unit Mortality Governance meetings and Mortality Surveillance Group meeting dates are in the process of being aligned to the Trust reporting schedule to improve accuracy of reporting and minimisation of duplicative workload.

5.4 The variation in services provided by Community Trusts and the flexibility with which a Community Trust can “carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach” has to-date prevented benchmarking across Community NHS Trusts for mortality data. We continue to work with NHS Benchmarking to ascertain a way to benchmark our data against comparable trusts for comparison.

## 6 Recommendations

6.1 The Board is recommended to:

- Receive the assurance provided regarding the Trust mortality process
- Confirm that they wish to receive specific quarterly Mortality Reports to maintain focussed oversight regarding the mortality within the Trust

## 7 References

7.1 The Mid Staffordshire NHS Foundation Trust Inquiry: Independent Inquiry into care provided by Mid Staffordshire NHS Foundation Trust, January 2005 to March 2009, volume 1, chaired by Robert Francis QC, published 24 February 2010.

7.2 National Guidance on Learning from Deaths, National Quality Board, First edition march 2017

NHS
Leeds Community Healthcare
NHS Trust

**AGENDA ITEM 2018-19 (97)**

| | | |
|---|---|---|
| **Meeting:** Trust Board 1 February 2019 | **Category of paper** *(please tick)* | |
| **Report title**<br>Quarterly Report of the Guardian of Safe Working Hours | **For approval** | |
| **Responsible director** Interim Executive Medical Director<br>**Report author** Guardian of Safe Working Hours | **For assurance** | ✓ |
| **Previously considered by**<br>Quality Committee 21 January 2019 | **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
- Continue to support HR to develop accurate database of doctors under contract with the Trust.

**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

There are 23 Junior Doctors and Dentists employed throughout the Trust (in different specialities) as detailed in the table below. Doctors and Dentists are mostly employed through honorary contracts.

| Department | No. | Grade | Status |
|---|---|---|---|
| **CAMHS** | 3 | STs | Employed (fulltime) |
| | 4 | CTs | Honorary |
| **GP** | 3 | GP trainee | Honorary |
| **MSK** | 1 | ST | |
| **Community Paediatrics** | 5 | STs | Honorary |
| **Sexual Health** | 2 | ST | Honorary |
| **Dental** | 3<br>2 | ST<br>Foundation | Honorary<br>Honorary |

**QUARTERLY OVERVIEW**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Vacancies | | There are 2 vacancies in the CAMHS Specialty Trainee (ST) establishment.<br>LCH produce and populate an ST 2nd on call rota in CAMHS. | | | | | |
| Rota Gaps (number of nights uncovered) | | November | | December | | January | |
| | | CT | ST | CT | ST | CT | ST |
| | Gaps | n/a | 10 | n/a | 16 | n/a | 17 |
| | Internal Cover | n/a | 6 | n/a | 10 | n/a | 2 |
| | External cover | n/a | 4 | n/a | 6 | n/a | 15 |
| | Unfilled | n/a | 0 | n/a | 0 | n/a | 0 |
| Exception reports (ER) | | 0 | \|0 | 0 | 0 | 0 | 0 |
| | | | | | | | |
| Fines | | None. | | | | | |
| Patient Safety Issues | | None | | | | | |
| Junior Doctor Forum | | TBC February 2019 | | | | | |

**Rota gaps**

The CAMHS ST rota is not fully recruited to. There are 2 FTE post unfilled.

External locums have been sourced directly by the Trust to populate the CAMHS 2nd on call rota. The CAMHS Clinical Lead and HR are developing CAMHS second on call locum bank. Locums are now predominantly sourced internally.

**Implementing the role of GSWH**

**Feedback from trainees**

No issues raised. Junior Doctors Forum to be arranged in February 2019.

**Challenges**

<u>Engagement</u>

We continue to experience challenges in recruiting to the Local Negotiating Committee (LNC).

Administrative support

HR have been restructured this year. Since the last Guardian report, work has taken place to consolidate an accurate database of junior doctors in training at LCH.

## 4.0 Impact

### 4.1 *Quality*

4.1.1 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.

## 6.0 Recommendations

6.1 The Board is recommended to:

- Continue to promote interface between GSWH and trainees
- Continue to support HR to develop accurate database of doctors under contract with the Trust.

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (98)**

| | | |
|---|---|---|
| **Meeting** Trust Board 1 February 2019 | **Category of paper** | |
| **Report title** Safe Staffing | **For approval** | |
| **Responsible director** Executive Director of Nursing<br>**Report author** Interim 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 highlighting if 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. The statutory requirements and data is contained in an appendix with the main body of the paper being used to provide assurance to the Board in relation to the effect of staffing pressures on services and how these are being mitigated.

Safe staffing has been maintained across all inpatient units for the time period. There continue to be pressures in a number of the neighbourhood teams. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this is possible.

**RECOMMENDATIONS**

The Board is recommended to:

- Continue to meet the national monthly collection and publication of staffing data as recommended in “Hard Truths”
- Keep staffing levels under constant review
- Note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting

## Safe Staffing

### 1.0 Background

1.1 In line with the NHS England requirements and the National Quality Board (NQB) recommendations, this paper presents the six monthly nursing establishment's workforce review.

1.2 In addition to reporting on the in-patient areas the paper also provides information on some of the other keys services, in particular the neighbourhood teams and the Health Visiting service.

1.3 The paper also provides some triangulation of patient safety data to staffing numbers to provide assurance to the Board in relation to the effect of staffing pressures on services and how these are being mitigated.

### 2.0 Safe staffing

2.1 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 (Appendix 2).

2.2 The Board receives monthly data via the Performance brief in relation to safe staffing on the in-patient units within LCH.

### 3.0 Community Neurological Rehabilitation Unit

3.1 The Unit has maintained safe staffing levels throughout the reporting period of both registered and non-registered staff (see appendix 3).

3.2 There have been no serious incidents reported during this time and no complaints received in relation to care on the Unit.

### 4.0 Hannah House

4.1 The unit has maintained safe staffing levels throughout the reporting period (See appendix 3). In order to maintain this occasionally a child's stay has to be cancelled and this has occurred on five occasions during this reporting period. On every occasion families were offered alternative dates and these have all been taken up. Cancelling stays remains the last option but even with support from the other community children's services sometimes it is the only option available to ensure safe staffing levels.

4.2 Recruitment has been ongoing and all care staff vacancies are now filled and band 5 registered nurse posts are in the process of being recruited.

4.3 There have been no serious incidents reported during this time.

4.4 There have been three complaints during this time and the details of these were as follows:

One was in relation to eligibility criteria for the service and was responded to by the Commissioner.

One was in relation to lack of feedback following an incident and was partially upheld via the complaints process but was not related to any staffing issues.

One was in relation to care and was related to staff not having the necessary information to carry out all cares required and was not related to any staffing issues.

## 5.0 Little Woodhouse Hall

5.1 The unit has maintained safe staffing levels during this reporting period of both registered and non-registered staff (see Appendix 3)

5.2 There have been no serious incidents reported during this time and initially one complaint was made about care and record keeping within the service, however, this was later withdrawn.

## 6.0 Health Visiting Service

6.1 In preparation for mobilisation of the new contact in April 2019 the service is delivered through 9 Health Visiting teams working across Leeds, with each team covering a defined geographical area. Safe staffing in the service has been maintained throughout the reporting period and the detail related to caseload size etc. can be seen in Appendix 3.

6.2 There have been no serious incidents reported during this time.

6.3 There have been three complaints during this time as below:

Two were in relation to data breaches/inappropriate sharing of information and had no connection to staffing levels.

One was in relation to staff conduct and again not related to staffing levels.

## 7.0 Neighbourhood Teams

7.1 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.

7.2 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. Actions are initiated to ensure patient and staff safety is maximised. Following recommendations from Internal Audit and discussions with colleagues in Neighbourhood Teams, the Capacity and Demand tool has been updated and relaunched in October 2018. The revised version is simpler to complete and addresses some inconsistencies in the previous version.

7.3 The main recruitment challenges in Neighbourhood Teams are registered nursing and therapy roles. Close working with CLaSS (the LCH temporary staff service) ensures that available bank and agency staff are targeted at teams with the greatest staffing challenges. A Trust wide Short Term Resourcing Group has been established to complement work on medium to long term resourcing solutions with targeted action to improve staffing for key services during the winter period. In addition the contract continues with a local provider to support care home work in a number of teams.

7.4 Quality, safety and patient experience continue to be 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.

7.5 There have been a number of serious incidents in relation to the Neighbourhood Teams with a total of 13 during the reporting period which were either pressure ulcers or falls. On further scrutiny none of these incidents appear related to staffing concerns or issues. This will be monitored very carefully as always and any issues related to staffing will be escalated for immediate attention to the senior management team (SMT).

7.6 There have been a total of 20 complaints in relation to the Neighbourhood Teams during the reporting period, 3 of which are linked to a serious incident as well. None of these appear to have been related to staffing concerns or issues. This will continue to be monitored closely and any issues related to staffing will be escalated for immediate attention to SMT.

## 8.0 Conclusion

8.1 This paper presents the six monthly review to Board in relation to safe staffing. The paper demonstrates that the Trust has maintained safe staffing in the six month reporting period. It has also triangulated the staffing data to patient safety incidents and complaints and the Board should take assurance that none of the reported Serious Incidents or complaints have been linked to staffing concerns or issues.

8.2 This report will continue to be developed further for the next iteration in 6 months' time to ensure continued scrutiny on safe staffing and triangulation with patient safety issues.

## 9.0 Recommendations

9.1 The Board is asked to receive and note this report.

**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

Data:

## Community Neurological Rehabilitation Centre

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:

| | Community Rehabilitation Unit | | | |
|---|---|---|---|---|
| | Day | | Night | |
| | % registered nurses | % care staff | % registered nurses | % care staff |
| Apr 2018 | 98.3% | 100.0% | 100.0% | 100.0% |
| May | 101.8% | 98.7% | 100.0% | 100.0% |
| Jun | 100.0% | 100.0% | 100.0% | 100.0% |
| Jul | 98.0% | 98.7% | 100.0% | 100.0% |
| Aug | 100.0% | 98.8% | 100.0% | 100.0% |
| Sep | 100.0% | 100.0% | 100.0% | 100.0% |
| Oct | 100.0% | 100.0% | 100.0% | 100.0% |
| Nov | 100.0% | 100.0% | 100.0% | 100.0% |
| Dec | 100.0% | 100.0% | 100.0% | 100.0% |
| YTD | 99.8% | 99.6% | 100.0% | 100.0% |

## Hannah House

| Month 2018 | Hannah House | | | |
|---|---|---|---|---|
| | Day | | Night | |
| | % registered nurses | % care staff | % registered nurses | % care staff |
| Jul | 90.9% | 81.1% | 100.0% | 80.0% |
| Aug | 83.9% | 94.1% | 87.5% | 100.0% |
| Sep | 78.9% | 89.4% | 80.6% | 103.9% |
| Oct | 92.6% | 89.8% | 105.9% | 98.0% |
| Nov | 92.3% | 106.5% | 97.1% | 100.0% |
| Dec | 88.0% | 96.9% | 100.0% | 87.5% |

## Little Woodhouse Hall

| Month 2018 | Day | | Night | |
|---|---|---|---|---|
| | % registered nurses | % care staff | % registered nurses | % care staff |
| **Jul** | 100.0% | 100.0% | 100.0% | 100.0% |
| **Aug** | 100.0% | 97.8% | 100.0% | 100.0% |
| **Sep** | 100.0% | 97.8% | 100.0% | 100.0% |
| **Oct** | 99.0% | 97.1% | 100.0% | 100.0% |
| **Nov** | 100.0% | 99.4% | 100.0% | 100.0% |
| **Dec** | 98.7% | 98.1% | 102.9% | 96.6% |

## Health Visiting Service

The Table 1 illustrates the caseload size for each geographical area, using the number of children under 5 years. The number of Health Visitors working in each geographical team is determined by a weighting tool. The tool takes account of Index of Multiple Deprivation (IMD) of each geographical area, alongside the number of families living in the top 3%, 5%, and 10% super output areas (SOA). The caseload size per WTE health visitor is determined by the number of health visitors within each team and whether there are vacancies within that team. The service also takes account of caseload size recommendations described in Lord Laming reports (2009 and 2016), following the deaths of Victoria Climbie and reviewed following Baby P's death, where national average for caseloads should be 400, with a reduction to 250 for the most deprived areas.

Table 1: Staffing by team December 2018

| Team | No's of under 5's | Staff in post December 2018 | % achieved | Caseload size per WTE with current staffing levels | Tool to adjust caseload | Vacancies : December 2018 |
|---|---|---|---|---|---|---|
| **Parkside** | 5740 | 14.00 | 87 | 410 | 16.04 | 2.04 |
| **Bramley** | 5431 | 11.80 | 93 | 460 | 12.70 | 0.90 |
| **East Leeds** | 5112 | 17.00 | 105 | 301 | 15.95 | -1.05 |
| **Kirkstall** | 3398 | 8.60 | 93 | 395 | 9.13 | 0.53 |
| **Seacroft** | 7298 | 13.20 | 83 | 553 | 16.21 | 3.01 |
| **Reginald Centre** | 8774 | 18.80 | 91 | 467 | 20.61 | 1.81 |
| **Middleton** | 6089 | 15.00 | 100 | 406 | 14.98 | -0.02 |
| **Thornton** | 3032 | 8.71 | 100 | 348 | 8.75 | 0.04 |
| **Yeadon** | 5869 | 10.04 | 95 | 585 | 10.60 | 0.56 |
| **Total** | **50743** | **117.15** | 94 | **368.34** | **125.00** | **7.82** |

Table 2: Health Visiting total number staff in post July –December 2018

| | Quarter 2 | | | Quarter 3 | | |
|---|---|---|---|---|---|---|
| | **Jul-18** | **Aug-18** | **Sep-18** | **Oct-18** | **Nov-18** | **Dec-18** |
| **Staff in post** | 118.43 | 117 | 120.1 | 119.5 | 118.7 | 117.15 |

Vacancies and capacity issues are discussed weekly at team meetings and the services leadership management meetings.

Staff move across the 9 teams to support service delivery requirements. The service also uses CLASS and offer staff additional hours as part of managing vacancy. Two health visitors have just been recruited and a further 7- 10 Band 6 practitioners are in the process of recruitment, meeting the requirements of the new 0-19 service mobilisation.

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (99)**

| | | |
|---|---|---|
| **Meeting** Trust Board 1 February 2019 | **Category of paper** *(please tick)* | |
| **Report title** Realising our strategic direction | **For approval** | |
| **Responsible director** Chief Executive<br>**Report author** Katherine Sheerin/Chief Executive | **For assurance** | |
| **Previously considered by** *n/a* | **For information** | |

**Purpose of the report**

To provide an update on progress in realising Leeds Community Healthcare NHS Trust's (LCH) strategic direction in the light of our work over the last six months and the publication of the *NHS Long Term Plan*.

**Main issues for consideration**

The report describes the strategic direction for the Trust and how this could be realised.

It explains the work undertaken to date to enable stronger front line relationships with primary care, social care and the third sector, and our commitment to strengthen these further.

It also describes our partnership working with organisations at city wide levels and beyond, and how critical these are to nurturing and further strengthening community services, in particular our relationship with the Leeds GP Confederation.

The report also reflects on the recently published *NHS Long Term Plan*, and how the course set out within the plan should help to accelerate our direction of travel.

**Recommendations**
**The Board is recommended to:**

- Receive this update on the Trust's strategy in the light of the publication of the *NHS Long Term Plan* and our work to date for discussion and reflection.

# Realising our strategic direction

## 1. Purpose of this report

1.1. To provide an update on progress in realising Leeds Community Healthcare NHS Trust's (LCH) strategic direction in the light of our work over the last six months and the publication of the *NHS Long Term Plan*.

## 2. Where are we now?

2.1. The Board set a strategic direction of travel several years ago and have continued to shape and reflect on this. We set a strategic direction of travel of approaching the next five years with a clear focus on creating partnerships which help to sustain and nurture community health services, re-designing services so that more is achieved within the available resources – whilst at the same time ensuring we recruit and retain a healthy, motivated workforce. Over the last few years we have focussed on realising this ambition particularly in relation to partnerships with primary care, social care and hospital services, and working ever more closely with these partners. This paper focusses particularly on our work with primary care and the Leeds GP Confederation as its representative body.

2.2. Fundamental to this is the programme of work we have embarked on with the GP Confederation, whereby we are working with them to ensure ever greater integration between primary and community services. Examples of how this is materialising include:

- Joint appointments across Leeds Community Healthcare and Leeds GP Confederation Executive Teams (Executive Director of Nursing, Executive Medical Director and Director of Workforce)
- Provision of joint services (e.g.GP Streaming, Weight Management) and developing joint bids in response to tenders (e.g. IAPT) where we are providing an under-arching support to primary care clinical leadership
- The development of a range of integrated services from MSK services to bold work looking at integrated nursing across our services
- Joint development sessions to consider how we move forward
- The establishment of Leeds Primary Healthcare Collaborative – a committees in common between Leeds GP Confederation and Leeds Community Healthcare which enables us to co-ordinate decision making across the two organisations

2.3. In addition we have strengthened our relationship with the other NHS providers in Leeds and our mental health partners in West Yorkshire through two further committees in common which aim to improve alignment and integration of services:

- *Leeds Providers' Integrated Care Collaborative* – a committees in common between Leeds GP Confederation, Leeds Teaching Hospitals

NHS Trust, Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust

- *West Yorkshire Mental Health Collaborative* – a committees in common between the four mental health and community trusts in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnership NHS Foundation Trust and Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership NHS Foundation Trust)

2.4. Leeds Community Healthcare is recognised as a key partner in the Leeds and wider West Yorkshire system, actively contributing to delivery of the Leeds Health and Wellbeing Strategy, Leeds Plan and the plan for the West Yorkshire and Harrogate Health and Care Partnership. Our work with the GP Confederation is increasingly attracting interest across the Integrated Care System and England as an excellent example of innovative and creative work which is really driving integration.

