NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (held in public)
Friday 5 October 2018, 9.00am – 11.45am
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2018-19 (46)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2018-19 (47)	Declarations of interest	Neil Franklin	N
9.10	2018-19 (48)	Questions from members of the public	Neil Franklin	N
9.15	2018-19 (49)	Patient's story: Health Case Management Team	Steph Lawrence	N
9.30	2018-19 (50)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 3 August 2018 and 7 September 2018 b. Actions' log c. Committees' assurance reports: i. Quality Committee: 24 September 2018 ii. Business Committee: 26 September 2018	 Neil Franklin Neil Franklin Ian Lewis Brodie Clark	 Y Y Y Y
		Quality and delivery		
9.50	2018-19 (51)	Chief Executive's report – including seasonal resilience	Thea Stein	Y
10.00	2018-19 (52)	Leeds Providers Integrated Care Collaborative - Committees in Common: Memorandum of Understanding	Thea Stein	Y
10.10	2018-19 (53)	Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common: Memorandum of Understanding	Thea Stein	Y
10.20	2018-19 (54)	Performance brief and domain reports	Bryan Machin	Y
		Strategy and planning		
10.35	2018-19 (55)	Report on Delivery of 2018/19 Operational Plan Priorities	Bryan Machin	Y
10.45	2018-19 (56)	Organisational development strategy: draft framework document	Laura Smith/ Jenny Allen	Y
10.55	2018-19 (57)	Workplace Race Equality Standard (WRES): update report	Laura Smith/ Jenny Allen	Y
		Reports		
11.00	2018-19 (58)	Emergency preparedness annual report 2017/18	Sam Prince	Y
11.10	2018-19 (59)	Infection prevention and control annual report 2017/18	Steph Lawrence	Y
11.20	2018-19 (60)	Safeguarding annual report 2017/18	Steph Lawrence	Y
		Governance		
11.30	2018-19 (61)	Significant risks and assurance report	Thea Stein	Y
11.40	2018-19 (62)	Board workplan	Thea Stein	Y
		Minutes		
11.45	2018-19 (63)	Approved minutes (for noting): a. Quality Committee: 25 June and 23 July 2018 b. Business Committee: 27 June and 25 July 2018 c. Leeds Health and Wellbeing Board: 14 June 2018	Neil Franklin	 Y Y Y
11.45	2018-19 (64)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 7 December 2018, 9.00am-12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PF

Leeds Community Healthcare NHS Trust

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

AGENDA ITEM 2018-19 (50ai)

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

Friday 3 August 2018, 9.00am – 11.30am

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
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Interim Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development (OD) and System Development
Apologies:	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Jenny Allen	Director of Workforce, OD and System Development
In attendance:	Diane Allison	Company Secretary
	Sam Austin	Palliative Care Lead (for Item 23)
	Clare Redmond	Neighbourhood Palliative Care Lead (for Item 23)
	Carolyn Nelson	Head of Medicines Management (for Item 34)
Minutes:	Liz Thornton	Board Administrator
Observers:	Katherine Sheerin	Interim Director of Strategy, NHS Leeds Clinical Commissioning Group
	Roohi Collins	Insight Programme participant
	Sophia Nichols	Development Lead, Organisational Development
Members of the public:	One member of the public was in attendance	

Item	Discussion points	Action
2018-19 (20)	**Welcome and introductions** The Chair welcomed Board members, observers and one member of the public to the meeting. **Apologies** Apologies were noted from Richard Gladman, Professor Ian Lewis and Jenny Allen. **Opening remarks** The Chair welcomed Ruth Burnett, Interim Executive Medical Director and Laura Smith, Director of Workforce, OD and System Development who were attending	