## 3. National and local context

### *NHS Long Term Plan*

3.1. The recently published *NHS Long Term Plan* has set the agenda for the NHS for the next decade. It sets out:

3.1.1. How the NHS will move to a new service model in which patients get more options, better support, and properly joined-up care at the right time in the optimal care setting. This includes a major emphasis and funding for out of hospital care, 'dissolving' the boundaries between primary and community services and creating integrated teams with a focus on population health

3.1.2. New, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities

3.1.3. Priorities for care quality and outcomes improvement for the decade ahead, including for children and young people, cancer, mental health and long term conditions

3.1.4. How current workforce pressures will be tackled, and staff supported

3.1.5. A programme to upgrade technology and digitally enabled care across the NHS

3.1.6. How the NHS will achieve financial stability.

3.2. The Plan also calls for some significant legislative changes, including supporting the creation of NHS integrated care trusts, for example, to deliver primary care and community services; remove the counterproductive effect that general competition rules and powers can have on the integration of NHS care; free up NHS commissioners to decide the circumstances in which they should use procurement, subject to a 'best value' test to secure the best outcomes for patients and the taxpayer.

***Local context***

3.3. The Leeds system has already embarked on a programme of change which resonates with much of what is in the *NHS Long Term Plan*. The overarching framework for this is our Health and Wellbeing Strategy which has the overall vision that:

> **'Leeds will be a caring city for people of all ages, where the health of the poorest improves the fastest.'**

3.4. This is echoed in the Leeds Clinical Commissioning Group's Strategic Plan, which focuses on achieving value and addressing health inequalities through commissioning integrated services across providers.

3.5. The Leeds Plan then describes how this will be delivered, with a partnership approach across commissioners, providers, patients and the public.

3.6. Leeds Community Healthcare's contribution to this is shown as follows:


3.7. A key part of this is the development of Local Care Partnerships (LCPs). These are based on GP registered lists of 30–70 000, and bring together the full breadth of primary and community care, social care and the third sector. LCPs offer new ways to connect into local communities to improve health and wellbeing, and offer a focus for more specialised services to connect in.

3.8. This aligns very well with the objective set out in the *NHS Long Term Plan* for Primary Care Networks, the emphasis on pre-hospital care and the focus on providers working together to improve population health and reduce inequalities.

*'The £4.5 billion of new investment will fund expanded community multidisciplinary teams aligned with new primary care networks based on neighbouring GP practices that work together typically covering 30-50,000 people. As part of a set of multi-year contract changes individual practices in a local area will enter into a network contract, as an extension of their current contract, and have a designated single fund through which all network resources will flow. Most CCGs have local contracts for enhanced services and these will normally be added to the network contract. Expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and AHPs such as physiotherapists and podiatrists/chiropodists, joined by social care and the voluntary sector. In many parts of the country, functions such as district nursing are already configured on network footprints and this will now become the required norm.'*

***NHS Long Term Plan***
**January 2019**

## 4. What does this mean for LCH?

4.1. Leeds Community Healthcare is in a good position to respond to the direction of travel set out in the *NHS Long Term Plan* as the plan reinforces much of our work over the last few years to strengthen collaboration with our partners, in particular General Practice and Adult Social Care. This is demonstrated by:

- Our well established Neighbourhood Teams (2014) which bring together community and social care staff in 13 teams across the city covering identified GP lists, enabling greater co-ordination of care. Teams work in clusters with GP practices and this is the heart of primary care networks and, in turn, LCPs
- The 17 LCP Localities which map clearly on the neighbourhood teams also offer the health/social care component of Local Care Partnerships, which will include third sector organisations and other services which contribute to the health and wellbeing of the local population.

4.2. These partnership arrangements are embedding across the city. This is a significant change for everyone and is a challenge for all providers to work and think differently – focussing our services around populations rather than our own organisations. We have been on this journey in Leeds Community Healthcare however for some years and we have good examples of how we can ensure, for example, that our specialist services can actively support the Localities whilst at the same time strengthen how they integrate with colleagues in other providers who serve the same people, e.g. diabetes, stroke, respiratory, where our major partners span primary care, acute and social care.

4.3. There is a strong emphasis in the *NHS Long Term Plan* on the importance of ensuring people get more control over their own health and more personalised care when they need it. This fits well with the emphasis we have had in the Trust over the past few years to support all our staff in health coaching and motivational interviewing techniques, and the development of self care practitioners across our neighbourhood teams, and new approaches across CAMHS and ICAN.

## 5. Next steps

5.1 It is clear that there is a great deal that is going well in realising our strategic intent and it is pleasing that the *NHS Long Term Plan* clearly supports the direction of travel we have been pursuing. In moving the strategy forward over the next year we will be:

5.1.1. Continuing to develop our relationship with the GP Confederation and exploring all possible options for how we can move forward our integration to serve the public better and make best use of the Leeds pound.

5.1.2. Strengthening our working in localities and clusters around populations from our neighbourhood teams, to our new health visiting and school nursing services working in local areas around school clusters.

5.1.3. Working with partners to ensure that services which need to be provided 'once' for the city are indeed provided once and in the pursuit of local flexibility do not lose city wide consistency, inadvertently increase inequalities or move away from evidence based care

5.2 Our aim, reflected in our operational plan for 19/20, will be to ensure that we:

5.2.1. Enable services to be more responsive to local needs with variation where there is a demonstrated need

5.2.2. Enable the skills and strengths of professionals and their knowledge of patients to be better shared and utilised

5.2.3. With our primary care and social care colleagues to become the "centre" for the Local Care Partnerships, and a focus for how more specialist services will connect with primary/community services colleagues to deliver more integrated care on the ground.

5.2.4. Continue to develop our specialist longer term condition services, in line with the expectation of commissioners and funding, to be able to support more people at home and in a community setting. These services to be increasingly integrated across providers and will be community led.

5.2.5. Work on further developing a governance framework with partners which facilitates integration and ensures quality. The committees in common described above will support us with this, as will our full participation as a partner in the Health and Social Care Academy.

5.2.6. And finally, to optimise city-wide expertise and support including increasingly how we offer managerial and other expertise to partners, particularly in primary care. We will continue to build on the joint arrangements already in place with the GP Confederation and the opportunities presented in the *NHS Long Term Plan*, and explore how to get the best from both organisations in order to deliver the ambition of fully integrating primary and community services.

## 6. Conclusion

6.1. We have much to be proud of in the Trust and the progress we are making in realising our aspiration to integrate further with partners to better serve the public. Our staff are recognised as valuable people by patients, carers and colleagues from across Leeds; our services are of very high quality and our organisation is seen as a positive partner in the system. In order to ensure we sustain, nurture and grow community services for the people of Leeds, we need to continue to ensure that we adapt as an organisation and respond to the changing environment. The *NHS Long Term Plan* offers a great opportunity to accelerate work we have already been doing with partners to strengthen services; it is now our responsibility to ensure we take this opportunity and secure our vision that the best care is provided in every community for the next decade and beyond.

6.2. Our strategy is at an exciting point in its implementation and the next 18 months will be crucial in realising its ambition.

## 7. Recommendation

- The Board is asked to receive this update on the Trust's strategy in the light of the publication of the *NHS Long Term Plan* and our work to date for discussion and reflection.

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (100i)**

| **Meeting** Trust Board; 1 February 2019 | **Category of paper** *(please tick)* | |
|---|---|---|
| **Report title**<br>Workforce Strategy 2019-21 | **For approval** | √ |
| **Responsible director**<br>Director of Workforce – Jenny Allen / Laura Smith<br><br>**Report author**<br>Director of Workforce – Jenny Allen / Laura Smith | **For assurance** | |
| **Previously considered by**<br>Business Committee, 23 January 2019 | **For information** | |

**Purpose of the report:**

The Board is presented with the draft Workforce Strategy (2019-21) for approval.

This strategy is the successor to the current Organisational Development Strategy, and incorporates the both workforce and OD strategic priorities.

Its aim, aligned with the Trust's overall aim, is **to ensure LCH's workforce is able to deliver the best possible care in all our communities**, adapting and responding to current and anticipated requirements, challenges and opportunities.

A range of stakeholders has been involved throughout the development of the Workforce Strategy, including both managerial and staff side colleagues; as well as colleagues within the Workforce Directorate.

Subject to its Board approval, the final Workforce Strategy will be shared with the organisation; with a much shorter "plan on a page" summary used to widely disseminate and discuss its priorities and content

**Main issues for consideration:**

- The alignment of the 6 priorities outlined in the Workforce Strategy with the organisation's overall strategic direction
- The embedding of the 6 priorities in the LCH Seven Magnificent Behaviours
- The setting of the Workforce Strategy within a culture of engagement
- The 2 year tenure of the Workforce Strategy, in light of the current pace of change

**Recommendations**

**The Board is recommended to:**

- Approve the Workforce Strategy 2019-21 for delivery and dissemination

# Workforce Strategy 2019-21

# Contents:



# Appendices:

# 1. Foreword:

Dear colleagues and partners,

Welcome to the Leeds Community Healthcare NHS Trust Workforce Strategy, 2019-2021.

Its aim, aligned with the Trust's overall aim, is to **ensure LCH's workforce is able to deliver the best possible care in all our communities** both within Leeds and beyond in terms of the regional services that we provide, adapting and responding to current and anticipated requirements, challenges and opportunities. The Workforce Strategy, which is a successor to the previous Organisational Development (OD) Strategy, and incorporates our OD aspirations, is launched at a time when community and primary care services are recognised as the key to achievement of better, more sustainable and more cost effective health outcomes for communities and as clearly set out in the NHS Long Term Plan published in January 2019.

It is important to note that this is a strategy and not a detailed operational plan but is underpinned by and sets the direction for the Workforce directorate business plan as well as aiming to both influence and respond to the business plans from the business units operating within LCH whilst recognising that our business units with have particular priorities that they wish to focus on.

Our direction of travel is towards increased integration with health and care partners across primary care; across the city of Leeds and across our integrated care system, the West Yorkshire & Harrogate Health and Care Partnership. The pace of change is swift, and organisational agility is essential. With that in mind, this strategy covers just two years in the first instance.

We propose to achieve the aim of the Workforce Strategy by focusing on the following key priorities:

- **Leadership & skills**
- **Resourcing**
- **Proactive analytics**
- **Wellbeing**
- **Diversity & Inclusion**
- **Integration & Partnership**

Underpinning our priorities is a commitment to a **culture of engagement** and **a culture that is just and fair**, seeking at all times to embody the Leeds Community Healthcare **values and behaviours**.

This strategy is the product of careful research, analysis, and reasoned debate through our organisation's business meetings, Committees and Board. But it has not been produced behind closed doors. It is rooted in the lived experience of the LCH workforce. We are grateful for the candour of colleagues across the organisation, often in stakeholder meetings and direct conversations, sometimes facilitated via our Freedom to Speak Up Guardian and Staff Side partners.

Particular thanks go to those individuals who have hosted us on our service visits; and to those who have shared with us personal experiences, both positive and negative, from their working lives. These interactions helped us to craft the priorities and initiatives of this Strategy with the daily reality and future aspirations of LCH's workforce firmly in mind.

Whether you are an LCH employee, a stakeholder or part of our wider communities, we invite you to read the strategy in the spirit in which it is written – with positivity, pragmatism, as well as a commitment to continuously improving and innovating – and always with the aim to impact positively on the working lives of our staff and crucially on the communities that we all serve. And always keep telling us what you think.

With thanks

**Jenny & Laura**


**Jenny Allen & Laura Smith**
**Director of Workforce, OD & System Development**
**jennyallen.laurasmith@nhs.net / @HRD_Jenny_Laura**

# 2. Vision, Values & Behaviours:

The LCH Vision, Values and Behaviours, **"Our Eleven"**, permeate this Strategy. Our objectives within each of the six priority areas identified have each been tested against them; making sure that each contributes to our one **vision** and operates in line with our three **values** and our **magnificent seven behaviours**.

We have used the **magnificent seven behaviours** icons in **Section 7** to indicate which behaviours are facilitated or demonstrated by each priority's achivement.

# 3. Context:

The aim of this Workforce Strategy is to **ensure LCH's workforce is able to deliver the best possible care in all our communities**, adapting and responding to current and anticipated requirements, challenges and opportunities.

In designing the Strategy to achieve this aim, we have considered in detail the context within which LCH works now, and will work in the future recognising that the external and internal context in which the organisation operates converges to inform and shape workforce priorities. This includes a large range of internal, external and cultural factors, summarised below:

## 3.1 Health and Social Care context:

Essential to the delivery of sustainable health and care services now and in the future is a transfer of focus away from acute services to primary and community services – this was clearly and explicitly signalled in the NHS Long Term Plan published in January 2019.

This shift of focus, sometimes referred to as the "left shift", is key to the strategic intent of our local systems, including Leeds as a city; and the West Yorkshire & Harrogate Sustainability and Transformation Partnership (STP). The left shift offers opportunities for LCH to work increasingly collaboratively with partners across the health and care system, in particular our primary care partners, to deliver the best possible care to our communities.

Many parts of the health and care system are currently engaged in re-thinking pathways of care to create this more integrated and joined-up system, so we need to develop a workforce which will be able to support these pathways. More people being treated outside of hospital will lead to a growth in community based roles. Workforce demand will increase, and the need for flexibility of our structures, people and our systems is also critical. Therefore we should build capability to develop strong robust and flexible systems. We need confidence in our systems, processes and procedures and specialists to manage them.

Both the recruitment and retention of staff are key focuses within the NHS Long Term Plan although labour market continues to impact significantly on our ability, and that of other organisations, to recruit professionally qualified people across a range of our roles.

We will respond to this by seeking increasingly innovative recruitment methods to help attract people to work for LCH; whilst giving close attention to the growth and development of our existing workforce to fulfil the skills requirements of our services. Additionally it will be important to introduce new roles where appropriate to meet demand and to recognise the potential of digital and technological capability to deliver activities in new and innovative ways.

And, of course, we work at all times within the regulatory and national frameworks & guidance established to ensure we deliver the highest quality of care.

## 3.2 External workforce context:

Beyond predictions of the replacement of many people in the future with digital, robotic and AI capability, there are a number of other trends of note in the external workforce and people management context. Where the competition for skills at all levels and particular across key professions within the NHS is scarce, individuals will be keen to understand the cultural and engagement context within which they will operate – so what are the values and behaviours prevalent within an organisation as well as how important is development, health and well-being, and the capability of leaders and managers. Prospective staff as well as our existing workforce will assimilate and assess their fit with our organisation and alignment of one to the other will be critical in terms of retaining staff.

Innovation, fairness, respect, diversity and inclusion and compassion will become key factors upon which individuals make decisions as well as the stretch and development they experience now and they can foresee in the future – the effective management of talent and an inclusive approach to this will be important. A further and as yet un-tested area within our own workforce is the impact of age segmentation or of now having five generations working together in the same workplace.

These themes point us to key areas for delivery within our Workforce Strategy including cultural shift, leadership and management development, and a suite of engagement initiatives.

## 3.3 Internal context

As the largest provider of community services in Leeds, spending £150m each year, LCH employs 3000 people across 58 services and 120 sites. We receive 215,000 referrals and deliver 2 million patient contacts every year.

We work in all parts of the city, and deliver some services across a broader geographical footprint. We are privileged to work with many thousands of people in their own homes, as well as in the full range of other health and care settings.

Our LCH vision is *'We provide the best possible care to every community'* and this is underpinned by our 3 values and 7 behaviours. Within this context for 2019/20, LCH's first strategic goal is workforce-related and is in fact the overarching aim of this Workforce Strategy: **to ensure that LCH's workforce is able to deliver the best possible care in all of our communities.**

This goal is further broken down into four workforce priorities for LCH in the 19/20 financial year and these are:

1. ***Engagement:*** We will improve overall engagement levels across the organisation through a range of initiatives including the development of an engagement as well as just and fair culture.
2. ***Resourcing:*** We will recruit the right people with the right skills and deploy them to deliver the best possible care in all of our communities for now and for the future.
3. ***Leadership:*** We will support the development of our leaders to ensure that every individual at LCH experiences good or excellent leadership.
4. ***Integration and Partnership:*** We will work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across primary care, the city of Leeds and the Strategic Transformation Partnership (STP) area delivering benefits to our patients and communities.

The Workforce Strategy works alongside other key organisational strategies and plans, including the Estates Strategy and Digital plans as well as of course the outlined LCH Strategic Goals, Priorities and risks providing us with a clear internal context and priority areas of focus for this Workforce Strategy.

Within the above context it is anticipated that LCH's existing high scoring workforce-related organisational risks will remain in place certainly as we move into the first part of the 19/20 financial year – these both relate to resourcing from the perspective of challenges in sourcing skills as well as sickness absence leading to reduced resourcing capacity.

## 3.4 Cultural context

Culturally, LCH is an organisation which strives to live its **values and behaviours**; and to engage meaningfully with all of its employees.

We have examined with interest the success of other NHS organisations who have implemented new methodologies to significant effect in this area, including MerseyCare's use of a model called A Just & Learning Culture. The work of Professor Michael West, who perceived a link between high levels of employee engagement and higher levels of organisational performance, has also helped to shape our thinking.

The resulting approach to the **creating a just and fair culture and one in which our staff are engaged** we are seeking to foster across LCH is described in more detail at **Section 6** of this Strategy.

# 4. Workforce Priorities:

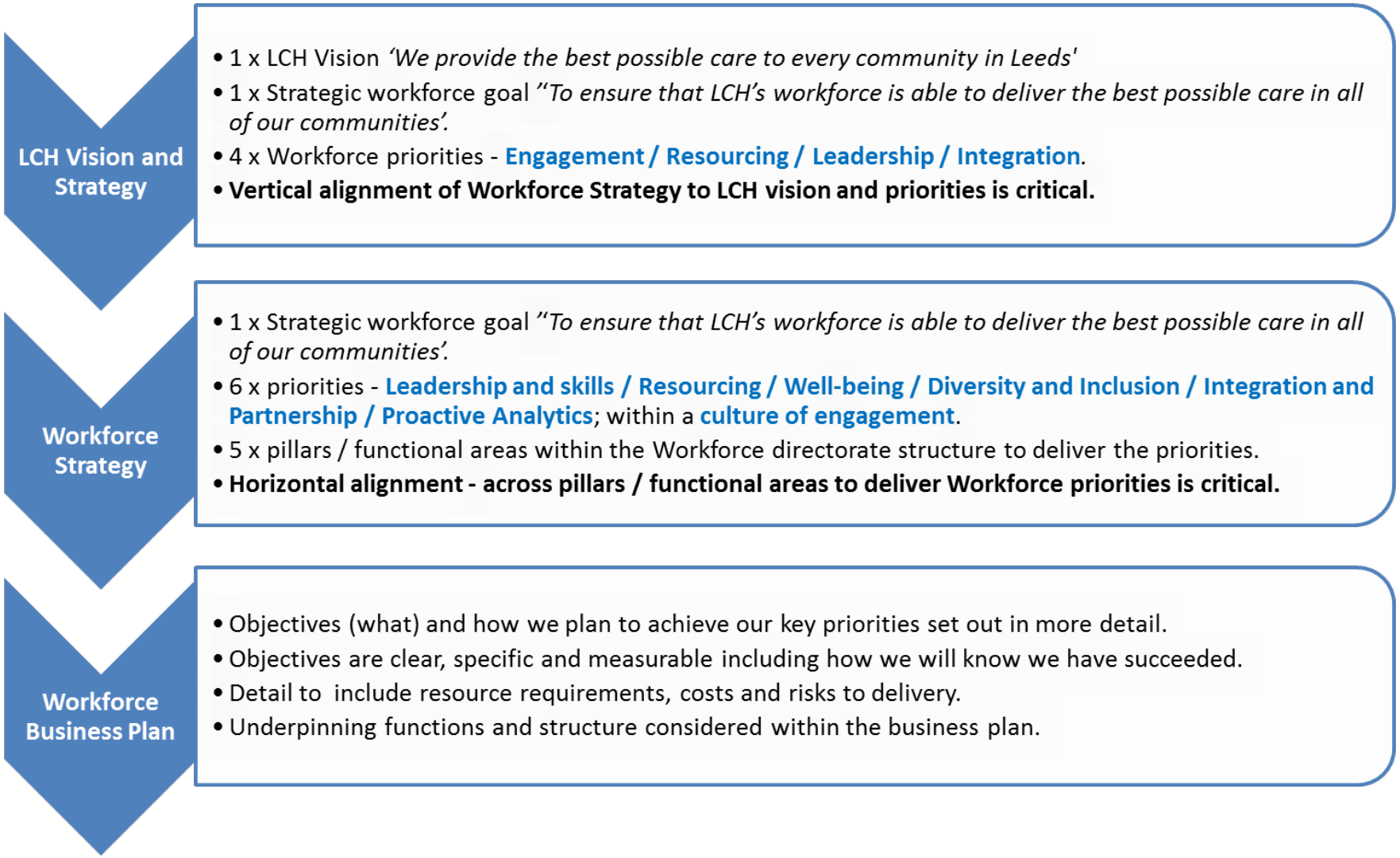
The Workforce Strategy has 6 key priorities, responding to Leeds Community Healthcare's organisational and contextual goals, risks and opportunities.

Each priority has an overarching aim, described below. The underpinning objectives and initiatives to achieve each aim are set out in **Section 7.**

1. **Leadership & skills:** We will support the development of our leaders to ensure that every individual at LCH experiences good or excellent leadership and has access to appropriate training and development, regardless of where in the organisation they work.
2. **Resourcing:** We will recruit the right people with the right skills and deploy them to deliver the best possible care in all of our communities for now and for the future.
3. **Proactive analytics:** Workforce systems including the Electronic Staff Record are improved by a newly-created Systems & Intelligence function, delivering sophisticated workforce data and analytics that drive impactful business decisions.
4. **Wellbeing:** Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18.
5. **Diversity & Inclusion:** Each member of the workforce is treated as an individual, with particular regard to advancing equality for those with a protected characteristic.
6. **Integration & Partnership:** We will work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across primary care, the city of Leeds and the Strategic Transformation Partnership (STP) area delivering benefits to our patients and communities.

# 5. Making the Connections:

The visual below sets out the connections between various internal documents containing our LCH goals and priorities and the detail in terms of how these will be delivered – in essence to demonstrate both vertical alignment of this Workforce Strategy with the organisational vision as well as horizontal alignment within this context. There is also connectivity across all to both the LCH overall business plan and Workforce Plan.



# 6. Our Organisational Culture:

Underpinning our priorities is a commitment to fostering a **fair and just culture** and one in which our staff are engaged, seeking at all times to embody the Leeds Community Healthcare **values and behaviours**. When we talk about culture at LCH, we mean, ***"how we do things around here"***.

Cultural shift is a complex and long term process, not under the direct control of an organisation's senior leadership. Our aspirations to continually improve our culture align with the NHS Long Term Plan which specifically references the development of modern employment cultures which are inclusive, compassionate, collaborative, with a focus on diversity and inclusion and support for staff health and well-being.

However through actions and role modelling carried out by senior leaders, supported by careful reviews of key organisational processes and approaches, we aspire to achieve the following indicators of a **culture of engagement** and **a fair and just culture**:

- We work as an Organisation of Adults; with each employee encouraged to use common sense and compassion to consider situations carefully, before consulting organisational policies.
- We treat each individual with kindness and respect and we aim to take appropriate action where behaviour is not aligned with our values.
- We empower our leaders to take decisions based on sensible conversations and their own good judgment, balancing business needs with individual needs.
- People employed by LCH feel listened to and involved, which in turn increases their sense of satisfaction and engagement at work
- We will judge our progress on shifting our culture using the LCH annual NHS Staff Survey Results, supplemented by the quarterly staff Family & Friends Test.


Initial actions we are taking to support achievement of the indicators set out on this page include:

1. Reviewing people management approach through **a fair and just culture** lens and working alongside clinical colleagues to support the introduction of this approach in the clinical arena.
2. Continually engaging with and seeking feedback from colleagues across the organisation utilising Staff Survey and FFT.
3. Re-engagement with LCH values and behaviours throughout the employee lifecycle.
4. Implementation of HR case conferences to support embedding of new people management practices.

# 7. Priorities for Delivery:

The subsequent six pages set out how each of the Workforce Strategy's 6 priorities will be delivered.

## Key:

1. The following icons are used to show how each priority aligns with the LCH Values and Behaviours;







# 7.1 Leadership & Skills:


| Priority's Aim: | We will support the development of our leaders to ensure that every individual at LCH experiences good or excellent leadership and has access to appropriate training and development, regardless of where in the organisation they work. |
|---|---|

| What do we plan to achieve? | How will we achieve it? | How will we know that we've achieved it? |
|---|---|---|
| **Objectives** | **Initiatives** | **Outcomes** |
| Leaders and managers understand the competencies and behaviours expected of them, and these can be objectively assessed. | Launch of LCH Leadership Competency Framework. | LCF embedded in appraisal processes<br>LCF regularly utilised in recruitment & selection processes |
| Increasing numbers of leaders and aspiring leaders have the skills to lead across LCH and wider system. | Embedding and expanding a new Leadership & Management development offer. | Improvement in Staff Survey leadership question results. |
| Clear alignment of learning & development opportunities with organisational need; and clarity over access to development. | Redevelopment of the LCH Learning & Development offer and infrastructure<br>Redesign of statutory, mandatory and role based training requirements in ESR. | Training Policy in place / Increased training uptake.<br>Stat&Mand compliance improves, remaining within or exceeding tolerance i.e. 95% or higher. |
| Skills gaps and opportunities are identified and filled (e.g. Digital skills; Mental Health First Aid). | Engagement with Health & Care Academy<br>Alignment of L&D offer with LCH business plan | L&D provision is in place for identified skills |
| Creation of clear career pathways for our staff. | Embedded in appraisal cycle and linked to identification of training needs. | Succession planning in place / improved recruitment to roles / enhanced retention. |
| Organisational succession planning is supported by a clear Talent Management approach. | Identification of critical roles<br>Development & introduction of Talent Management approach | Talent Management tool is used in recruitment planning<br>90% of leadership roles are filled first time |
| Programme of Board development scoped and implemented. | Design and implementation of a Board Development Programme. | Board assessment questionnaires.<br>CQC review. |

**This priority aligns with the following organisational behaviours:**

# 7.2 Resourcing:


| Priority's Aim: | We will recruit the right people with the right skills and deploy them to deliver the best possible care in all of our communities for now and for the future. |
|---|---|

**What do we plan to achieve?** **How will we achieve it?** **How will we know that we've achieved it?**

| Objectives | Initiatives | Outcomes |
|---|---|---|
| Vacancy rates are reduced year-on-year across a range of critical professions | Development & implementation of an organisation wide workforce plan + focused action plans for "hard to recruit" roles. | Vacancy rates drop |
| Workforce plans for each Business Unit based on a thorough understanding of workforce supply and demand | Organisation and Business Unit workforce plans address critical skills shortages including through apprenticeships.<br>Implementation of E Rostering and Bank systems as well as E Job Planning. | E-rostering implementation is completed against plan<br>Apprenticeships are aligned with workforce needs and plans |
| Innovative and effectively targeted resourcing campaigns + integration with wider system initiatives as appropriate. | Source permanently the digital marketing skills needed.<br>Develop and implement resourcing campaigns aligned with workforce needs. | Applications have increased<br>Fill rate for roles is higher<br>Number of "hard to recruit" roles is reduced |
| Standardised and consistent on-boarding approach from recruitment to engagement. | Review and refresh of on-boarding approach.<br>Initiatives to keep in touch and share stories of new staff. | Retention in less than 12 months service improves. |
| Aligning to the talent management approach, we will provide guidance on who and how we source, develop and retain. | Efficient and effective resourcing services, utilising the latest approaches to attract key skills groups, and engage on the most appropriate employment terms. | Vacancy rates drop |
| A joint operational resourcing approach for contingent and permanent labour is in place. | Development of a joint operational resourcing approach for contingent and permanent labour. | Single point of contact for our customers.<br>Simplified route to market. |
| New roles are developed to anticipate and address skills gaps & integration opportunities | Nursing Associate programme + Apprenticeships<br>Consideration of expanded preceptorship options | Vacancy rates drop<br>Career development options expand |

**This priority aligns with the following organisational behaviours**

# 7.3 Proactive Analytics:


| Priority's Aim: | Workforce systems including the Electronic Staff Record are improved by a newly-created Systems & Intelligence function, delivering sophisticated workforce data and analytics that drive impactful business decisions. |
|---|---|

| What do we plan to achieve? | How will we achieve it? | How will we know that we've achieved it? |
|---|---|---|
| **Objectives** | **Initiatives** | **Outcomes** |
| Transparency and access to information across the organisation which is used to inform decision making ultimately positively impacting on our communities and patients. | Provide customers with access to standard workforce information and performance metrics via a single user friendly interface. | A suite of standard reports produced and reviewed periodically<br>Ad hoc information requests are reduced because services routinely receive information that meets their needs |
| Development of a specialist workforce function which applies analytical techniques to drive strategic workforce decisions and help the organisation to evolve. | Development of strategic workforce planning methodology and tooling.<br>Working alongside the business to achieve mutual granular understanding of skills and functions rather than roles<br>Routinely measure staff engagement, supplementing traditional engagement surveys | Resourcing decisions are based on sound workforce plans<br>New ways of working are modelled, in partnership.<br>Staff engagement is valued on a par with traditional business data. |
| Standardised, consistent and managed service offering which looks to protect our workforce systems and data, and ensure that systems are utilised and fit for purpose | Critical systems and processes reviewed and enhanced where controls allow<br>Support and education for Systems & Intelligence team and customers | Data quality is measured and managed aligned to our organisational goals.<br>Continual monitoring of system utilisation to ensure that they are being used correctly and provide maximum benefit. |

**This priority aligns with the following organisational behaviours**

# 7.4 Health and Wellbeing:


| Priority's Aim: | Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18. |
|---|---|

| What do we plan to achieve? | How will we achieve it? | How will we know that we've achieved it? |
|---|---|---|
| **Objectives** | **Initiatives** | **Outcomes** |
| A reduction in staff sickness absence between 18/19, 19/20 and 20/21 resulting in declining resourcing challenges. | Delivery of all associated objectives and initiatives.<br>Sickness absence project to understand better measurement and reporting + getting people back to work. | Reduction in sickness absence percentage.<br>Reduction in incidents of absence – including within long term sickness absence. |
| Support leaders and managers to create positive workplace cultures – improve morale and wellbeing and eliminating bullying and harassment. | Design and develop the principles of "people before process".<br>Focus on anti-bullying at defined points throughout the year.<br>Leadership development programme. | Sickness absence rates improve or remain within tolerance.<br>Positive impact on related Staff Survey questions.<br>On-going "temperature" checks of staff engagement demonstrating improvement. |
| Staff feel supported when ill and upon return to work and that support comes in part from excellent leadership. New leaders understand the competencies and behaviours expected. | Management and leadership skills requirements incorporated into part of new leadership programme. | Reduction in formal people processes.<br>Leadership programme evaluation.<br>Staff Survey and other engagement initiatives indicating achievement. |
| Clear health and wellbeing offer for staff to access. | HWB Engagement Group established which reports to a HWB Steering Group and in turn Business Committee on progress.<br>Focus throughout the year(s) on particular areas e.g. mental health, bullying and harassment, MSK. | Feedback from staff stories.<br>Statistics on numbers of staff accessing services at start of "feel good pledge" are increasing.<br>Improvements in HWB staff survey questions<br>Achievement of HWB CQUIN |

**This priority aligns with the following organisational behaviours**

# 7.5 Diversity & Inclusion:

Diversity & Inclusion

| Priority's Aim: | Each member of the workforce is treated as an individual, with particular regard to advancing equality for those with a protected characteristic. |
|---|---|

| What do we plan to achieve? | How will we achieve it? | How will we know that we've achieved it? |
|---|---|---|
| **Objectives** | **Initiatives** | **Outcomes** |
| Increase the Board's knowledge and understanding of experiences and challenges BAME staff from different backgrounds face. | Design, develop and launch a BAME Reverse Mentoring Scheme | Improvement in experience of BAME staff measured through Staff survey results.<br>Feedback from Mentor and Mentee at start/during and at the end of the Programme. |
| Leaders and managers understand the WRES action plan and behaviours expected of them in improving BME staff's experience and opportunities. | Development of a Trust WRES Action plan<br><br>Race for Equality Event | Feedback from BME staff on working in LCH.<br>Delivery of action plan.<br>Active participation at event + clear next steps agreed. |
| Leaders, managers and staff understand the behaviours expected of them and legal requirements under the Equality Act. | Develop a Trust WRES and WDES Action plans.<br>Deliver disability training to managers.<br>Disability Confident – Leaders accreditation | WDES action plan ratified by Trust board.<br>WRES metrics improvement.<br>Evaluates well and training put into place.<br>Achievement of Disability confident level. |
| Continue to promote workforce diversity and inclusion across all protected characteristics by working with appropriate partners. | Delivery of WRES and WDES action plans.<br>Partnership working with Stonewall Diversity Champions programme. | Staff survey results.<br>Externally recognised through awards for dedication to workplace diversity |
| Understand the Gender Pay Gap and take action to address gaps / areas of concern. | Review and interpret 2018 analysis and identify actions to close the gap | Gender Pay gap as measured nationally reduced or mitigated |

**This priority aligns with the following organisational behaviours**

# 7.6 Integration and Partnership

| Priority's Aim: | We will work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across primary care, the city of Leeds and the Strategic Transformation Partnership (STP) area delivering benefits to our patients and communities. |
|---|---|


| What do we plan to achieve? | How will we achieve it? | How will we know that we've achieved it? |
|---|---|---|
| **Objectives** | **Initiatives** | **Outcomes** |
| The healthcare workforce in Leeds can flow across organisational boundaries with minimal disruption to clinical working time. | Automatic transfer of recognised statutory and mandatory training via ESR Inter Authority Transfer<br>Strategic leadership of the Leeds "One Workforce" Statutory & Mandatory training work-stream | New employee time spent on statutory and mandatory training is reduced by >50%<br>Elements of statutory and mandatory training are universally shared across Leeds NHS providers |
| The GP Confederation directly employs staff, with a suite of policies, procedures and contractual terms in place – all of which are CQC ready. | Establishment of GPC Workforce Subgroup and associated resources to design and implement working arrangements | GPC operates its own Remuneration Committee, contracts and suite of policies & procedures<br>TUPE of key staff to GPC has taken place |
| LCH bank arrangements fill some temporary staff assignments in primary care settings. | Introduction of bank Practice Nurse opportunities and training | Practice Nurse assignments are filled by LCH bank arrangements on a regular basis |
| Integrated working with colleagues employed by partner organisations is normal, not exceptional. | Support to teams exploring integration<br>Facilitation of joint and hosted recruitment | More LCH teams are integrated with partners<br>LCH regularly recruits with / for partners |

**This priority aligns with the following organisational behaviours**

# 8. Delivery of this Strategy:

The priorities set out in **Section 7** will be delivered by the five "Pillars" or functional areas of the Workforce Directorate – ODI / Resourcing / Systems & Intelligence / Human Resources / System Development.

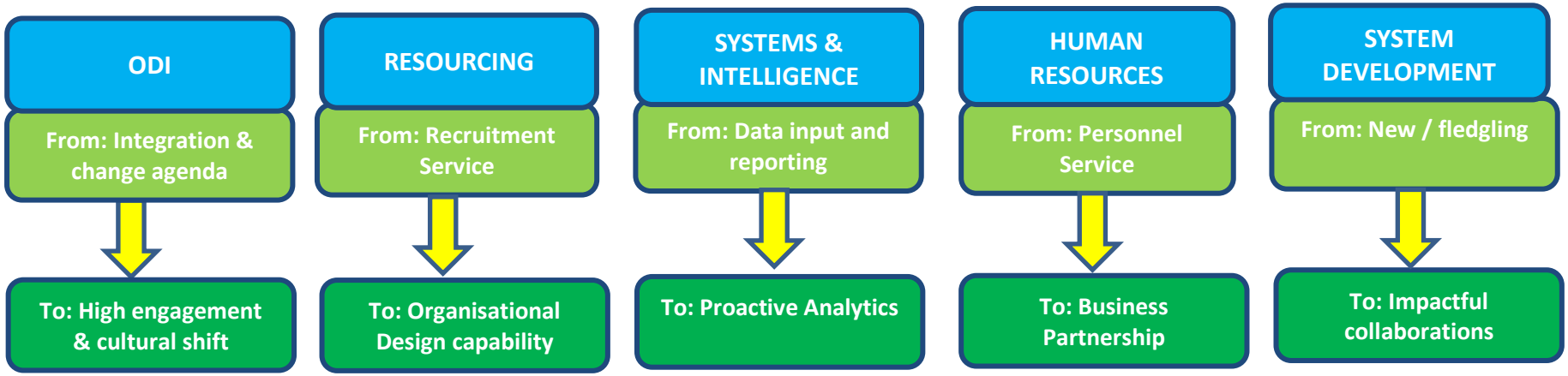
Delivery of the strategy will be further supported by the underpinning Workforce Directorate Business Plan and scrutiny in terms of delivery and performance will come from the oversight of the LCH Business Committee (a sub-committee of our Trust Board).