	their first meeting as new members of the Board. The Chair agreed to re-order the agenda as set out in these minutes to allow Item 34: Research and development strategy update to be taken after Item 24.	
2018-19 (21)	**Declarations of interest** A Non-Executive Director (JM) declared an interest in Item 26 in relation to the involvement of the University of Leeds in the development of the Leeds Health and Social Care Academy and Item 34 in relation to the Trust's research links with the University of Leeds and her position on the Board of the National Institute for Health Research Clinical Research Network (NIHR CRN). There were no declarations of interest made in relation to any items on the agenda.	
2018-19 (22)	**Questions from members of the public** There were no questions from the member of the public in attendance.	
2018-19 (23)	**A patient's story** The Executive Director of Nursing introduced the patient's story item and welcomed Sam Austin, Palliative Care Clinical Lead and Clare Redmond, Neighbourhood Palliative Care Lead to the meeting to speak about the end of life care they were providing to a patient at home. The Neighbourhood Palliative Care Lead explained that the patient concerned was still receiving care and was content for the team to speak about their experience. End of life care can be delivered at home by neighbourhood teams under a multi-disciplinary approach where care is designed to focus on the patient's wishes and preferences. This particular story related to a patient who was given a terminal diagnosis in hospital following surgery and radiotherapy and had initially been discharged to a hospice but wished to spend some time at home before returning to the hospice as their preferred place of death. The Palliative Care Lead described how the discharge was handled in terms of communication between the hospital, the hospice and the GP practice. About the development of care and pain management plans, listening to the patient's wishes and balancing the concerns and emotional welfare of the family. She explained that arranging discharge from the hospice had not been as smooth as the family or the team would have wished for a number of reasons, including a lack of availability of a care agency to support the Neighbourhood Team in delivering safe and effective care in the patient's home, sourcing the necessary equipment and staff capacity issues. Feedback from the family had been very positive. The patient and family members had felt fully involved in every aspect of the care they had received which was being delivered with dignity and in the right place. A Non-Executive Director (BC) noted the comments made about the challenges the team faced in co-ordinating various services to support the transfer from the hospice to home and wondered what more support could be provided to make it easier, quicker and more efficient. The Executive Director of Operations said that in certain areas of the city care agencies did not have the capacity to meet the demand for care. The Trust was working with Leeds City Council to look at increasing patient flow through the	

	system. The Trust was also looking to increase the number of support staff in the neighbourhood teams. In response to a question from the Chief Executive, the Neighbourhood Palliative Care Lead said that she felt that relationships with GP practices were, on the whole, very positive and in this case she had been able to attend regular meetings which had ensured the continuity of care for the patient. The Chair thanked the team on behalf of the Board for taking the time to attend and tell such a powerful story about the care and support they provided to allow patients to die in their preferred place. He said that he was very encouraged by what he had heard and commended all the staff who worked in this emotionally challenging environment for the excellent care they provided.	
2018-19 (24) **(24a)** **(24b)** **(24c)**	**Minutes of the previous meeting held on 25 May 2018 and matters arising** **Minutes of the previous meeting held on 25 May 2018** The minutes were reviewed for accuracy and agreed to be a correct record subject to the following amendment: <u>Item 2018-19 (5ci): Performance Brief April 2018 (safe domain)</u> Amend wording: the Committee was advised that there had been a 42.8% reduction in avoidable ***category 3*** pressure ulcers during 2017-18. Managing avoidable pressure ulcers remained a key priority for the Trust and the target for 2018-19 of 10 avoidable **category 3** pressure ulcers was a challenging one. **Items from the actions' log** ***Item 2018-19 (97): Significant risk and risk assurance report – CAMHS Tier 4*** The Executive Director of Finance and Resources reported that it was unlikely that the cost of the new CAMHS Tier 4 unit could be contained within the existing allocation of £13 million. He advised that the Trust and Leeds and York Partnership NHS Foundation Trust were currently exploring options for managing the extra costs within existing capital resources. In response to a question from the Chair, the Executive Director of Finance and Resources confirmed that the plan was for the unit to be handed over to the Trust in Spring 2020 and be fully operational by Summer 2020. In response to a question from a Non-Executive Director (JM), the Executive Director of Finance and Resources said that the financial arrangements would be considered in detail by the Business Committee and recommendations made to the Board for final approval. The completed actions from previous meetings were noted. There were no other matters arising from the minutes. **Assurance reports from sub-committees** **Item 24c(i) – Charitable Funds Committee held 22 June 2018** The report was presented by the Chair of the Committee and Non-Executive Director (BC) who drew the Board's attention to the key issues, namely: • **More than a welcome** – an event for front of house staff had taken place in April 2018 which had provided an important opportunity for staff to engage with John Lewis. • **Future work** – the Committee had discussed the future direction of charity work in the Trust and agreed that this should be discussed further by the Senior Management Team (SMT). • ***Future collaboration with Leeds Teaching Hospitals NHS Trust (LTHT)*** – the Executive Director of Nursing provided an update on a meeting with	

the Chief Executive of Leeds Cares, formerly known as Leeds Hospital Charitable Foundation. Discussions had included the potential for more partnership working and the opportunity for joint fund raising initiatives. Any proposals would be reported to the Board.

Item 24c(ii) – Nominations and Remuneration Committee held 22 June 2018
The report was presented by the Chair of the Committee and Trust Chair who drew the Board's attention to the key issues, namely:

- **The Chief Executive's and Director's appraisals and performance** – outcomes had been reported to and noted by the Committee.
- **Clinical Excellence Awards** – the Committee had ratified the awards made by the panel. A full report would be presented to the Board meeting held in private on 5 October 2018.

Item 24c(iii) – Audit Committee held 20 July 2018
The report was presented by the Chair of the Committee and Non-Executive Director (JM) who highlighted the key issues discussed, namely:

- **Internal audit** – the Committee had reviewed the report on Emergency Response Planning which had received a limited assurance opinion and had asked the SMT to review testing of the major incident plan and any resultant learning.
- **Charitable Funds accounts** – the Committee received the annual report and accounts for the Trust's charity and had recommended adoption of the accounts by the Charitable Funds Committee at its next meeting in September 2018.
- **GDPR update** – the Committee had received an update report on the Trust's actions to ensure compliance with the GDPR legislation which came into effect on 25 May 2018. A further report would be provided to the Committee in October 2018.
- **Board Assurance Framework (BAF)** – the Committee had undertaken the formal annual review of the BAF. Key controls and sources of assurance had been re-appraised along with gaps in controls and sources of assurance. The Committee reviewed the Strategic Risks in detail and requested further work to be done with SMT to ensure that there was a common approach to the risk scoring – initial, current and target – and that Directors should ensure that actions listed under gaps in controls or gaps in assurance should aim to be sufficient to achieve the target risk score.

Item 24c(iv) – Quality Committee held 23 July 2018
The report was presented by the Deputy Chair of the Committee and Non-Executive Director (TD) who highlighted the key issues discussed, namely:

- **Service spotlight –** the Committee had received a presentation from the Health Case Management Team, a relatively new service which operated seven days a week, providing timely case management for patients who are eligible for NHS fast track and continuing healthcare funding. The Committee had heard about how the team were being supported through a period of change and the challenges they faced including increasing demand for the service in terms of end of life case management activity.
- **Performance brief April 2018 (safe domain) –** the Committee was advised that two category 3 pressure ulcers were reported in June 2018 which were currently under investigation and no avoidable category 4 pressure ulcers. A change in the reporting process for VTE assessments had meant that the percentage reported was inaccurate but the Committee had received assurance that this was a recording issue and not a patient safety issue.
- **Little Woodhouse Hall CQC visit –** the Committee had been briefed on the CQC's unannounced Mental Health Act (MHA) inspection in June 2018.

	Issues identified by the inspectors included the need to repeat MHA rights to young people, the need to alleviate boredom and issues concerning the ethics of 'blanket' restrictions of certain items. An action plan had been developed and the committee received reasonable assurance from the report provided. • **Clinical Audit –** the Committee had been concerned about the lack of progress on the 2017-18 clinical audit programme. The update presented to the Committee showed that the clinical audit programme had been delivered and achieved by the end of quarter 4. • **Quality Improvement Plan (QIP) –** the Committee received an update on the outstanding 'must do' and 'should do' actions set out in the QIP plan. Issues that remained outstanding included compliance with training. The Committee noted that the Quality Challenge Plus visits were focussing attention on the QIP areas when services were visited. **Item 24c(v) – Business Committee held 25 July 2018** The report was presented by the Chair of the Committee and Non-Executive Director (BC) who highlighted the key issues, namely: • **Workplace Race Equality Standard (WRES) –** the Committee had received an update on the Trust's current performance against the nine indicators. The Committee had agreed that WRES indicator 1 should be included in the performance brief and offered its support in addressing the issues raised in the report. An action plan would be presented to the Committee in September 2018. The Director of Workforce, OD and System Development (LS) reported that a working group had already met and an action plan had been developed to address the concerns raised in the report presented to the Committee. A further update would be provided to the Board on 5 October 2018. **Action: A further update on the Trust's performance against the WRES indicators to be provided to the Board on 5 October 2018.** • **Neighbourhood teams –** the Committee had discussed what would be expected of the teams in the new world of collaborative business delivery. The Committee recognised the pressures faced by the teams in terms of protecting the delivery of core services against the need to transform and work more closely with partners such as local care partnerships. The Committee would maintain a focus on this issue. • **Podiatry update –** the Committee received an update on the new foot protection service, staff training in health coaching to promote self-management and the service's participation in a joint LCH/commissioner 'roadmap' review. • **Board Assurance Framework (BAF) –** following a recommendation by the Audit Committee that the SMT review BAF scores to ensure that there was a common approach to scoring and that actions listed under gaps in control were sufficient to achieve the target score, the Committee had agreed to undertake some further work on scrutinising its responsibilities within the report. **Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted.	**Director of Workforce, System Development and OD (LS)**
2018-19 (34)*	**Research and development strategy** The Head of Medicines Management presented the paper which reported on the	