A diagram describing the Pillars in detail, including their associated core functions, is at **Appendix B**

The work of the Pillars is horizontally aligned, with each priority in this Strategy delivered by a combination of different pillars. **Appendix D** shows which pillars contribute to each priority's delivery.

The Pillars themselves are subject to an ongoing process of review and improvement *(Fig 1),* which will continue throughout the lifespan of the Workforce Strategy; ultimately improving their capacity and capability to deliver.

***Fig 1: Moving from Transactional to Transformational***



# 9. Risks to Delivery:

There are a number of risks to delivery of the priorities and initiatives set out in this Strategy, set out in the table below; together with mitigating actions.

| Risk | Likelihood (RAG) | Severity (RAG) | Mitigation |
|---|---|---|---|
| **Organisational engagement with the Workforce Strategy**: if the workforce and its leaders do not perceive this strategy's priorities to be relevant or realistic, the strategy's initiatives are less likely to gain traction or deliver the desired results | | | The **culture of engagement** work that underpins this strategy; together with the broad engagement over its content, give it a strong foundation. Ongoing dialogue and continued monitoring of results / impact will be essential to managing this risk on an ongoing basis |
| **Capacity to deliver:** A number of the initiatives outlined in this strategy are dependent upon a small number of people, including a cohort of roles currently funded non-recurrently | | | Budget and resourcing conversations are underway internally through 19/20 budget setting and with Primary Care and citywide partners to ensure that sufficient resource can be identified to enable delivery.<br><br>If required, timescales for delivery will be reviewed. Delivery scope to be altered only as a last resort; unless organisational requirements change. |
| **Capability to deliver**: the ability to deliver of some initiatives is dependent on development or identification of new or extended capability within the Workforce Directorate | | | Relevant development opportunities to be identified for Workforce Directorate members based on business and individual needs<br><br>Recruitment to vacancies to be utilised to bring new capability into the directorate, for example in the field of digital and social media campaigning skills & experience |

# 10. Conclusion

The Workforce Strategy you have just read aims to **ensure LCH's workforce is able to deliver the best possible care in all our communities**.

With community and primary care services recognised as the key to achievement of better, more sustainable and more cost effective health outcomes for communities, the two years covered by the Workforce Strategy will be a fast-paced period of significant challenge, change and opportunity.

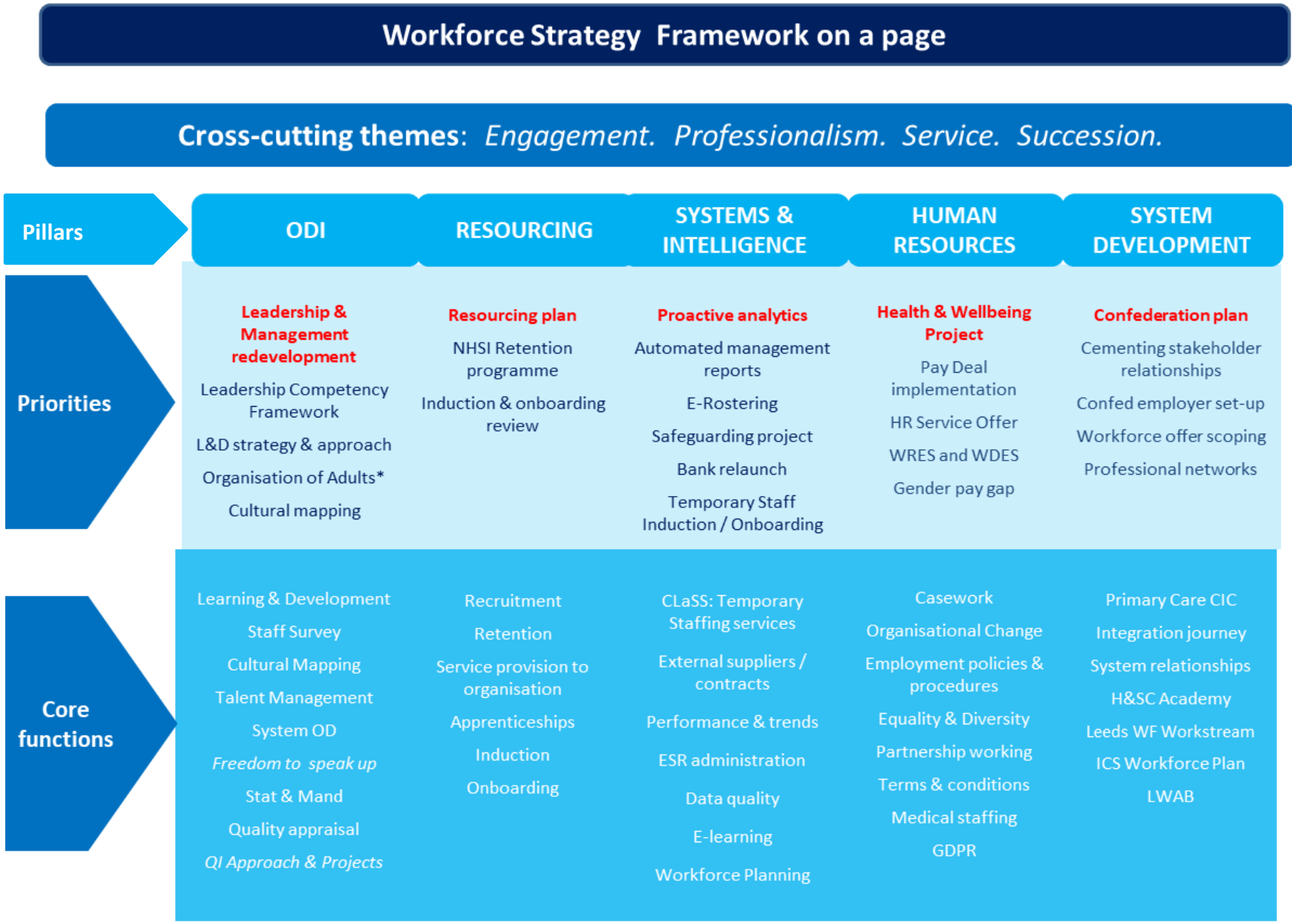
We are confident that our engaged and talented workforce, combined with strong organisational leadership and the dedication and skills of Workforce Directorate colleagues, puts LCH in the best possible position to deliver on the priorities set out in this strategy, enabling positive and tangible improvements to the care we deliver.

# Appendix A

## References and Associated Documents:

- **LCH Strategic Goals & Priorities**
- **Leeds Plan**
- **WY&H ICS Workforce Strategy**
- **LCH Estates Strategy**
- **LCH Digital Strategy**
- **Kings Fund Michael West engagement paper (2012)**
- **Kings Fund Integrated Care Systems one year on (2018)**
- **NHS England Five Year Forward View next steps document (2017/18)**
- **Professor Sidney Dekker Just Culture: https://sidneydekker.com/just-culture/**
- **Developing People, Improving Care - NHS Improvement**

# Appendix B: Workforce Directorate Detailed Framework



# Appendix C: Alignment of Workforce Strategy Priorities with Workforce Pillars

| Workforce Strategy Priority | Workforce Pillars most instrumental to delivery |
|---|---|
| Leadership & Skills | ODI, RESOURCING, HUMAN RESOURCES |
| Resourcing | ODI, RESOURCING, SYSTEMS & INTELLIGENCE, HUMAN RESOURCES |
| Proactive Analytics | RESOURCING, SYSTEMS & INTELLIGENCE |
| Health & Wellbeing | SYSTEMS & INTELLIGENCE, HUMAN RESOURCES |
| Diversity & Inclusion | RESOURCING, SYSTEMS & INTELLIGENCE, HUMAN RESOURCES |
| Integration & Partnership | ODI, RESOURCING, SYSTEMS & INTELLIGENCE, HUMAN RESOURCES, SYSTEM DEVELOPMENT |

# Appendix D: Employee Voices

The voices and opinions of many LCH, primary care and wider system colleagues have inspired and contributed to the development of this Workforce Strategy. A small selection of their words and stories is below; taken from Staff Survey and Family & Friends Test responses; and from direct testimony

WHAT HELPS STAFF WHEN THEY FACE AN INVESTIGATION OR PROCESS

This year I had to go through a process at Leeds Community Healthcare. Every week or month we will have staff going through investigations, panels, suspensions or other forms of process. It is a very difficult thing for a person to go through. I would like to say what I think helps.

(1) Listen. Managers need to listen to staff affected. They should spend time with staff and do what they can to understand. Whatever the issue is, there is a human person at the centre of all this.

(2) Be Kind. This is very important. Harsh words and treatment can crush a person

The staff that work in the organisation are passionate about the care that they provide and the patients they are treating. This is what makes the organisation what it is.

(Specialist Business Unit)

more equality and diversity in recruitment and selection, please

(Children's Business Unit)

Please can we streamline the ridiculously complicated training (ESR) system so it's user friendly and easy to navigate?!

(Children's Business Unit)

I respect my line manager, she appreciates me as an individual and does not strictly adhere to protocols. This takes into account my work life balance and enables me to be more effective at work.

(Corporate directorates)

The attitudes and behaviour of some of the members of my team have created an unpleasant atmosphere at work. I enjoy the role I do, but recently I have not enjoyed working with some of my team members due to their behaviour, it has not felt like a team, and this has led me to consider looking for a new job.

(Children's Business Unit)

It is sometimes quite a lonely and difficult job delivering ever changing expectations to teams. There can be resistance and so personal wellbeing and resilience is essential.

(Manager)

My supervisor and line managers are excellent - very supportive and approachable. They have supported me enormously when have been dealing with anxiety and depression.

(Specialist Business Unit)

We should give more positive feedback, praising others for the good things they do every single day rather than criticising what has not gone so well in a way that is not necessarily constructive and alienates people who then stop doing the best they can with the resources we have.

(Children's Business Unit)

ESR training needs to be more simplistic. Get rid of training on there that is now invalid (just delete it) make it easier to find the training relevant to your role. So could it be that my list is bespoke to me and I can just click it when it is due? This would save time in that I do not have to spend ages trawling through lots of training not even suited to my role to try and find the relevant one.

(Specialist Business Unit)

managers look after their staff, and happy staff makes for a happy workforce and better care. Staff are valued and supported in learning and development. Ideas are listened to and change / service development is welcomed, which makes it a good place to work.

(Specialist Business Unit)

I have only worked here for a while but already feel I have a sense of belonging and being valued and my manager is very supportive. I have had opportunity to have a very thorough induction too which I really appreciated.

Everyone works as a team and as one. There is no difference between the lowest band and the highest band as when you are in the office or in the workplace everyone gets treated the same.

(Adult Business Unit)

Managers need training to deal with staff with additional needs fairly and with understanding.

(Specialist Business Unit)

I have been supported with my long term health condition. Adjustments have been made to my workstation as well as my working hours.

(Corporate directorates)

The neighbourhood teams have a very good leadership structure in place which has lots of potential.

(Adult Business Unit)

[I'd like to see] appreciation of and increased awareness of the extra hours (unpaid) that current staff are working in order to meet the demand and maintain a high quality service. Being aware of this before suggesting staff 'do more', 'do it quicker' etc...

(Manager)

Since leaving my last Trust and starting at LCH, I have felt much happier in myself. I am being reminded what it feels like to work in a supportive/healthy environment and feel valued, respected and treated as a person.

The trust needs to be more diverse in some teams and at senior level.

(Specialist Business Unit)

At a very challenging time in relation to **personal health, a** manager was extremely supportive in helping me initially remain at work and later following a period of sick leave supported me in my return to work. This supportive attitude helped immensely.

(Children's Business Unit)

Comparing my experience with another Trust and a hospice environment the main advantages with Leeds Community Healthcare are that the managers are much more positive and have a 'we're all in it together' supportive attitude. Also the team working at the neighbourhood I work with is fantastic from Admin staff to therapists, managers to nurses and health care assistants, everyone helps everyone else and I'm proud and glad to work there. Any problems are dealt with fairly and supportively.

(Adult Business Unit)

My manager, senior manager + senior staff encourage staff to voice their opinions and difference of opinion is also encouraged and taken on board, feel opinions are respected from staff at all levels. Also a very supportive team environment, supportive both professionally and personally.

(Children's Business Unit)

Managers seem reluctant to tackle staff who are not pulling their weight and not working in the spirit of team work and co-operation.

(Children's Business Unit)

I want to be treated as an adult and not reported for trivial things that could be sorted out informally which causes stress and anxiety resulting in absence from work

(Specialist Business Unit)

# Appendix E: Glossary

| Acronym / Abbreviation | Meaning |
|---|---|
| AI | Artificial Intelligence |
| BAME | Black, Asian & Minority Ethnic |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality & Innovation |
| ESR | Electronic Staff Record |
| GP | General Practitioner |
| GPC | General Practice Confederation |
| HR | Human Resources |
| HWB | Health & Wellbeing |
| ICS | Integrated Care System |
| L&D | Learning & Development |
| LCF | Leadership Competency Framework |
| LCH | Leeds Community Healthcare NHS Trust |
| MSK | Musculoskeletal |
| NHS | National Health Service |
| OD | Organisational Development |
| ODI | Organisational Development & Improvement |
| Stat&Mand | Statutory & Mandatory Training |
| STP | Sustainability & Transformation Partnership |
| TUPE | Transfer of Undertakings & Protection of Employment |
| WDES | Workforce Disability Equality Scheme |
| WRES | Workforce Race Equality Scheme |
| WY&H | West Yorkshire & Harrogate |

Leeds Community Healthcare NHS Trust

**AGENDA ITEM 2018-19 (101)**

| | | |
|---|---|---|
| **Meeting** Trust Board – 1 February 2019 | **Category of paper** *(please tick)* | |
| **Report title** Quality Strategy Implementation plan | **For approval** | |
| **Responsible director** Executive Director of Nursing<br>**Report author** Professional Lead for Nursing | **For assurance** | √ |
| **Previously considered by** Quality Committee 21 January 2019 | **For information** | |

**Purpose of the report**

The report shows the updated Q3 implementation plan for the Quality Strategy 2018 –2021. The purpose is to assure the committee that work to deliver the strategy is in progress.

**Main issues for consideration**

The Quality Strategy 2018-21 was approved by the Trust Board in February 2018. The Strategy describes an overarching quality objective to strengthen our approach to quality improvement with a focus on four priority areas:

1. Prevention, proactive care and self-management
2. Patient experience and engagement
3. New models of care
4. Workforce

There has been good progress made across all four quality improvement areas in the last quarter notably progress has been made in aligning QI work with other quality initiatives across the Trust,

**Key points of note for each quality improvement area**

**Prevention, proactive care and self-management**

- The 15 new Self-Management Facilitators appointed in September 2018 within the Neighbourhood Teams have all received training and are supporting the Neighbourhood Teams to embed self -management. Case study evidence (n=3) clearly demonstrates released capacity in the NT's in terms of insulin administration and stoma care, each case study demonstrates up to 4 hours per day time saved.

**Patient experience and engagement**

- To date in excess of 300 staff and 100 patients and carers have attended *Always Events* awareness sessions
- 2/6 services have been identified to implement Always Event methodology. Formal support has been identified from NHES/I including training and supervision. The next steps are to identify more services across the 3 BUs.

**Workforce**

- 8 Nursing Associates (NA's) supported by LCH will register with the NMC on the 28th January. All the NAs have secured posts within the Trust and a job description and skills matrix have been developed to support their development in clinical teams. A celebration event for our LCH NAs will take place at Stockdale on registration day. This is the start of the development of new roles in line with recommendations of The Long Term Plan (2019)

- Staff Survey 2018 went live during Q3, supported by an active communications and engagement plan, resulting in a take-up of 52%. Analysis and feedback of results will be a focus during Q4, providing a targeted approach to supporting services which benchmark significantly below LCH average, while learning from and celebrating those services which feedback most positively.

**New models of care**

- The Quality and Professional Development Team have greater involvement in ensuring parity in terms of governance arrangements when new tenders /services are being developed in collaboration with LCH business managers.

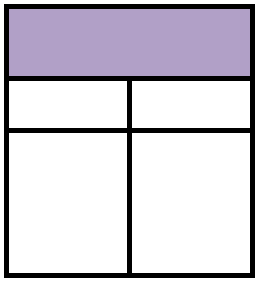
The updated implementation plan contains the actions that have been taken within Q3 of the first year of the strategy and progress to date against these. Additional plans will be developed for subsequent years.

**Recommendations**

**The Board/Committee is recommended to:**
Note and accept the Q3 update of the implementation of the Quality Strategy.

## Completed actions

| | Quality strategy action areas | Actions | Progress to date | Additional work to do | Time frame | Lead | RAG rating |
|---|---|---|---|---|---|---|---|
| | **Continuous Quality Improvement (including monitoring)** | | | | | | |
| 2 | Refreshed quality challenge | Roll out refreshed Quality Challenge+ and ensure all services visited in the next 18 months. | Revised quality challenge tool rolled out and several quality visits unedertaken. Detailed report of progress and plans for nexxt year to quality committee in January 2017. | Complete. Continue with plan as business as usual | | Helen Rowland and Helen Blenkinsopp | |
| 6 | Quality dashboards | Impliment quality dashboards in all inpatient areas and neighbourhood teams. | Quality boards now introduced and quarterly report produced. Very positive feedback from teams re impact and other teams asking for them in the organisation. | Monitor impact of quality boards and how they are being used to continuously improve qulaity. Links to the action below. | | Quality leads | |
| 8 | Board commitment | Board commitment and leadership of agenda<br>Review and refresh of Organisational Development Strategy<br>Participation in pan Leeds planning and strategy development | Board commitment and leadership of agenda via NED visits to services embeded<br>Revised Organisational Development Strategy accepted at board and action plan being developed at next Board workshop<br>Participation in pan Leeds planning and | Implimentation of OD strategy action plan | | Steve Keyes | |
| 9 | Our Eleven | Refresh and re-launch of our behaviour framework - The Magnificent Seven<br>Targeted use of available resources to support the development of leadership and culture in key service areas | Magnificant 7 embeded in Our Eleven vision, values and behaviours<br>Development of the working life you wantthrough the OD strategy<br>Appointment of freedom to speak up guardian role | Continued to embed the working life you want and freedom to speak up guardian role as business as usual. | | SMT | |
| 11 | 50 Voices | Work to understand barriers to staff engagement and ownership | 50 Voices Group third cohort about to commence.<br>Working groups now developed around E&D, BME and staff as carers. | 50 Voices group established. Actions arising form meetings progressing. Specific actions in relation to subgroups | | Thea Stein | |



**Leeds Community Healthcare NHS Trust**

**Agenda item 2018-19 (102)**

## Trust Board public workplan 2018-19
## Version 13 : 24 January 2019

| Topic | Frequency | Lead officer | 3 August 2018 | 7 September 2018 Extraordinary | 5 October 2018 | 7 December 2018 | 1 February 2019 | 5 April 2019 | 24 May 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 (End of life care) | | X | X | X | X | X |
| **Quality and delivery** | | | | | | | | | |
| **Chief Executive's report** | every meeting | CE | X | | X | X | X | X | X |
| **Performance Brief** | every meeting | EDFR | X | | X | X | X | X | X |
| **Perfomance Brief: annual report** | Annual | EDFR | | | | | | | X |
| **Care Quality Commission inspection reports** | as required | EMD | | | | | | | |
| **Quality account** | annual | EDN | | | | | | | X |
| **Mortality report** | 4 x year | EMD | | | | | X | | X |
| **Staff survey** | annual | DW | | | | | | X | |
| **Safe staffing report** | 2 x year | EDN | X | | | | X | | |
| **Seasonal resilience** | annual | EDO | | | 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 Six monthly report | | | X Annual report |
| **Freedom to speak up report** | 2 x year | CE | X Annual report | | | X | | | |
| **Guardian for safe working hours report** | 4 x year | EMD | X | | | X | X | | X Annual report |
| **Strategy and planning** | | | | | | | | | |
| **Operational plan including financial plan** | 2 x year | EDFR | | | X | | | | X End of year report |
| **Service strategy** | as required | EDFR | | | | | | | |
| **Quality strategy** | annual | EDN | | | | | X | | |
| **Workforce Strategy (formerly Organisational Development strategy 2017-19)** | 2 x year | DW | X Deferred from May | | X | | X | | X? |
| **Research and development strategy** | annual | EMD | X | | | | | | |
| **Governance** | | | | | | | | | |
| **Medical Director's report: doctors' revalidation** | annual | EMD | X | | | | | | |
| **Nurse revalidation** | annual | EDN | X | | | | | | |
| **Well-led framework** | as required | CS | X CEs report | | | X Action plan | | | |
| **Annual report** | annual | EDFR | | | | | | | X |
| **Annual accounts** | annual | EDFR | | | | | | | X |
| **Letter of representation** | annual | EDFR | | | | | | | X |
| **Audit opinion** | annual | EDFR | | | | | | | X |
| **Audit Committee annual report** | annual | CS | | | | | | | X |
| **Standing orders/standing financial instructions review** | annual | CS | | | | | | | X |
| **Annual governance statement** | annual | CS | | | | | | X | |
| **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 | | | | | | | |
| **Reports** | | | | | | | | | |
| **Equality and diversity report** | annual | DW | | | | X | | | |
| **Safeguarding annual report** | annual | EDN | | | X | | | | |
| **Infection prevention control annual report** | annual | EDN | | | X | | | | |
| **Emergency preparedness annual report** | annual | EDO | | | X | | | | |
| **Additional items** | | | | | | | | | |
| **West Yorkshire Mental Health Services Collaborative** | as required | CE | X Verbal | | | | | | |
| **Leeds Health and Care Academy - Partner Board briefing** | as required | CE | X | | | | | | |
| **Leeds Providers Integrated Care Collaborative - Committees in Common** | as required | CE | | | X (MOU APPROVAL) | | | | |
| **Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common** | as required | CE | | | X (MOU APPROVAL) | | | | |
| **CAMHS Tier 4 - Building** | as required | EDFR | X Verbal | | | | | | |
| **West Yorkshire and Harrogate Health and Care Partnership (Formerly STP)** | as required | CE | | X (MOU APPROVAL) | | | | | |

**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

AGENDA ITEM 2018-19 (103a)

**Quality Committee**
**Monday 26 November 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 |
| | Ruth Burnett | Interim Executive Medical Director |
| | Stephanie Lawrence | Interim Executive Director of Nursing |
| In Attendance | Sam Prince | Executive Director of Operations |
| | Carolyn Nelson | Head of Medicines Management |
| | Elaine Goodwin | Clinical Lead for Specialist Services |
| | Diane Allison | Company Secretary |
| | Caroline McNamara | Clinical Lead for Adult Services |
| | Debbie Myers | Deputy Director of Nursing |
| | Helen Rowland | Clinical Lead for Children's Services |
| | Suzanne Slater | Clinical Governance Manager |
| | Nikki Stubbs | Interim Professional Lead for Nursing |
| Observing | Kayleigh Abbott | Clinical Quality Lead/ANP for Police Custody Healthcare Services |
| | Catherine Duff | Quality Lead, Children's Services |
| Minutes | Lisa Rollitt | PA to Executive Medical Director |
| Apologies | Neil Franklin | Trust Chair |

| Item no | Discussion item | Actions |
|---|---|---|
| **Welcome and introductions** | | |
| **2018-19 (56a)** | **Welcome and Apologies**<br>The Committee Chair opened the meeting and welcomed the members.<br><br>The group introduced themselves.<br><br>Apologies were received from Neil Franklin. | |
| **2018-19 (56b)** | **Declarations of Interest**<br>Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members.<br><br>The chair has asked if there were any additional interests. There were no additional declarations of interest received. | |
| **2018-19 (56c)** | **Minutes of meeting held on 22 October 2018**<br>The minutes were reviewed for accuracy and agreed as a true record of the meeting. | |

| | | |
|---|---|---|
| **2018-19 (56d)** | **Matters arising and review of action log**<br>It was agreed that all completed actions would be removed from the action log.<br><br><u>Action 2018-19 (31a) Performance brief and domain reports</u><br>The action was completed:<br><br>The Executive Director of Operations provided a verbal update following the Transitions Conference in October 2018. A number of members and attendees of the Quality Committee had attended the conference and agreed it was a good conference and that there had been useful networking opportunities for people who work with the same patients.<br><br>The Chair commented that relevant NICE guidance was not discussed at the Transitions Conference and that there was a lack of adult services for children to transition into. The Executive Director of Operations advised that the Trust needs to work in partnership and that some investment in adult services was required. The Interim Executive Director of Nursing agreed to consider how to raise this with the wider community in Leeds.<br><br>The Clinical Lead for Children's Services stated that a report would be drafted following the conference which would be brought to the Committee in January. The main issue for consideration was how to transition children to adult services. It was agreed that the paper would include a baseline assessment tool.<br><br>**Further action: Clinical Lead for Children's Services to provide an update on transition to adult services including a baseline assessment tool to the Committee meeting in January 2019**<br><br><u>Action 2018-19 (32b) Quality improvement priorities position</u><br>The action was completed:<br>An update was included in the Clinical Leads report for Children's Services. One staff member still requires training. The Clinical Lead for Children's Services will advise the Company Secretary when this is completed and the Company Secretary will remove the item from the action log.<br><br><u>Action 2018-19 (38d) Matters arising: Clinical Audit Programme 2017-18 update</u><br>The Interim Executive Medical Director confirmed that she would be meeting with the Interim Executive Director of Nursing in December 2018 to prepare the audit response in January 2019 and would update the Committee at the next meeting.<br><br><u>Action 2018-19 (40a) Hannah House</u><br>The action was completed:<br>A revised improvement plan is on the Committee agenda November 2018.<br><br><u>Action 2018-19 (40c) Outcome measures approach</u><br>The timescale was revised to January 2019 with the agreement of the Committee.<br><br><u>Action 2018-19 (41a) Director of Nursing quality and safety report</u><br>The action was completed:<br>The Clinical Lead for Specialist Services updated the Committee, confirming that the inconsistent figures were due to a time-lag in data inputting. | **Clinical Lead for Children's Services** |

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| | Action 2018-19 (41f) Always events update<br>The action was completed:<br>The update is included in the Clinical Governance Report November 2018.<br><br>Action 2018-19 (41g) Professional strategy update<br>The action was completed:<br>A verbal update was provided by the Interim Executive Director of Nursing, who advised the Committee that the Professional Strategy was to be included as an appendix in the Quality Strategy.<br><br>Action 2018-19 (51b) Performance brief and domain reports<br>The action was completed:<br>A narrative section on mortality has been added to the Clinical Governance Report. | |
| **Service Spotlight: Specialist Business Unit** | | |
| **2018-19 (57)** | **Virtual Respiratory Ward**<br>The Clinical Lead for Specialist Services introduced Kate Fenton, Clinical Lead for Virtual Ward Respiratory Nurse Specialist and Alwyn Herbert, Respiratory Nurse. The group introduced themselves.<br><br>The Clinical Lead for Specialist Services introduced the presentation.<br><br>The service has been operational since 1 June 2018 and it was noted that respiratory illness was one of the major causes of surge escalation in the system.<br><br>The Clinical Lead for Virtual Ward Respiratory Nurse Specialist gave an overview of the service and described the LVRW model:<br><br>Early hospital discharge and admission avoidance<br>Rapid and intensive support promoting self-management<br>Integrated model with Leeds Teaching Hospitals NHS Trust (LTHT) and Primary Care (PC)<br>Promotion of independence and self-management.<br><br>*Integrated approaches*<br>It was noted that the service has a good relationship with LTHT and was engaged with primary care providers. It was also positive to note that the GPs in Armley were showing an interest in the service.<br><br>*Key achievements*<br>The service has been operational since 1 June 2018; however a medical model is yet to be signed off. The Committee noted however, that as the core respiratory team were experiencing a high amount of staff sickness, the service was picking up some of the areas that they would usually cover, leading to an opportunity for the Virtual Ward staff to learn more about respiratory skills.<br><br>The evidence based standard operating procedure (SOP) has been completed and should be signed off imminently.<br><br>*Challenges and risks*<br>Recruitment of specialist staff / physiotherapists continues to be a challenge. The Clinical Lead for Adult Services commented that offering rotational roles could assist in addressing the issues. | |

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| | There was a discussion around the challenges with consultant support. The Committee recognised that the model currently being used was a medical model, and ideally should be a multi-disciplinary model. The Interim Executive Medical Director offered to attend some of the meetings with consultants to assist with the relationship.<br><br>The Chair recognised that the service was still at a very early stage of development but was keen to hear about the benefit to patients from this approach.<br><br>It was noted that the key priority for the service was expansion of provision.<br><br>In response to a query from a Non-Executive Director (TD), the Respiratory Nurse Specialist confirmed that initially, it was difficult to manage patients due to long standing conditions and a change of behaviours. However, building relationships had been key to making the change to a virtual ward successful.<br><br>A Non-Executive Director (TD) asked what the current capacity of the service was. It was confirmed that the current patient capacity was up to ten.<br><br>The Clinical Lead for Adult Services stated that the Adult Business Unit, along with other partners in the City, was looking to develop a virtual frailty ward and asked about learning and an educational model to support staff. It was agreed that joint working would be possible between the services.<br><br>The Chief Executive stated that the citywide Committees in Common have discussed respiratory healthcare as a top priority and were looking at moving more resource from hospital to community.<br><br>The Chair noted that there was a great commitment across the City in support of this work, as it does relieve system pressure; however it was important to determine the best way of expressing effectiveness in terms of outcomes and impact on patient flow. It was recognised that there is still work to do around working relationships between the organisations involved.<br><br>**Action: Clinical Lead for Specialist Services to feed back on the progress being made with the MDT model to the Committee in April 2019 within Clinical Governance Report**<br><br>The Committee Chair thanked the Clinical Lead for Virtual Ward Respiratory Nurse Specialist Respiratory Nurse Specialist for the presentation. | **Clinical Lead for Specialist Services** |
| **Key issues** | | |
| **2018-19 (58a)** | **Hannah House improvement plan**<br>The Interim Director of Nursing updated the Committee on progress with the improvement plan.<br><br>The Executive Director of Operations confirmed that there had been much progress over the last 6 to 10 months, there was a positive cultural change, and the staff desired for the service to be rated as “good”.<br><br>The Chair commented that he agreed with the rating of “requires improvement” following the recent Quality Challenge plus visit, but also noted the positive change in culture. He expressed concern that there was about to be a change in leadership and the unit management was potentially less stable. The Chair added that Hannah House was an under used resource during the day, when | |

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| | the majority of patients would be at school. The Clinical Lead for Children's Services confirmed that ideas for utilising Hannah House in other ways were being considered.<br><br>A Non-Executive Director (TD) asked about engagement with families and with other organisations. The Clinical Lead for Children's Services advised the Committee that the service was now much better at engaging with parents, and were looking at developing a parents' group, collectively with Martin House and Rainbow House.<br><br>The Committee agreed that updates on Hannah House would continue to be provided to each Committee meeting via the Clinical Leads Reports.<br>**Level of assurance: Reasonable** | |
| **(58b)** | **Outcomes measures update**<br>The Interim Executive Medical Director updated the Committee with the current position. A 2-3 year plan had been worked up and reviewed by Senior Management Team. It was confirmed that further work was required, including a workforce plan, before it could be signed off, and given the financial implications it will need to be considered alongside the 19.20 priority planning.<br><br>**Action: Outcomes Measures update report to be provided at the Committee in January 2019. (see action 40c on action log)** | **Interim Executive Medical Director** |
| **(58c)** | **Internal audit reports**<br>The paper included two completed audits from the 2018/19 plan<br><br>Complaints Management<br>Clinical Audit<br>1. Complaints Management<br>The Interim Executive Director of Nursing advised the Committee that it had been agreed to move the timescales forward on the two important actions and assured the Committee that these would be embedded from Quarter 4 2018/19. The Committee Chair agreed to update the Audit Committee, as it had previously expressed concern about the protracted timescales for important actions.<br><br>2. Clinical Audit<br>The Interim Executive Director of Nursing updated the Committee on the five recommendations:<br><br>*'At the time of the audit review the Clinical Audit Policy was in the process of being reviewed'*<br>It was confirmed that this would be achieved by the end of December 2018.<br><br>*'The Rolling Clinical Audit Programme was approved and ratified by the Quality Committee on 21 May 2018, after the start of the financial year'*<br>This would be presented to the Quality Committee before the end of March 2019.<br><br>**Action: Interim Executive Director of Nursing and Company Secretary to agree and update work plan to include rolling Clinical Audit Programme to be presented to Quality Committee in March 2019**<br><br>*'Audit testing of a sample of 10 clinical audits revealed two instances where there was an absence of an audit plan and registration form, one missing* | **Interim Executive Director of Nursing** |

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| | *action/improvement plan and one audit with incomplete actions on the action/improvement plan'*<br>Training is being rolled out to services with a completion date of 31 March 2019.<br><br>*'Quality assurance feedback has not been retained for all clinical audits.'*<br>The Clinical Audit and Effectiveness Manager is undertaking an independent review of audits and sending feedback to lead auditor<br><br>*'The outcomes of the clinical audits are identified and shared locally but not widely across the Trust'.*<br>Work is ongoing to develop a process to disseminate findings across the Trust. This is expected to be completed by April 2019.<br><br>Both internal audit reports provided Reasonable assurance. | |
| **(58d)** | **Safeguarding action plan arising out of CQC looked after children review**<br>The Interim Executive Director of Nursing presented the report. It was confirmed that an inspection had taken place in June 2018, and the report was published in August 2018.<br><br>The Committee noted that:<br>• The action plan is responsive to the recommendations made to LCH as a result of the CQC review.<br>• The actions are deliverable within current resources<br>• While the CQC award no judgement as a result of this type of review, the level and extend of recommendations made to LCH implies that improvements can be made onto a sound base of practice<br>• Progress has already been made to address the recommendations and a monthly review process is in place to monitor actions to the point of completion.<br><br>The Committee Chair noted that most of the recommendations concerned improvements required for processes rather than outcomes.<br><br>**Assurance level: Reasonable.** | |
| **(58e)** | **Winter planning – quality implications**<br>The Executive Director of Operations assured the Committee that the City and the Trust were advanced in preparing for winter and that all partners were working well together. It was noted that there had been a Winter Project Manager in post for the last few years and that the Trust was better prepared this year than in the past to deal with emergencies and to know who to contact for assistance.<br><br>The Chair asked about the clinical and other risks to patients that the Trust could face as a consequence of pressure over winter and if any effectiveness measures, for example emergency readmission rates, were available to demonstrate whether the Trust's plans were having a positive impact.<br><br>The Chief Executive described the remit of the Strategic Resilience Assurance Group and advised the Committee that poor discharge incidents are reported on Datix ® and analysed. The number of incidents of inappropriate discharge is reducing. A dashboard of effectiveness measures has been developed and it was agreed that the Executive Director of Operations would share the dashboard of effectiveness measures with the Committee. | |

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| | **Action: Executive Director of Operations to circulate latest dashboard of measures to the Committee.**<br><br>A Non-Executive Director (TD) asked about transfer of care policy and how robustly it was being implemented. The Chief Executive confirmed that as this had been launched only a week ago, the impact could not be evidenced. It was noted however that this time last year there were approximately 23 patients in non-designated areas compared to zero this week. | **Executive Director of Operations** |
| **(58f)** | **Sub Group items to escalate to Committee**<br>The Interim Executive Director of Nursing advised the Committee that there were no minutes available for the Patient Safety and Experience Group as the group had not met recently. It was confirmed that the terms of reference would be reviewed in January 2019 and that patients would be encouraged to be members of the group. | |
| **Quality governance and safety** | | |
| **2018-19 (59a)** | **Performance brief and domain reports**<br>The Interim Executive Director of Nursing asked the Committee to note that work on the design of the reports were ongoing.<br><br>*Effective*<br>The Interim Executive Director of Nursing confirmed that the information relating to this domain was reported quarterly, with no information due this month.<br><br>*Responsive*<br>The Interim Executive Director of Nursing referred to IAPT waiting time rates, stating that the paper would be reviewed at the Business Committee, but could be made available if Quality Committee members wished to view it. The Committee Chair said that the risks to patients who were waiting for services were a concern for the Quality Committee.<br><br>*Well-Led*<br>The Interim Executive Director of Nursing referred to Safeguarding training and stated that a 90% compliance rate was expected to be achieved by the end of December 2018.<br><br>The Chair queried the figures reported in terms of the reduction of the number of staff leaving the organisation within 12 months. It was noted that SMT have identified this and it was being explored further.<br><br>**Assurance Level: Reasonable** | |
| **2018-19 (59b)** | **Clinical Governance Report**<br>The Interim Director of Nursing presented the report and advised the Committee that enhancements to the reporting of mortality data, to include more narrative, themes and learning were ongoing.<br><br>The Committee received an update on the progress being made with the Always Events Framework. Staff had been made aware of the Framework at local conferences and at Trust induction. The message to staff was that patient engagement and co-production should be an integral part of how we work. Progress with the Framework will be included in the Quality Account quarterly reports to Committee. The Committee Chair asked what the always events questions were. The Interim Director of Nursing advised the Committee that work was ongoing to develop these questions and that the National team was to | |