Brought forward	progress of the Research and Development strategy (2015-2018) implementation plan from August 2017 to July 2018. The Head of Medicines Management advised that after an initial period of significant change both locally and nationally, which had slowed momentum and anticipated progress, work had gathered momentum during 2016-17 with accruals significantly over targets reported in the last report. The Board discussed the challenges facing the Trust in achieving the strategic aims of the strategy. In response to a question from a Non-Executive Director (BC), a Non-Executive Director (TD) confirmed that the Quality Committee received an implementation update twice a year and the Chair of the Committee, Non-Executive Director (IL) had met with the Head of Research and Development to discuss the current and new strategy for 2019-22. A Non-Executive Director (JM) noted that the external funding allocations from the NIHR CRN had fallen for 2018-19 and she agreed to feedback the Trust's perspective about strengthening links with them and other research organisations. **Outcome:** The Board noted the strategy implementation report and received reasonable assurance on the progress of research delivery within the Trust.	
2018-19 (25)	**Chief Executive's report** The Chief Executive presented her report which included: • Appointment of an Interim Executive Medical Director and Deputy Medical Director • Work on developing Integrated Nursing • Insight Programme • Staff dress code • Board to Board meeting 19 July 2018 • Newton Europe summit meeting A verbal update on two recent developments was provided. *Health Visiting Service* The Chief Executive was pleased to report that the Health Visiting Service had recently been awarded the UNICEF breastfeeding gold standard award. *Her Majesty's Inspectorate of Prisons report - Wetherby YOI* The Executive Director of Nursing advised that the Trust had received the final report and informed the Board that it included very positive feedback including excellent examples of good practice. The Executive Director of Operations said that she was also pleased with the recent report on the unannounced inspection of HM YOI Wetherby. Her Majesty's Chief Inspector of Prisons had said "it is reassuring to see very real progress made at Wetherby and Keppel". The report across four domains was "good" with "not sufficiently good" in the domain of safety. She explained that the prison inspection regime was based on four domains and healthcare fell into the "respect" domain. In this domain the Chief Inspector reported good access to age-appropriate health services, noticeably short waiting times but too many did not attends (DNAs), dentistry and medicines management were very good, mental health services well integrated. Recommendations included improving space for therapy and more training in Mental Health for officers. The Executive Director of Nursing agreed to circulate a copy of the final report to Board members.	

	Action: The Executive Director of Nursing to circulate a copy of the final HMI Inspectorate of Prisons report. No questions were raised on any other items in the Chief Executive's report. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	**Executive Director of Nursing**
2018-19 (26)	**Leeds Health and Social Care Academy** The Director of Workforce, OD and System Development presented the report from the Leeds Health and Care Academy which updated the Board on progress and next steps as the Academy approached the conclusion of its planning and implementation stage. **Outcome**: The Board noted the update report.	
2018-19 (27)	***Performance brief and domain reports June 2018*** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during June 2018. The Executive Director of Finance and Resources said that the report highlighted any current concerns relating to contracts held by the Trust, a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. ***Safe*** The Board noted that there were no avoidable category 4 pressure ulcers reported in June 2018 and there were two category 3 pressure ulcers which were under investigation. In response to a concern raised by the Chair about the percentage of VTE risk assessments completed in June 2018, the Executive Director of Nursing clarified that a change in the reporting process for VTE assessments had meant that the percentage reported was inaccurate but she assured the Board that this was a recording issue and not a patient safety issue. ***Caring*** The Trust had inpatient beds in both specialist and children's business units. The percentage of inpatient respondents recommending care had dropped to 75% in June 2018 but was based on only eight responses. There was a small decrease in the percentage of respondents who would recommend care in the community. The adult business unit (92.5%) was rated red against a target of 95.0%. Both children's and specialist business units remained above target and were rated green. **Effective domain** Services were making good progress towards achieving compliance with NICE Guidance. Compliance with clinical supervision was reported at 75% against a target of 80%. ***Responsive*** The Trust had performed well in respect of its indicators relating to waiting lists and all were rated green for June 2018. Referring to the data breaches on waiting time, a Non-Executive Director (JM) was concerned that the figures for 2018-19 showed that to date there had been 132 breaches compared with 158 in total for the whole of 2017-2018.	