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| | share learning, to inform this work.<br><br>Part C: Clinical lead reports<br><br>*Adults Business Unit*<br>The Clinical Lead for Adult Services highlighted to the Committee that preparations for winter were advanced. There were challenges around maintaining quality improvements but progress continued. The ABU report also highlighted that over 25% of care delivered in the neighbourhood teams is wound care related. Work was underway to ensure there was evidence-based practice to improve wound care within the ABU.<br><br>The Clinical Lead for Adult Services thanked the business team for the support on performance data, where there had been substantial improvements in recording and analysing data, which helped teams to monitor their own performance. The un-outcomed visits graph demonstrated a significant improvement in this area.<br><br>A Non-Executive Director (TD) commented on the presentation of data which displayed substantial variants. The Clinical Lead for Adult Services agreed to review the format of these graphs.<br><br>*Specialist Business Unit*<br>The Clinical Lead for Specialist Services updated the Committee on the recent outcome measures workshop, jointly held with commissioners, to establish the work that needed doing to move towards outcome-based commissioning.<br><br>The Committee was advised that with some exceptions, performance was generally good in terms of waiting times. Wait times in the Foot Protection service, Diabetes and SLT continued to present a challenge; however, there are plans in place to ensure that there are no breaches. The Executive Director of Operations stated that there was a number of issues to resolve in IAPT, but were working on a recovery plan with commissioners.<br><br>*Children's Business Unit*<br>The Clinical Lead for Children's Services advised the Committee that the Head of Service for Integrated Children's Additional Needs and her team were nominated for, and was highly commended at the Health Services Journal award for the 'Let Me Show You' app.<br><br>A Quality Challenge+ visit at the CAMHS in-patient unit was rated 'Good', with outstanding handover of patient care observed.<br><br>Challenges noted for the business unit included sickness in 0-19 Years' service, with an 8.37% WTE absence rate across health visiting and a 4.6% absence rate in CAMHS. | |
| **2018-19 (59c)** | **Risk Register**<br>The Company Secretary highlighted that there were 6 new risks on the register. It was noted that two of the risks around recruitment and retention in neighbourhood teams had been on the register previously as one risk, but had been separated into two distinct risks.<br><br>Two extreme risks were noted:<br>CAMHS T4 building costs | |

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| | Staff sickness across the Trust.<br><br>There was a discussion around the difference between controls and actions. The Committee expressed concern that Risk 945 had no controls recorded. Chief Executive stated that a risk should not be presented without mitigation in place.<br><br>**Action: Company Secretary to advise risk owner that risk 948 (face-fit testing) requires updating** | **Company Secretary** |
| **2018-19 (59d)** | **Quality Priorities quarterly position**<br>The Committee was apprised of two areas where there is concern; these are waiting times for Autistic Spectrum Disorder assessment in pre-school children within the ICAN service and the number of services using outcome measures: The Interim Executive Director of Nursing referred to the concern around children waiting times for Autistic Spectrum Disorder assessment in pre-school children with the ICAN service. It was noted that a plan is in place with the waiting list initiative commencing in September 2018. The Chair asked about children waiting times for Autistic Spectrum Disorder in CAMHS. The Executive Director of Nursing explained that ICAN saw children under 5 and CAMHS assessed children over 5. | |
| **(59e)** | **Guardian for Safe Working Hours quarterly report**<br>The Interim Executive Medical Director presented the paper and stated that engagement was significantly higher in CAMHS than from other specialist areas. A plan was in place to improve engagement with the other areas. | |
| **(59g)** | **Freedom to Speak Up report (6 monthly)**<br>The Chief Executive presented the paper in the absence of the Freedom to Speak Up Guardian who was unable to attend the meeting.<br><br>A Non-Executive Director (TD) asked about the GP Confederation. The Chief Executive confirmed that the Freedom to Speak Up Guardian would work with the GP Confederation to look at how to embed Freedom to Speak Up in practices.<br><br>The Trust's Well led review peer led by Cambridgeshire Community NHS Trust had identified that people felt culturally supported to speak up at LCH. It was confirmed that the Freedom to Speak Up Guardian would undertake a further peer review with a Freedom to Speak Up Guardian from another local trust. | |
| **(59h)** | **Board members' service visits**<br>The Interim Executive Medical Director presented the report, which detailed four Non- Executive Director visits:<br><br>• CUCS<br>• Community Dental Service<br>• Health Visiting<br>• IAPT<br><br>It was noted that the Executive Director of Operations had provided a detailed response to the issues raised in the Community Dental Service and Health Visiting reports. The CUCS team were to attend Business Committee in November 2018 and the issues raised in the NED report would be addressed in that meeting. IAPT issues were on the agenda for the November 2018 Business | |

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| | Committee meeting.<br><br>The Interim Executive Director of Nursing highlighted that at the recent clinical quality review meeting with the commissioner, the CUCs service received fantastic feedback with regards to their staff.<br><br>The Committee agreed that these reports and subsequent service responses provided excellent feedback. | |
| **Clinical effectiveness** | | |
| **2018-19 (60a)** | **Patient group directions (PGD)**<br>The Committee was asked to ratify two PGDS:<br><br>• Administration of EMLA Cream<br>• Measles, Mumps and Rubella Vaccine<br><br>It was confirmed that the PGDs had been through the correct processes and were recommended for ratification.<br><br>**Outcome:** The Committee ratified the two approved PGDs. | |
| **2018-19 (60b)** | **NICE guidance compliance update**<br>The Head of Medicines Management presented the update and it was noted that the position statement covered two years for the first time.<br><br>The Committee Chair reiterated that the transition from Childrens' to Adult Services was a large piece of work.<br><br>The Committee Chair queried why the report did not include the details behind the position statement. The Interim Executive Medical Director confirmed that the details were reviewed at the CEG meetings and were included in the minutes. It was agreed that future Committee reports would include the details as key points where compliance with guidance was not progressing adequately.<br><br>A Non-Executive Director (TD) referred to NG11: Challenging behaviours and LD Children's Business Unit and asked why this was delayed. It was agreed that the details would be included in the update to the Committee in January 2019.<br><br>The Clinical Lead for Children's Services stated that it was important to consider what was within the scope of the Trust to deliver. The Committee Chair agreed, but added that the Trust has a responsibility to be influential across the system to achieve compliance. | |
| **Committee's annual review** | | |
| **2018-19 (61a)** | **Committee's review of effectiveness and agenda composition**<br>The Committee reflected on whether its current format was effective. The Chair referred to the review at beginning of the year where it was agreed that there would be six business meetings, with workshops in-between (deep dive). Two workshops had been conducted so far and feedback had been favourable. Agenda composition was under constant review during Committee agenda setting meetings.<br><br>Committee members agreed to review its effectiveness again in March 2019. | |

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| **Sub Group minutes** | | |
| **2018-19 (62a)** | **Clinical Effectiveness Group minutes: 18 October 2018**<br>The Chair commented on the number of apologies at the CEG meetings and where it was recorded that the people were not there to present agenda items, as it would be difficult for the group to challenge any reports if the responsible author was not in attendance. The Interim Executive Medical Director stated that there were issues with date settings and business units sending appropriate representation; these issues were being addressed to ensure maximum attendance. | |
| **2018-19 (62b)** | **Safeguarding Children's and Adults Group minutes: 11 October 2018**<br>The Interim Executive Director of Nursing referred to training that is non mandatory but very important in terms of safeguarding. The teams are looking to provide this training in the early evenings to maximise staff attendance. | |
| **2018-19 (62c)** | **Mental Health Act (MHA) Group minutes: 26 September 2018**<br>It was noted that the Chair also chairs the MHA Group meeting, which may be inappropriate, in terms of governance, as the group reports into the Quality Committee. The Chairing of the subgroup meeting would be reviewed at the end of the year.<br><br>The Interim Executive Medical Director asked the Committee to note that Dr Kraam, Deputy Medical Director would attend the subgroup meetings on her behalf.<br><br>A Non-Executive Director (TD) expressed concern around the number of incomplete actions. The Committee Chair confirmed that the group had recently engaged an external advisor from LYPFT and as part of this, issues around certain ways of working have been identified. The advisor had offered to provide additional information, but he was not at that meeting to provide an update on actions. The Clinical Lead for Children's Services confirmed that the actions are now complete.<br><br>The Committee was advised that membership of the subgroup was under review.<br><br>A Non-Executive Director (TD) referred to the recent Community Treatment Order incident, and asked about the scrutiny that had been put in place. The Clinical Lead for Children's Services confirmed that an investigation was in place, led by the Medical Lead. | |
| **Policies and reports for approval or noting** | | |
| **2018-19 (63a)** | **Mortality Surveillance Group annual report**<br>The annual report provided a summary of the subgroup's activities and a review of its effectiveness.<br><br>The Chair commented that the annual reports were out of sync as they provided belated information.<br><br>It was noted that all the subgroups' annual reports should provide assurance to the Committee that the subgroups are carrying out their functions effectively, in line with their approved terms of reference, not just to provide information. | |

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| | **Action: Company Secretary to review schedule for Board, Committee and subgroups annual effectiveness reports.** | **Company Secretary** |
| **2018-19 (63b)** | **Safeguarding Committee annual report**<br>Effectiveness of the Safeguarding Committee was difficult to evaluate, based on the low numbers of response received by its members.<br>The Chair referred to the three outstanding actions on the subgroup's work plan and asked the Interim Executive Director of Nursing to find out if there had been any progress on these.<br><br>**Action: Interim Executive Director of Nursing to check actions on work plan and confirm whether they have been completed.** | **Interim Executive Director of Nursing** |
| **2018-19 (63c)** | **Mental Health Act Governance Group annual report**<br>The Committee received the subgroup's effectiveness report. There were no comments made. | |
| **2018-19 (63d)** | **Clinical Effectiveness Group annual report**<br>The Committee received the subgroup's effectiveness report. There were no comments made. | |
| **2018-19 (63e)** | **Patient Safety and Experience Group annual report**<br>The Committee received the subgroup's effectiveness report. The Interim Executive Director of Nursing reiterated that membership and attendance of the group would be reviewed to agree the function, purpose and membership of the group. | |
| **2018-19 (63f)** | **Clinical Quality Review Group minutes**<br>The Committee received the minutes of the July 2018 meeting.<br>It was noted that there had been two further meetings since the July 2018 meeting, which had not yet been approved. The Committee was advised that meeting dates were being reviewed.<br><br>The Committee discussed the subject of patient feedback, which featured in the minutes. The Committee Chair said that the Committee currently isn't hearing the 'patient's voice' within its own meetings and that there would be more focus on how the Committee achieves this during 2019. | |
| **Quality Committee work plan** | | |
| **2018-19 (64a)** | **Items from work plan not on agenda**<br>Clinical Audit update (6 monthly) – to be provided in January 2019.<br>Mortality Surveillance Group minutes: 23 October 2018 – to be provided in January 2019.<br>PSEGG minutes – meeting did not go ahead. | |
| **2018-19 (64b)** | **Work plan and service spotlight programme**<br>The Company Secretary confirmed that the January 2019 service spotlight will be from Police Custody.<br><br>The next deep dive workshop would focus on the Specialist Business Unit and safety huddles.<br><br>The Chair asked the Committee to consider areas that require a deep dive which would be added to the service spotlight schedule. | |

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| **2018-19 (65)** | **Matters for the Board and other Committees including assurance levels**<br>Service spotlight - Virtual Respiratory Ward<br>Improvements at Hannah House<br>Quality Priorities quarterly position<br>Safeguarding action plan from CQC looked after children's review<br>Delay of outcome measures paper<br>Non-Executive Director visits to services<br>Nice Guidance 43: Transition<br>Performance brief and domain reports - Safe and caring Domains | |
| **2018-19 (66)** | **Any other business**<br>The Company Secretary thanked everyone for their assistance in circulating the papers earlier in the month. | |
| | **Dates and times of future meetings (09:30 – 12:30)**<br>Monday 21 January 2019<br>Monday 18 February 2019<br>Monday 18 March 2019 | |

Leeds Community Healthcare NHS Trust

**Agenda Item 2018-19 (103b)**

# MINUTES

**Business Committee Meeting**
**Boardroom, Stockdale House**
**Wednesday 28 November 2018 (9.00am – 12.00 noon)**

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| **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:** | Jenny Allen | Director of Workforce, OD and System Development |
| | Diane Allison | Company Secretary |
| | Richard Slough | Assistant Director of Business Intelligence, (for item 55 only) |
| | Megan Rowlands | General Manager (Adults) – (for items 54 only) |
| | Debbie Lowe | Service Manager for Citywide Services (for item 54 only) |
| | Jane Higgins | Project Manager (for item 54 only) |
| | Peter Ainsworth | Operational Support Manager (for items 56b&c) |
| | Catherine Scott | Admin Services Manager (for item 56b only) |
| | Samantha Donaldson | Admin Review Project Manager (for item 56b only) |
| | Marie Hoddell | Admin Review Project Support Officer (for item 56b only) |
| **Apologies:** | None | |
| **Observers:** | Ruth Burnett | Interim Medical Director |
| | Kurt Stephen | NHS Digital |
| | Roohi Collins | Aspiring NED Programme |
| **Note Taker:** | Ranjit Lall | PA to Executive Director of Finance & Resources |

| Item | Discussion Points | Action |
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| 2018/19 **(53)** | The Committee Chair welcomed everyone to the meeting.<br><br>**Item 53a - Apologies:** None recorded.<br><br>**Item 53b - Declarations of Interest**<br>Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members.<br><br>The Committee Chair asked if there were any additional interests. There were no additional declarations of interest received.<br><br>**Item 53c - Minutes of last meeting**<br>The public and private minutes of the meeting dated 24 October 2018 were noted for accuracy and approved by the Committee.<br><br>**Item 53d – Matters arising from the minutes and review of actions** | |

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| | **<u>46b – Traded services income generated opportunities</u>:**<br>(Please see private minutes) | |
| 2018/19<br>**(54)** | **Service area focus**<br>**Continence, Urology and Colorectal service (CUCS)**<br>The representatives from continence, urology and colorectal service attended the meeting to present service issues and challenges about waiting list management, product spend and sickness absence.<br><br>The service provided the Committee with a briefing paper in advance of the meeting. The paper also identified a number of areas for reflection in the meeting and welcomed further conversation or feedback.<br><br>The Executive Director of Operations said that this was one part of the roadmap work with Commissioners. She said that she had received positive feedback at the Contract Management Board meeting on 27 November 2018 about the service provided. The Commissioners noted insufficient capacity in staffing and suggested that any savings in product reduction was re-invested into staffing. The Committee supported the service's approach to redesigning its staffing structure.<br><br>The service had already secured significant cost reduction through tighter control on product issues and was looking to reallocate those savings to additional staff recruitment. The general manager said that the main focus was identifying key issues including Commissioner engagement, team involvement and clinical staff involvement within the service.<br><br>The Service Manager said that currently there were some product related queries, issues and complaints that the service was finding it difficult to resolve. It took away patient care time to be able to resolve the clinical issues. Part of the process in place was having a joint working group with commissioning work and looking at ways to revise the standard operating procedure. The Executive Director of Operations suggested that the team talks to the complaints team about the standard approach.<br><br>The Committee Chair noted difficulties with service approach to products and clinical engagement and cost reduction in line with the Commissioner requirement. He asked about the time spent with patients about what was required in the contract. The Executive Director of Operations said that the Commissioners have said they would like to see re-assessments taking place in a much more timely way to possibly make a saving. The initial letter to patients about managing expectations now included that the service is only commissioned to provide a certain amount of pads.<br><br>The General Manager said that another challenge identified was the staff managing patient expectations, making sure that the same message was relayed by other services who were in contact with the same patients. The Service Manager said that she had also looked into workforce management; the kind of patients seen, duration of assessments and telephone assessments. She said that some of the telephone assessment work undertaken by assistant practitioners was now being undertaken by administration support.<br><br>The Service Manager said that pathway to improve DNA rates; patients were contacted prior to their appointment to check their attendance. The team was looking at converting some of the staff nurse posts into a band 6 post. | |

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| | The General Manager said that work with colleagues in Leeds Teaching Hospitals NHS Trust was still to be reviewed. She said the team was well engaged with the service review and about the negotiations with the Commissioners.<br><br>The Executive Director of Operations said that waiting times in CUCS had now improved, and no one was waiting over 18 weeks. She was pleased with the outcome and said 'well done' to the team.<br><br>The Executive Director of Operations said that she would be happy to visit the service during their next team meeting to support the team with these challenges. The Interim Medical Director offered to support conversations with GPs around this subject and about the wider primary care issue. The Interim Medical Director also agreed to visit the service with the Executive Director of Operations.<br><br>The Committee Chair thanked the CUCS team, particularly the Service Manager for her commitment and leadership. The Business Committee noted encouraging work in the service around workforce management, dealing with sickness absence, supporting the re-grading of post issues and tackling and challenging DNAs.<br><br>The Committee Chair summarised the discussion. There was a rigorous approach to product issues and positive conversation with Commissioners. The Team had picked up some valuable learning from the Bradford area that could be transferred across, particularly the approach to product issuing. The service should capitalise on sponsored nurse posts.<br><br>The Committee Chair thanked the representatives from the CUCs team for the hard work and progress made.<br><br>**Outcome:**<br>The Committee reflected on the excellent leadership of this service; it invited the service to focus further on productivity issues and confirmed it would provide strong support for positive developments. | |
| 2018/19<br>**(55)** | **Strategy development and implementation**<br><br>**Digital strategy update**<br>The Assistant Director of Business Intelligence, Systems & IT introduced the digital strategy paper and highlighted the key points as follows:<br><br>Positive progress with implementing the original strategy and most of the work was either completed as business as usual or in progress. The regional and citywide priorities were becoming much clearer and had started to consume resource. The two items off track were the single sign on and electronic transfers of care and e-referrals. The Assistant Director of Business Intelligence, Systems & IT said he had made contact with a company called Imprivata to progress solutions. The e-referral service was originally designed for consultant led outpatient services which is different to neighbourhood teams frequent visits<br><br>The report described a number of new strategic priorities which had arisen since the strategy was adopted by the Board, including Local Care and Health Record Exemplars, Cyber security, the shared city platform, and the conclusion to the regional procurement process for the replacement to the existing network connection. | |

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| | The Committee discussed the need for the strategy to have a customer service approach so that staff could understand how digital innovations could help them to improve patient care. The Committee recommended that technical innovators should explain the possibilities to staff, as well as support being available to assist and empower staff to use new and complex software.<br><br>A Non-Executive Director (RG) noted a number of positive outcomes, addressing technology debt and building foundations, for example, use of electronic patient record and e-rostering. He said it was about getting to a good position to take advantage of some of other regional and national opportunities. He said most importantly it was getting basics right and being led by services in the future and how digital technology would help to do that to improve the quality of care provided.<br><br>The Executive Director of Finance & Resources said that he would like time to consider the guardianship of use of data and innovation, and having a conversation with the Chief Clinical Information Officer in the Trust, to bring technological innovators into the organisation to explain the alignment with the organisational vision and an opportunity to modernise the use of technology.<br><br>The Chief Executive said that the Board Assurance Framework (BAF) risks should also be linked with the overall strategy; alignment to recruitment and retention and demographic pressure in the city.<br><br>The Committee Chair asked for an update at a future meeting with a new digital strategy. The Executive Director of Operations said that the new strategy should be based on customer service and how it will support staff to use digital technology to the best effect; accessing out of hours support, training and development, etc.<br><br>The Committee Chair agreed that a new digital strategy needed the fullest engagement with people in the Trust and also with people across Leeds.<br><br>The Chief Executive said that the revised Digital Strategy should reflect work discussed in today's meeting and also include the 10 year forward plan and digital leadership. A further update on the digital strategy is to be provided to the Committee in February 2019.<br><br>**Action:**<br>The Committee to receive an update on the digital strategy in February 2019.<br><br>**Outcome:**<br>The Business Committee noted progress against each of the digital strategy priorities set by the Trust Board and the increasing impact of new digital priorities which were not present when the original strategy was created.<br><br>**Leeds City digital strategy: transition to the community cloud**<br>The paper provided the Committee with an update on development within the citywide digital strategy, known as the "Community Cloud". This will combine the data storage requirements of the Trust, Leeds City Council, the Clinical Commissioning Group and the GPs of Leeds and provide improved security and resilience through the provision of a modern shared infrastructure.<br><br>The Assistant Director of Business Intelligence, Systems & IT said that this would be the best use of technology resource by combining requirements across organisations, and having the opportunity for real financial savings. It was noted that the data to be moved was by and large the corporate static | BM |

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| | data files, and not the clinical systems, finance systems or ESR systems.<br><br>The Assistant Director of Business Intelligence, Systems & IT said that as part of this work there was a need to establish the details of a public partnership agreement and service level agreements to cover the Trust in terms of service levels expected to receive from local authority who were handling this piece of work on behalf of the city. He said once there was an agreement, EMBED (who is the provider of current data storage solutions) would formally be given notice. The Trust would then be in a position to migrate data from quarter two onwards in 2019.<br><br>The Committee Chair asked if the costs were estimated or actual. The Assistant Director of Business Intelligence, Systems & IT confirmed they were estimated, although some were indicative. The Executive Director of Finance & Resources asked if the costs were less than the incumbent supplier and this was confirmed.<br><br>**Outcome:**<br>The Committee agreed to the Trust committing to formally joining the shared infrastructure and gave its recommendation to the Trust Board to sign off the proposal presented. | |
| 2018/19<br>**(56)** | **Project management**<br>**Projects report (Change Board)**<br>The Executive Director of Operations introduced a brief paper on Change Programme Board. A plan on a page was attached to give an overall summary.<br><br>**Administration review**<br>The Committee Chair asked about the proposal to commence consultation on the most senior roles within the structure. The Executive Director of Operations said that at the moment because of work within administration staff in different business units there were concerns about who would have overall responsibility for bringing people together into one professional department. It was recommended that consultation commenced on the most senior roles within the administration structure to bring additional leadership to the project.<br><br>A Non-Executive Director (RG) agreed with the proposal to have strategic leadership in place to support and influence the project.<br><br>**Digital innovation**<br>The Committee Chair noted that some of the examples of changes were not being followed through, ie. video conferencing or the use of Skype. The Executive Director of Operations said that organisational development support was needed for making those changes. There was a proposal of recruiting a project manager for a period of six months to support digital innovation and use of Skype. A Non-Executive Director (RG) advised that a clinical and service led proposal for digital solutions would be most supportive and be effective in delivering care.<br><br>The Committee Chair said that part of the remit of Change Board was to try to connect different pieces of work and achieve that synergy.<br><br>**Outcome:**<br>The Committee received an overview of the Trust's major change projects. The report provided the Committee with reasonable assurance, particularly around the plan on a page. No other issues had been escalated from the projects. | |

**56(b) – Patient administration update (presentation)**
The representatives from the patient administration team were welcomed by the Committee Chair to the meeting. The overall vision was the development of patient administration for the Trust and business support network around all the Trust services. The approach had been different for each of the business units.

The project team described the progress so far and how this had been communicated to staff.

The presentation covered the project management aspect, processes and framework, identified benefits realisation and a robust governance assurance structure including timelines and outline plans.

The Project Team described the challenges, including the time and resource required and the need for clarity of roles and responsibilities, and changes within services. The mobilisation phase was anticipated to start in April 2019.

The Committee Chair asked whether the project was receiving senior level support and remaining linked to other changes across Leeds primary care. It was noted that this had not been introduced in the city; work was based around the projects within the organisation. The Director of Workforce (JA) said the foundations should be put in place for career ladders.

A Non-Executive Director (RG) said there was a danger of everything ultimately not fitting together and asked if there was a framework. The Executive Director of Operations confirmed that the models that the patient administration team were working towards were clear. The patient administration team advised that it had to be flexible for project to move forward.

The Committee Chair reflected on the challenges identified and asked if there was enough support available in terms of delivery. The Operational Support Manager said that the plan is for everyone to be on core job description in the model; everyone to share standard operating procedures and in term of design model, options were being explored. The Executive Director of Operations said that there was a cost improvement plan (CIP) attached to the project but it had not been the main driver of the work. The Executive Director of Finance & Resources added that in his view there would be additional CIP next year that will require debate and challenge.

It was noted that the Service Manager and the Director of Workforce (JA) were undertaking a piece of work to clarify the model to try and introduce consistency in the three business units in achieving a fair rate of pay across the organisation. A Non-Executive Director (RG) said that the administration review team was on the right path and he offered his support.

**Outcome:**
The Committee recognised that there were some current difficulties with the project and the information provided to date gave only limited assurance towards the project.

**56(c) – Estates strategy and rationalisation plan including capital spend for 2019/29** (Please see private minutes).

**56(d) – Child and Adolescent Mental Health Service (CAMHS) Tier 4 update** (Please see private minutes).

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| 2018/19 **(57)** | **Performance management**<br>**Item 57a – Performance brief and domain reports**<br>The Executive Director of Finance and Resources introduced the report and said that the Senior Management Team (SMT) had noted concern about the number of staff leaving the Trust within the first 12 months of employment and had asked for further review of this over the next month. The Director of Workforce (JA) said that this appears to be a wider issue in the NHS, and she will provide an update at the Board meeting.<br><br>There was a good performance overall in the Trust. The high level summary highlighted good practice in safeguarding training, winter preparations and staffing which remained under review and the issue of turnover of staff within their first year with the Trust.<br><br>The Committee was pleased to learn that there had been good engagement with NHS Leeds Clinical Commissioning Group (CCG) at the Contract Management Board on 27 November 2018, and agreed to adjust the neighbourhood teams' activity level profile. CCG had formally accepted the review profile and LCH was complimented on the approach and the engagement between CCG staff and LCH to provide that level of understanding.<br><br>An updated paper will be provided to the December 2018 Trust Board meeting. The improved position was reflected in the October 2018 performance data.<br><br>**The Committee reviewed each domain in turn, as follows:**<br><br>**Safe and caring domains**<br>The Quality Committee received a clinical governance report at its meeting on 26 November 2018 which dealt with safe and caring domains. The Executive Director of Finance & Resources said that some of the details presented was to be merged so that this Committee could view the quality and business in a way that colleagues from Cambridge Community Services NHS Trust had advised. Work was continuing to further triangulate information and reflect variance and service level.<br><br>**Responsive domain**<br>The Committee noted that the Quality Committee had discussed the friends and family test, and that the percentage of staff recommending community care remained above target.<br><br>**Effective**<br>The measures in the effective domain were reported quarterly; there was no information reported this month.<br><br>**Well-led**<br>The Director of Workforce (JA) said that there was a national trend across other organisations concerning difficulties in retaining staff in their first 12 months of employment. Further analysis was required to link some of the triangulations with engagement levels and sickness levels. It was noted that permanent contracts had been offered to eight nursing associates. The Executive Director of Operations added that she was concerned about the neighbourhood teams' vacancy factor. There were a numbrt of initiatives in place to improve that position.<br><br>**Finance** | |

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| | The Executive Director of Finance & Resources said that the finance position was consistent with what had been reported previously. It was noted that the financial risk of £700k, a CCG income, had improved to circa £0.5m and that it was confirmed at the Contract Management Board meeting on 27 November 2018 that they would meet whatever the unreleased cost of that issue was.<br><br>**Outcome:**<br>The Committee was satisfied with most areas of progress in the performance brief.<br><br>**Item 57(b) – Improving Access to Psychological Therapies (IAPT) waiting times**<br>The Executive Director of Operations presented a paper that provided details of the issues she had raised at the last meeting about the current position of access waiting times and recovery rates. The Committee Chair asked if the waiting times issue would be a concern in the impending tender. The Executive Director of Operations advised that work was continuing with Commissioners on the action plan and it was noted that the Commissioners had accepted that this was not solely a provider issue. They felt they had not commissioned the correct capacity at level three. The Executive Director of Operations said that the action plan in place should improve the situation before year end.<br><br>**Outcome:**<br>The Committee noted that there was an action plan in place to get closer to being back on track by end of year.<br><br>**Item 57(c) – Operational and non-clinical risks register**<br>The Committee considered changes to non-clinical risks on the risk register as follows:<br>• Two new risks<br>• No risks have an increased score<br>• Three risks have a decreased score<br>• Three risks have been closed since the previous report<br><br>The Committee Chair queried the controls for risk 952, inconsistent criteria across LCH services regarding services provided to patients resident in care homes. It was recorded that planned actions included work with Commissioners to review the current situation and to identify actions for improvement. The Executive Director of Operations advised the Committee that the CQC system review may draw out some further actions.<br><br>**Outcome:**<br>The Committee noted the recent revisions made to the risk register.<br><br>**Item 57(d) – Reference costs and Item 57(e)**<br>This report provided an overview of the results of the 2017/18 Reference Costs exercise and the Committee was asked to note the published reference costs for the Trust's services.<br><br>The Executive Director of Finance & Resources said that it was interesting to note that the pattern across the three business units were same as previously reported.<br><br>**Item 57(e) - Corporate benchmarking**<br>The paper informed the Committee of the results of the 2017/18 corporate benchmarking exercise and for SMT to consider approaches to efficiencies | |

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| | required in the future. SMT's review of this report was that there were a few service areas that required exploring further. A Non-Executive Director (RG) asked whether the Trust was getting value for money with outsourced services. The Executive Director of Finance & Resources said that these were being evaluated.<br><br>**Outcome:**<br>The Committee received the report.<br><br>**Item 48(f) - Internal audit reports**<br>The reports provided details of the completed internal audits for Cyber security and assurance review of General Data Protection Regulation (GDPR) compliance. The Committee considered the aspects of the reports relating directly to the role and functions of the Business Committee.<br><br>A Non-Executive Director (RG) queried whether there was sufficient resource for GDPR. The Executive Director of Finance & Resources explained that there had been some staff absence but temporary cover was now in place.<br><br>**Outcome:**<br>The Committee noted the final internal audit assurance review. | |
| 2018/19 **(58)** | **Business Committee work plan**<br>**Future work plan**<br>The work plan was reviewed by the Committee members and no changes were requested.<br><br>**Outcome:**<br>The Committee agreed the work plan. | |
| 2018/19 **(59)** | **Matters for the Board and other Committees**<br>• Service support session (CUCS)<br>• Digital strategy update / Community Cloud<br>• Projects update<br>• Patient administration<br>• Estates strategy and rationalisation<br>• CAMHS Tier 4<br>• Performance brief | |
| 2018/19 **(60)** | **Any other business**<br>None recorded. | |

Leeds Community Healthcare NHS Trust

# Audit Committee

Agenda item 2018-19 (103c)

Boardroom, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
**Friday 19 October 2018**
**9.00am–11.30am**

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| **Present:** | Jane Madeley (JM) | Chair |
| | Richard Gladman (RG) | Non-Executive Director |
| | Professor Ian Lewis (IL) | Non-Executive Director |
| **In Attendance** | Bryan Machin | Executive Director of Finance and Resources |
| | Tim Norris | Internal Audit Manager (TiAA Limited) |
| | Beric Dawson | Counter Fraud Specialist (TiAA Limited) |
| | Matthew Moore | External Audit Manager (KPMG) |
| | Narissa Leyland | Head of Information Governance & Data Protection Officer (for items 36a&b and 39) |
| **Apologies:** | Peter Harrison | Head of Internal Audit (TiAA Limited) |
| | Clare Partridge | External Audit Partner (KPMG) |
| | Diane Allison | Company Secretary |
| **Minutes:** | Liz Thornton | Board Administrator |

| Item | Discussion Points | Action |
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| **2018-19** (33) | **Welcome, introductions and preliminary business**<br>The Chair of the Committee welcomed members and attendees. | |
| **2018-19** (33a) | **Apologies**<br>Apologies were noted from Peter Harrison, Clare Partridge and Diane Allison. | |
| **2018-19** (33b) | **Declarations of interest**<br>There were no declarations of interest made in relation to any items on the agenda. | |
| **2018-19** (33c) | **Minutes of the previous meeting 20 July 2018**<br>The minutes of the meeting held on 20 July 2018 were reviewed and agreed as an accurate record. | |
| **2018-19** (33d) | **Actions' log**<br>The Chair of the Committee asked that verbal updates be given on the actions agreed at the previous meeting:<br>• *Audit of emergency planning:* The Executive Director of Finance and Resources confirmed that he had discussed with the Executive Director of Operations the concerns raised regarding the mapping process for any tests performed and where the results were reported. The Executive Director of Operations had advised that she felt that mapping processes were adequately covered in the Major Incident Plan but that currently no group had responsibility for oversight of the systematic testing process or received formal reports. | |

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| | The Chair of the Committee asked for the Senior Management Team (SMT) to review oversight of major incident testing, and recommend where results should be reported in order to ensure that there was a clear record of lessons learnt. An update on this should be provided to the Business Committee.<br><br>**Action:** Executive Director of Finance and Resources to ask the SMT to consider where oversight of major incident testing should sit including where testing results will be reported and implementation of actions will be monitored. An update report to be made available to the Business Committee.<br><br>• *Audit of data quality:* The Internal Audit Manager confirmed that he had discussed clinical audit with Non-Executive Director (IL), in his role as Chair of the Quality Committee including the terms of reference for the audit.<br><br>• *Audit of corporate governance – SMT terms of reference:* Following a decision by the Chief Executive not to adopt the recommendation that terms of reference be developed for the Senior Management Team (SMT), the Committee was provided with a paper which outlined SMT functions. The Committee discussed the summary paper which had been drafted.<br><br>• *Internal audit actions update report:* cyber security incident response management: The Executive Director of Finance and Resources reported that the Trust was now planning an earlier test of cyber security incident plans and procedures to be undertaken in January 2019.<br><br>**Action:** A test of cyber security and incident plans to be conducted in January 2019 a report to be made available to the Audit Committee on 15 March 2019.<br><br>• *Charitable Funds annual report and accounts: letter of representation:* the Executive Director of Finance and Resources reported that the Trust's charity was not an auditable charity and therefore further disclosure regarding fund raising was not a requirement. He added that it could be considered as good practice to follow the disclosure requirements in relation to fund raising activities and this would be considered in future.<br><br>• *Board assurance framework report 2018/19:* the Executive Director of Finance and Resources confirmed that the lead directors had reviewed the initial and current risk scores and that the Quality and Business Committees had undertaking a thorough review of the consistency of the scoring of risks, whether the controls were adequate and in light of the controls in place whether the target score was realistic.<br><br>There were no other matters arising from the minutes. | **Executive Director of Finance and Resources**<br><br>**Executive Director of Finance and Resources** |
| **2018-19**<br>(34a) | **Internal audit**<br>**Summary of Internal Controls assurance report**<br>The Internal Audit Manager introduced the report and advised that four audits had been completed: Clinical Effectiveness Group, Estates Management, Complaints Management and Payroll (follow up audit). The Committee discussed the executive summaries and management actions included in the report and noted that three of these indicated a reasonable assurance opinion, one audit; payroll was a follow up audit.<br><br>*Clinical Effectiveness Group* (CEG)<br>This audit had been determined as reasonable assurance with two | |

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| | recommendations, relating to the attendance at CEG meetings and the clarity and structure of the minutes of meetings.<br><br>A Non-Executive Director (IL), in his role as Chair of the Quality Committee reported that the Committee had reviewed the audit on 22 October 2018. The Quality Committee had taken assurance that the CEG was operating effectively and the group was able to provide assurance on clinical effectiveness. The Quality Committee was also satisfied that in relation to the two important recommendations about core membership, attendance and the structure and clarity of the meeting minutes the issues had all been addressed.<br><br>*Estates Management*<br>The audit had been assessed as reasonable assurance with four important recommendations relating to fire risk assessments and two routine recommendations relating to building service and maintenance schedules and targeted fire risk assessments to high risk areas within buildings.<br><br>The Chair of the Committee sought assurance that that the three outstanding fire risk assessments due for completion in 2018 would be completed by 31 December 2018.<br><br>The Executive Director of Finance and Resources advised that a programme and action plan was in place to ensure that this was the case.<br><br>**Action:** The Executive Director of Finance and Resources to provide a verbal update report on the progress to complete fire risk assessments by the 31 December 2018 at the next Audit Committee meeting.<br><br>In response to a question from a Non-Executive Director (IL), the Executive Director of Finance and Resources advised that the terms of reference for the audit did not include assessments of the buildings as this formed part of a separate estate management process.<br><br>The Chair of the Committee noted that the audit would be reviewed by the Business Committee on 24 October 2018. It was agreed that the Health and Safety Group should also have sight of the audit report.<br><br>**Action:** The Executive Director of Finance and Resources to share the audit report with the Health and Safety Group.<br><br>*Complaints Management*<br>The Committee noted that the audit had been assessed as reasonable assurance with two important recommendations relating to the risk assessment of complaints and completing action plans on Datix, and four routine recommendations relating to improving the dissemination of lessons learned and improving the functions within Datix.<br><br>Noting that complaints were a crucial measure of quality performance, the Committee expressed particular concern about the range of issues raised in the audit report and thought the implementation timetable associated with the management responses would not address the issues quickly enough.<br><br>The Chair of the Committee noted that the Quality Committee would receive the Complaints Management audit report at its next meeting on 26 November 2018, and the Chair of the Committee asked the Chair of the Quality Committee (IL) to provide a verbal update on the outcome of its review of the recommendations from | **Executive Director of Finance and Resources**<br><br>**Executive Director of Finance and Resources** |