	The Executive Director of Operations said that the Trust was performing within all nationally set targets and the figures were excellent when compared to most other trusts. She explained that factors outside the normal process had affected the number of breaches and this related to the number of doctors in the paediatric service. Locums were now in place and the expectation was that the figures would improve over the course of the year. Referring to the data on patient contacts, the Chair said that concerns remained about the variance from profile. A Non-Executive Director (BC) reported that the Business Committee had received a comprehensive presentation on neighbourhood team activity. He said that significant work had been undertaken to look at the factors which underpinned the data. The Business Committee would continue to monitor activity levels carefully. The presentation would be circulated to all Board members for information. **Action: The presentation made to the Business Committee on 25 July 2018 on the Neighbourhood Teams activity levels to be circulated to Board members.** ***Well-led*** The Board noted that total sickness absence was below target at 5.5% and rated as green but it had increased from 5.13% in May 2018. Short term absence stood at 2.2% and long term absence at 3.3%. Both were rated as green for June 2018. Staff turnover was 14.6%, slightly above the target of 14.5% and was rated as amber for June 2018. Staff leaving the organisation within 12 months, 13.20% in June remained lower than overall turnover and was rated as green. ***Financial position*** After three months of the financial year the Trust has spent slightly less than planned. This was due to pay costs being less than expected as a result of the number of vacancies. The forecast outturn demonstrated that there were some financial risks in delivering the control total set by NHS Improvement of £2.541 million for the year. Additional risks included the pay award, mitigating the loss of £1.2 million of income from the CCG and delivery of the planned cost savings. Overall, the Board was advised that the Trust would once again meet its financial target. **Outcome:** The Board noted the Trust's performance for June 2018.	**Company Secretary**
2018-19 (28)	**Serious incidents report** The Executive Director of Nursing introduced the report which provided an update on the outcomes, themes, actions and learning from serious incident investigations closed during the period April to June 2018. The report also provided an overview of coroner's inquests held in relation to serious incidents along with outcomes and any recommendations made. The Executive Director of Nursing reported that there had been a total of 16 serious incidents reported and verified during the period April to June 2018. 14 (87.5%) related to pressure ulcers; with two 'other' one of which related to an enteral feed error in a Special Inclusive Learning Centre (SILC). One record had been de-logged from StEIS. **Outcome:** The Board received the report noted the current position relating to the management of serious incidents.	
2018-19	**Safe Staffing report**	

(29)	The Executive Director of Nursing presented the report which set out progress on maintaining safe staffing over the last six months. The report outlined where the Trust was meeting safe staffing requirements and where there was further work to be undertaken and also included updates on agency spend and the development of the e-rostering tool. The Executive Director of Nursing reported that safe staffing had been maintained across all inpatient units for the time period. The report highlighted the current staffing pressures faced in a number of neighbourhood teams and included details of the mitigations in place until newly qualified community staff nurses started in autumn 2018. A Non-Executive Director (BC) observed that there would be risks in maintaining safe staffing levels and these would need to be addressed as part of the preparations and plans for winter. The Chief Executive said that the SMT was considering how staffing in teams could be made more robust to enable them to cope with 'surges' in pressure. Strategies to maintain staffing levels would be part of the winter resilience plan and the SMT was confident that everything possible was being done to maintain staffing levels over the coming months. **Outcome:** The Board noted the report and welcomed the assurance that staffing levels were being monitored to maintain safe staffing.	
2018-19 (30)	**Freedom to speak up annual report** The Freedom to Speak Up Guardian presented the report which provided an overview of his work, basic activity data and recommendations on the role and its development. The Guardian said that the role was working well and he had received strong support from the Chief Executive, directors and the wider Trust in establishing the role. A clear approach had been established which aligned to the Care Quality Commission's well led domain's aspect of the Trust's work. The Chief Executive reported that the new Freedom to Speak Up guidance recommended that trusts have a non-executive director lead on Freedom to Speak Up and Richard Gladman had agreed to take on this important role for the Trust. In response to a question from Non-Executive Director (BC), the Guardian said he felt that staff were becoming more confident about raising concerns with their line manager and line managers were becoming more confident in addressing and acting on any concerns raised. The Chair thanked the Guardian for presenting his report and commended his work in the Trust and his positive interaction with staff. **Outcome:** The report and activity to date was noted. The Board indicated its continuing support to embedding the work of the Freedom to Speak Up Guardian across the Trust.	
2018-19 (31)	**Guardian for Safe Working Hours: quarterly report** The Guardian for Safe Working Hours presented the report which included information on the issues affecting trainee doctors and dentists in the Trust, including morale, training and working hours. The Guardian provided a brief overview of the background and context to the report and drew Board members attention to the quarterly data summary.	

	The Chair, on behalf of the Board, expressed support for this work across the Trust and thanked the Guardian for attending to present his report. **Outcome:** The report was received and noted.	
2018-19 (32)	**Leases with Community Health Partnerships (CHP)** The Executive Director of Finance and Resources presented the report. He explained that the Trust was required to regularise its existing occupation of the LIFT properties. He reported that the Business Committee had considered a detailed version of the report at its meeting on 27 June 2018 and had recommended that the Board approve the signing of the leases for five properties. The Executive Director of Finance and Resources explained that due to the need to progress this issues in advance of this Board meeting, the Chair and Chief Executive had exercised the approval as an urgent decision. The Board was asked to formally ratify the urgent decision. **Outcome:** The Board ratified the urgent decision made by the Chair and Chief Executive that the Under Lease Plus Agreements for the five properties specified in the report be signed with a probable minimum cost commitment over three years of £9.7 million and, if no changes are made to the Trust's occupation, a total financial commitment to the end of the lease of £44.4 million.	
2018-19 (33)	**Organisational development refresh update** The Director of Workforce, OD and System Development presented the report which provided the Board with an overview of the development of a successor strategy to the existing Trust Organisational Development Strategy (2017-19). A Non- Executive Director (BC) welcomed the opportunity for the Board and committees to comment and inform the development of the refreshed strategy before the draft framework document was brought to the Board on 5 October 2018. **Outcome:** The Board noted the update.	
2018-19 (34)*	**Research and development refresh update** Brought forward on the agenda.	
2018-19 (35)	**Medical Director's report: medical revalidation** The Interim Executive Medical Director introduced the report which was a requirement for revalidation of doctors and provided assurance to the Board on the appraisal process. The report covered the period 1 April 2017 to 31 March 2018. The report followed the guidance: *Framework of Quality Assurance for Responsible Officers and Revalidation, June 2015.* The Board was asked to approve the statement of compliance which had been considered by the Quality Committee on 23 July 2018 and recommended for approval by the Board. **Outcome:** The Board approved the 2017-18 Executive Medical Director's report, noted the requirements by NHS England for inclusion in the statement of compliance and approved the sign off of the statement of compliance.	
2018-19 (36)	**Nursing and Allied Health Professional revalidation** The Executive Director of Nursing introduced the report which provided an overview of the last year in relation to nursing and Allied Health Professional	

	(AHP) revalidation. The information covered the year from 1 July 2017 to 30 June 2018. The Executive Director of Nursing explained that completing the report had been a significant challenge due to problems with the functionality of ESR at national level, which had meant that it had not been possible to ascertain the number of staff in the Trust that had revalidated in the last year. The Executive Director of Nursing said that based on her own intelligence, two nurses and one AHP employed by the Trust had failed to comply with the requirement but the systems in place appeared to be effective in that there was an early and timely alert to notify the Trust. The Executive Director of Workforce, OD and System Development advised that the problems with ESR had now been resolved. In response to a question from Non-Executive Director (JM), the Executive Director of Nursing advised that the normal procedure was to suspend staff who failed to revalidate without pay until they had completed the process. **Outcome:** The report was welcomed and noted.	
2018-19 (37)	**Mental Health Collaborative Committees in Common update** The Executive Director of Finance and Resources provided a verbal update on the West Yorkshire Mental Health Collaborative engagement event for non-executive directors and governors on the 17 July 2018. A progress update was provided on some of the programme's work streams including Child and Adolescent Mental Health Services (CAMHS), Eating Disorders and Learning Disabilities. In response to a question from a Non-Executive Director (TD), the Executive Director of Finance and Resources said that the work streams were still under development so a clear delivery timetable was not available but the development of a programme dashboard had been discussed to allow progress against each work stream to be tightly monitored. **Outcome:** The update was noted.	
2018-19 (38)	**Significant risk and risk assurance report** The Interim Company Secretary presented the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures and the board assurance framework (BAF) summary which gave an indication of the current assurance level for each strategic risk. The Board noted there were four risks with a current score of 15 or above relating to: • Reduced level of care due to prevalence of staff sickness in particular services and or across the Trust • Difficulties recruiting to and retaining staff within neighbourhood teams • New CAMHS Tier4 building • Risk of delays to new CAMHS Tier 4 service model Referring to the Audit Committee's scrutiny of the BAF 2018/19 report at its meeting on 20 July 2018, a Non-Executive Director and Chair of the Audit Committee (JM) said that the Committee had asked lead directors to ensure that there was a common approach to risk scoring. This piece of work should review the initial and current scores to determine if the actions taken to date had effected any movement in the scores, target scores should be reviewed to determine if the controls outlined against each risk were adequate, and if the target score was	

	realistic given the controls in place. A further update on the review of the BAF scores, gaps in control and sources of assurance would be provided to the Board on 5 October 2018. **Action: Further work to be done by SMT to ensure that there is a common approach to risk scoring and that directors ensure that the actions listed under gaps in controls or gaps in assurance are sufficient to achieve the target risk score.** **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	**SMT**
2018-19 (39)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information. She said that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	
2018-19 (40)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Audit Committee: 20 April 2018 and 23 May 2018 b. Quality Committee: 23 April 2018 and 21 May 2018 d. Business Committee: 25 April 2018 and 23 May 2018 e. Leeds Health and Wellbeing Board minutes: 19 February 2018	
2018-19 (41)	**Close of the public section of the Board** The Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 5 October 2018, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair:
Date: 5 October 2018