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| | the audit at the next meeting of the Audit Committee.<br><br>**Action:** The Chair of the Quality Committee (IL) to provide a verbal update on the outcome of the Quality Committee's review of the recommendations from the Complaints Management audit at next meeting of the Audit Committee.<br><br>*Payroll Audit – follow up*<br>This was a follow up review to consider whether the management actions taken addressed the control issues which gave rise to the recommendations contained in the audit completed in March 2018. Six of the seven recommendations from the original audit had been implemented. The Chair of the Committee asked for a further update and revised implementation timetable for the outstanding recommendation, which would require a change in the national ESR software, to be provided to the Audit Committee at its next meeting.<br><br>**Action:** A further update and revised implementation timetable for the outstanding recommendation to be provided for the next meeting of the Audit Committee.<br><br>The Committee reviewed progress against the Internal Audit *Annual Plan for 2018/19* and noted that draft reports had been issued for three further audits: Collaborative Partnership Working, Cyber Security and Clinical Audit. All three indicated a reasonable assurance opinion and should be presented to the appropriate Board sub-committee in November 2018 and the Audit Committee on 14 December 2018.<br><br>A Non-Executive Director (RG) asked if there was confidence that all audits planned would be completed within the financial year as some had been moved to later in the year. The Internal Audit Manager responded that he was confident all audits would be completed in year and the Executive Director of Finance and Resources confirmed that any proposed changes to the timings of audits had been discussed and agreed with him.<br><br>The Chair of the Committee commented that scheduling of audits was improving but remained concerned that audits were presented to the Audit Committee without the benefit of prior review by the Business or Quality Committee where appropriate.<br><br>**Outcome:** The Committee noted the contents of the summary Internal Controls assurance report, including conclusion of four audits and progress against the Internal Audit Plan for 2018/19. | **Non-Executive Director (IL)**<br><br>**Executive Director of Finance and Resources** |
| **2018-19**<br>(34b) | **Internal audit actions report**<br>The Executive Director of Finance and Resources introduced the report and the Committee members discussed the following recommendation:<br><br>*Managing waiting times - CAMHS*<br>The Committee noted work had been undertaken with the CAMHS teams to ensure the requirement for four appointments per day was fully understood. Annual leave during July and August had impacted on the delivery of this but it would be a key focus of work during Q3.<br><br>It was noted that the revised deadline of 31 December 2018 had been proposed.<br><br>**Outcome:** The Committee noted the status report. | |
| **2018-19**<br>(35) | **External audit technical update**<br>The External Audit Partner introduced the health sector external audit technical | |

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| | update for information.<br><br>A Non-Executive Director (RG) noted the reference in the section on temporary staffing agencies and the requirement for Trust Chief Executives to sign off any shifts which cost more than £100 an hour and report these to NHS Improvement. He asked whether the Trust had considered whether this requirement could be triggered by locum shifts.<br><br>**Action:** The Executive Director of Finance and Resources agreed to check and report back to the next Audit Committee.<br><br>**Outcome:** The Committee noted the technical update. | **Executive Director of Finance and Resources** |
| **2018-19**<br>(36a) | **Data Security and Protection Toolkit- baseline assessment**<br>The Head of Information Governance and Data Protection Officer presented the report which set out the plan in place to achieve the necessary compliance with the Data Security and Protection Toolkit (DSPT). She explained that the DSPT had replaced the IG Toolkit as a mechanism for NHS organisations to asses themselves against the standards of compliance with information governance.<br><br>The Committee discussed the Trust's baseline assessment which showed compliance with eight out of thirty-two mandatory assertions within the ten data standards by 31 October 2018 and noted the plans and work programme in place to ensure full compliance by 31 March 2019.<br><br>**Outcome:**<br>The Committee:<br>• approved the submission of the DPST baseline assessment report to NHS Digital on 31 October 2018<br>• received reasonable assurance that the Trust has a plan in place to achieve the necessary compliance with the mandatory requirements for this reporting year by 31 March 2019. | |
| **2018-19**<br>(36b) | **GDPR update**<br>The Head of Information Governance and Data Protection Officer introduced a progress report which outlined the Trust's actions to ensure compliance with GDPR legislation.<br><br>The Committee was informed that significant progress had been made with regard to the data mapping exercises throughout the organisation, with 65% completed by 31 October 2018. The Committee also received assurance that all exercises would be completed by mid-November 2018 which would allow publication of the Trust's data processing activities by 30 November 2018.<br><br>The Head of Information Governance and Data Protection Officer confirmed that she believed that the Trust could demonstrate to the Information Commissioner's Office (ICO), if requested, that it was making sufficient progress with the requirements of GDPR. A further update would be provided to the Committee in December 2018, by which time an internal audit report on progress will have been completed and the key findings from the data mapping exercise will be summarised and reported.<br><br>**Action:** A further update to be provided to the next meeting of the Committee to include the findings from the internal audit report on progress and a summary of the key findings from the data mapping exercise. | **The Head of Information Governance and Data Protection Officer** |

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| | **Outcome:** The Committee received assurance that the Trust's GDPR plans are robust and being delivered. | |
| **2018-19** (37a) | **Counter fraud mid-year update**<br>The Committee received a mid-year report from the Local Counter Fraud Specialist (LCFS); the report included a schedule of training and communications actions to raise awareness of counter-fraud and bribery prevention amongst staff. The Committee noted there were no formal investigations so far in 2018/19 although the LCFS reported that referrals had been made but that none had required an investigation.<br><br>The Chair of the Committee noted that TIAA Cyber specialists had undertaken a cyber security maturity assessment on how cyber risks are managed in the Trust. The Chair of the Committee asked for the report of their findings to be made available to the next Audit Committee meeting .<br><br>**Action:** A report on the findings from the TIAA Cyber security maturity assessment to be made available to the next Audit Committee meeting.<br><br>**Outcome:** The Committee noted the mid-year update report. | **Executive Director of Finance and Resources** |
| **2018-19** (38a)<br><br>**2018-19** (38b) | **Financial controls**<br>**Losses and special payments report**<br>The Executive Director of Finance and Resources introduced the report which contained one transaction for the period July to September 2018 of £4,219 credit. This was a reimbursement in respect of a clinical negligence claim by NHS Resolution.<br><br>**Outcome:** The Committee noted the report.<br><br>**Tenders and quotations waivers**<br>The Executive Director of Finance and Resources introduced the report and highlighted the three items on the Tender/Waiver Register.<br><br>**Outcome:** The Committee noted the report. | |
| **2018-19** (39) | **Minutes of noting**<br>**Information Governance Group: 14 August 2018 (draft)**<br>The minutes were noted and no questions raised.<br><br>The Chair of the Committee asked the Head of IG and Data Protection Officer if a summary of actions could be included on the front page of the minutes in future.<br><br>**Action:** A summary of actions to be included as a front page to the minutes in future.<br><br>**Outcome:** The draft minutes of the Information Governance Meeting on 14 August 2018 were noted. | **The Head of Information Governance and Data Protection Officer** |
| **2018-19** (40) | **Committee's Workplan**<br>There were no items removed or changes made to the workplan. | |
| **2018-19** (41) | **Matters for the Board and other committees**<br>The Chair noted the following items to be referred to Board colleagues:<br>• Internal Audit update<br>• General Data Protection Regulation (GDPR) update | |

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| | • Counter Fraud mid-year update<br>• Data Security & Protection Toolkit baseline assessment - approval of the submission on compliance to NHS Digital by 31 October 2018. | |
| **2018-19**<br>(42) | **Any other business**<br>There were no matters of any other business raised.<br><br>The Committee noted that the meeting on 14 December 2018 would start at 8.30am and finish at 10.30am. | |
| | **Date and time of next meeting**<br>Friday 14 December 2018 8.30 am – 10.30 am<br>Boardroom Stockdale House Leeds LS6 1PF<br>Stockdale House<br>Leeds LS6 1PF | |

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NHS
Leeds Community Healthcare
NHS Trust

**Charitable Funds Committee**

**AGENDA ITEM 2018-19 (103d)**

**Tuesday 30 October 2018**
**Meeting Room 1, Stockdale House**
**11:30 – 13:00**

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| Present | Brodie Clark | Committee Chair / Non-executive Director |
| | Neil Franklin | Trust Chair |
| In attendance | Bryan Machin | Executive Director of Finance and Resources |
| | Steph Lawrence | Acting Executive Director of Nursing |
| Minutes | Nicola Wood | PA to Acting Executive Director of Nursing |
| Apologies | None | |

| Item no | Discussion item | Actions |
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| **2018-19 (11i)** | **Welcome and Apologies**<br>The Committee Chair opened the meeting and welcomed the members.<br>There were no apologies to note. | |
| **2018-19 (11ii)** | **Declarations of Interest**<br>There were no declarations of interest received. | |
| **2018-19 (11iii)** | **Minutes of meeting held on 22 June 2018**<br>The minutes were reviewed for accuracy and it was acknowledged that there were a number of areas that lacked clarity; this was partly due to a changeover of key lead personnel.<br>The following amendments to the draft minutes were agreed:<br>• Date to be amended to 2018<br>• Minutes to be made more presentable and points clarified where necessary | |
| **2018-19 (11iv)** | **Matters arising and review of action log**<br><u>2016-17 (28iii) More than a welcome</u><br>The Committee discussed this action and the Acting Executive Director of Nursing agreed to progress this with the new Patient Engagement Manager once in post.<br>**Action: Acting Executive Director of Nursing to progress this work stream with the new Patient Engagement Manager once in post. Update to be given at December meeting.**<br><br><u>2016-17 (37) Charity development update</u><br>The Committee Chair highlighted that the Charity Development Group meeting he was due to attend had been cancelled. There was a discussion around how robust the group was and how it was operating. The Committee Chair confirmed that this action still stood. The Acting Executive Director of Nursing agreed to make further enquiries into the group and ensure the Committee Chair received an invite to the next meeting.<br>**Action: Acting Executive Director of Nursing to make further enquiries into the existence and functionality of the Charity Development Group and ensure the Committee Chair is invited to the next meeting.**<br><br><u>2017-18 (12iv) Charity development update</u><br>The Executive Director of Finance and Resources provided an update on this action for the Committee. A six facet survey of the Trust's owned premises had been organised and a technical assessment and formal consultation into the | **Acting Executive Director of Nursing**<br><br>**Acting Executive Director of Nursing** |

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| | condition of the premises would be conducted. The Executive Director of Finance and Resources pointed out that the results of these surveys were from the staff members' perspective and indicated that the patients' experiences of the Trusts health centre waiting areas were the missing element. Once finalised, the report would form part of the estates work plan that would be presented to Business Committee.<br><br>The Committee Chair agreed that the report would provide greater assurance that the buildings were 'fit for purpose' however noted that there was still work to be done to improve the general ambience of the waiting areas. The Executive Director of Finance and Recourses and the Acting Executive Director of Nursing agreed to look into this aspect in more depth.<br>**Action: Executive Director of Finance and Recourses to look into making improvements to the general ambience of the health centre waiting areas.**<br><br>The Executive Director of Finance and Resources reported that recruitment of three building managers, who would form part of the Estates Team, was underway. Two posts had been appointed and one post would be filled within the coming weeks.<br><br><u>2017-18 (15d) Meeting with Chair of the Charitable Funds Committee at Leeds Teaching Hospitals Trust (LTHT)</u><br>The Acting Executive Director of Nursing confirmed that a meeting with the Chief Executive of the Leeds Cares Charity at LTHT had been arranged and would take place on 8 November 2018. The Acting Executive Director of Nursing agreed to report the outcome back to the Committee at the next meeting.<br>**Action: Acting Executive Director of Nursing to report the outcome of the meeting with the Chief Executive of the Leeds Cares Charitable Funds Committee at LTHT back to the Committee at the next meeting.**<br><br><u>2018-19 (03) Charitable Funds application process</u><br>Action competed.<br><br><u>2018-19 (06) Charitable Funds request for funding</u><br>The Committee noted from the Finance Report that there had been substantial refurbishment work completed at Hannah House. Action completed.<br><br>The Committee Chair drew the Committee's attention to the colour coding of the action log and particularly the actions not progressing to timescale. The Acting Executive Director of Nursing and the Personal Assistant agreed to review the action log.<br>**Action: Acting Executive Director of Nursing and Personal Assistant to review the colour coding on the action log.** | **Executive Director of Finance / Resources**<br><br>**Acting Executive Director of Nursing**<br><br>**Acting Executive Director of Nursing / PA** |
| **2018-19 (12)** | **Charity development update**<br>The Committee acknowledged that due to the changeover of key lead personnel there was no update on the Trust's charity development.<br><br>The Acting Executive Director of Nursing emphasised that she would be in a better position to be able to provide an update at the next meeting, following discussions with the Chief Executive of the Leeds cares Charity at LTHT on 8 November 2018. There was a discussion around progression of work towards an 'in house' lottery scheme. The Committee noted that although there had already been some | |

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| | significant work, it now needed to be led more robustly to a successful conclusion.<br><br>The Committee acknowledged that, as a priority, there needed to be a renewed focus on the Charity Development Group and that it should be strongly linked with the Trust's patient engagement and involvement agenda. The Acting Executive Director of Nursing reported that once in post, the new Patient Engagement Manager would be the catalyst for progressing this work.<br><br>There was a discussion around the potential benefits of being part of the wider Leeds health charity by consolidating the Trust's charity with that at LTHT. The Trust Chair highlighted that because of the way in which health care was now being delivered in Leeds through partnerships, there was already strong established relationships that would support the integration of these services. In response to a query from the Trust Chair, the Acting Executive Director of Nursing confirmed that she felt confident in holding such conversations with the Chief Executive of the Leeds Cares Charity at LTHT at the meeting on 8 November 2018.<br><br>The Committee Chair expressed some concern around work streams not being progressed if there was a proposal to consolidate the Trust's charity with that at LTHT. The Trust Chair acknowledged the need to have preliminary discussions, but emphasised that the Trust would need to have 'something to offer' therefore the work would need to be progressed as a priority.<br><br>The Trust Chair suggested that the Clinical Leads of services should give some thought to how they might be involved in a charitable fund raising enterprise.<br><br>The Committee Chair summarised the four priority areas for the Charitable Funds Committee:<br>• Progress work on an 'in house' lottery scheme.<br>• Renewed focus on the Charity Development Group linked with the Trust's patient engagement and involvement agenda.<br>• More than a welcome programme: the general ambience of the health centres to be grafted into the estates remit alongside the fit for purpose work.<br>• Liaison with the Leeds Cares Charitable Funds Committee at LTHT to be progressed. | |
| **2018-19 (13i)** | **Finance report**<br>The Committee received the report.<br><br>The Executive Director of Finance and Resources drew the Committee's attention to two points in the report:<br><br><u>£1000 expenditure for Wi-Fi at Hannah House</u><br>The Executive Director of Finance and Resources indicated that the Trust received a capital grant and agreed to explore if a refund should be made to the Hannah House budget.<br>**Action: Executive Director of Finance and Resources to explore if a refund should be made to the Hannah House budget for the £1000 Wi-Fi expenditure.**<br><br><u>Donations made to the Trust Charity</u><br>The Executive Director of Finance and Resources raised a query around what action the Trust took in relation to acknowledgement of donations received and agreed to investigate this further.<br>**Action: Executive Director of Finance and Resources to review what action the Trust took in response to donations received.** | **Executive Director of Finance and Resources**<br><br>**Executive Director of Finance and Resources** |

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| | The Committee Chair queried some of the expenditure transactions and requested assurance that an adequate approval process was in place. The Acting Executive Director of Nursing agreed to provide this assurance at the next meeting.<br>**Action: Acting Executive Director of Nursing to provide assurance that an adequate approval process was in place for the Trusts charitable expenditures.** | **Acting Executive Director of Nursing** |
| **2018-19 (13ii)** | **Annual report and accounts**<br>The Committee noted and accepted the annual report and accounts. | |
| **2018-19 (13iii)** | **Letter of representation**<br>The Executive Director of Finance and Resources presented the letter of representation to the Committee and recommended the Committee approve it.<br><br>The Committee approved the letter and this was signed by the Committee Chair. | |
| **2018-19 (13iv)** | **Letter of comment**<br>The Executive Director of Finance and Resources presented the letter of representation to the Committee for noting. | |
| **2018-19 (14)** | **Purpose and direction of the Charitable Funds Committee**<br>The Committee Chair reported that a meeting had been scheduled for him to discuss the Purpose and direction of the Charitable Funds Committee with the Chief Executive and Executive Director of Finance and Resources; however this had been cancelled so the conversation had not taken place.<br><br>The Executive Director of Finance and Resources suggested that a proposal should go to the Senior Management Team once the Acting Executive Director of Nursing had reconnected with the Chief Executive of the Leeds Cares Charity at LTHT.<br><br>In response to a query from the Committee Chair, the Executive Director of Finance and Resources confirmed that there was no legal requirement to have a charitable function within the Trust.<br><br>The Committee agreed that it was important there was an 'in principle' side to the charity and more than just the function of funds. The Committee Chair and Trust Chair offered their support to the Executive Director of Finance and Resources and the Acting Executive Director of Nursing in identifying how this could be successfully achieved. | |
| **2018-19 (15)** | **Matters for the Board**<br>The Committee Chair agreed to summarise matters for Trust Board. | |
| **2018-19 (16)** | **Any other business**<br>None recorded. | |
| | **Dates and times of next meeting**<br>Friday 14 December<br>10:30-12:00<br>Meeting Room 1 Stockdale House | |