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Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (50aii)

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

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

Friday 7 September 2018 12.noon - 12.20pm

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Jenny Allen	Director of Workforce, Organisational Development (OD) and System Development
Apologies:	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Interim Executive Medical Director
	Marcia Perry	Executive Director of Nursing
	Laura Smith	Director of Workforce, Organisational Development (OD) and System Development
In attendance:	Diane Allison	Company Secretary
Minutes:	Liz Thornton	Board Administrator

	Discussion points	Action
2018-19 (42)	**Introductions and apologies** The Trust Chair opened the extraordinary public meeting. He explained that the purpose of the meeting was for the Board to consider the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership and to commit the Trust to work in partnership by authorising the Chief Executive to sign the MoU. Apologies were received from the Executive Director of Operations, Interim Executive Medical Director, Executive Director of Nursing and the Director of Workforce, Organisational Development (OD) and System Development (LS). .	
2018-19 (43)	**Declarations of interest** There were no declarations of interest made in relation to the one item on the agenda.	

2018-19 (44)	The Chief Executive introduced the paper. She reminded members that previous versions had been presented to the private Board meeting in February 2018 and a further draft circulated in August 2018. The Chief Executive explained that the MoU had been drafted to be consistent with the aspirations set out in the West Yorkshire and Harrogate Health and Care Partnership (previously referred to as sustainability and Transformation partnership STP) plan. Board members considered the final draft of the MoU and noted that: • the MoU was not a legal contract but a formal agreement between all of the partners to honour their obligations under it • there was no evidence to suggest that the MoU had been subject to any form of independent scrutiny by non-executive directors from members of the Partnership or by members of the public and this was registered as a matter of concern. The Chief Executive advised that work was ongoing to improve engagement with members of the Partnership at every level and representatives from communities across West Yorkshire and Harrogate. The Board agreed to support the underpinning principles set out in the MoU and authorised the Chief Executive to sign it. **Outcome:** The Board: • approved the MoU; and authorised the Chief Executive to sign it	
2017-18 (45)	**Close of the private Extraordinary Board meeting** The Trust Chair closed the Board meeting.	
Date and time of next meeting **Friday 5 October 2018,** **12 noon – 1.00pm** **Boardroom, Leeds Community Healthcare NHS Trust,** **Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair: Neil Franklin
Date: 5 October 2018

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AGENDA ITEM 2018-19 (50b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 5 October 2018

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting Friday 3 August 2018				
2018-19 (24cv)	**Business Committee 25 July 2018 Chair's assurance report:** A further update on the Trust's performance against the WRES indicators to be provided to the Board in October 2018**.**	Director of Workforce, System Development and OD	5 October 2018	Agenda 5 October 2018
2018-19 (25)	**Chief Executive's report:** Her Majesty's Inspectorate of Prisons report - Wetherby YOI – a copy of the final report to be circulated.	Executive Director of Nursing	August 2018	Completed
2018-19 (27)	**Performance Brief June 2018: responsive domain -** A copy of the neighbourhood teams activity levels presentation made to the Business Committee on 25 July 2018 to be circulated.	Company Secretary	August 2018	Completed
2018-19 (38)	**Significant risks and Board Assurance Framework:** Further work to be done by SMT to ensure that there is a common approach to risk scoring and that directors ensure that the actions listed under gaps in controls or gaps in assurance are sufficient to achieve the target risk score.	SMT	5 October 2018	Completed

Key		
Total actions on action log	**4**	
Total actions on log completed since last Board meeting: 3 August 2018	**4**	
Total actions not due for completion before 5 October 2018; progressing to timescale	**0**	
Total actions not due for completion before 5 October 2018; agreed timescales and/or requirements are at risk or have been delayed	**0**	
Total actions outstanding as at 5 October 2018; not having met agreed timescales and/or requirements	**0**	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (50c)

Report to: Trust Board 5 October 2018
Report title: Quality Committee 24 September 2018: Committee Chair's assurance report
Responsible Director: Chair of Quality Committee **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 held on 24 September 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service spotlight:

The Committee received a presentation from the Community Falls Service. The service provides a single point of referral for non-urgent falls referrals, including a triage process to ensure patients are provided with the most appropriate service to meet their needs. The service also complete multi-factorial falls risk assessments and interventions to high risk complex falls patients and work collaboratively with other services and organisations as part of the falls pathway. The Committee learned that the team now receive approximately 180 referrals per month, which a considerable increase when compared to the previous year, due in part to referrals being received from the falls clinics. This has been a challenge for the service. Other challenges the service spoke about included the increasing complexity of falls, assessments and intervention required. The Committee asked about compliance with NICE guidance, evidence relating to outcome measures, and how the service integrated with LTHT. The responses provided the Committee with reasonable assurance.

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

Hannah House

The Quality Committee is maintaining a focus on Hannah House, with reports being presented to the Committee at each formal meeting. The action plan is progressing and the Committee was pleased to learn that there has been a noticeable improvement in the physical environment, in staff following agreed systems, and a change in culture, which had permeated to the majority of staff. Feedback from parents is now more positive. Children's Business Unit leaders are working to ensure staff from this service feel more integrated and connected with the wider children's nursing service. A Quality Challenge plus visit is being planned for quarter three. The Committee has asked for a further service update at its next formal meeting in November 2018.

Report on Her Majesty's Inspectorate of Prisons unannounced inspection to Wetherby YOI and Kebbel Unit

The Committee received a report on the unannounced inspection, which was jointly undertaken between Ofsted, the Care Quality Committee (CQC), the General Pharmaceutical Council and HM Inspectorate of Prisons. The Committee heard that for the first time, the Chief Inspector of Prisons made reference to healthcare in his introductory paragraphs within the report. Of the ten good practice notes made in the report, five related to healthcare provision, including: governance, access, feedback, health promotion, and physical and mental health support. The CQC has now withdrawn its improvement notice, which it had issued following a previous inspection. The Committee recognised that some of the challenging recommendations contained in the report were beyond the direct control of healthcare services, and related to jointly held actions with the prison management. The Committee questioned whether sufficient focus was given at the Prisons' Operational Board to healthcare matters and this was confirmed. The Committee Chair committed to writing to the healthcare team to commend them on this positive report.

Clinical Outcomes Programme
The Committee was presented with an update on the Clinical Outcomes Programme. It heard how the programme had been embedded into the Trust's 'plans on a page', and linked to the CQC's effectiveness domain. The Committee was provided with examples of good practice, including the CAMHS Service and Podiatry, who use outcome measures for benchmarking and for demonstrating changes in clinical state. Programme challenges that have been identified have been worked through at a recent Clinical Effectiveness Group workshop, which was very well attended. The plan for the next 12 months of the programme was shared with the Committee, along with a strategic five-year vision. The Committee felt the update only provided limited assurance and requested a further paper to be presented at its November 2018 meeting, suggesting this should include a more defined and shorter term plan (two to three years, rather than five years), as well as the systems and process required to support the plan.

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

Performance brief and domain reports

Safe
There were no avoidable Category 3 or 4 pressure ulcers reported in August 2018.There were 9 admissions that qualified for a VTE Risk Assessment in August with all 9 recorded as complete.

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

Caring
100% of inpatient respondents recommended care. The percentage of patients recommending community care remains above target.

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

Quality Improvement Priorities (Q1 position)

The Committee received a progress report on the Quality Account's quality improvement priorities. There are 27 indicators, 19 of which have an agreed timescale, six are progressing as planned and two have not met the agreed timescale. The Committee was advised that for the two that are currently not on track, actions have been identified to mitigate the risk of not achieving them. The Committee were reasonably assured that sufficient work had been completed to date on the quality improvement priorities.

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

Internal audit review of Clinical Effectiveness Group
The Committee received the internal auditor's review of the Clinical Effectiveness Group (CEG), which is a subgroup of the Quality Committee. The Committee had requested this review as part of the Trust's 2018/19 internal audit programme. The CEG was found to be operating effectively and the auditor concluded that he was satisfied the subgroup was able to provide assurance on clinical effectiveness to the Committee. There were two important recommendations about core membership and attendees, and issues with previous meeting minutes – which had since been addressed. The internal audit review gave the CEG a reasonable assurance opinion.

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

Safeguarding team annual report 2017/18
The Head of Service for Safeguarding presented the service's annual report to the Committee. The report reflected the close partnership working with front line services, and across the multi-agency partnership. The Committee was advised that safeguarding is a complex and dynamic environment and that 2017/18 was a busy and productive year for the team. Key themes emerging from the annual report will shape the team's objectives. These themes included maintaining quality standards, responding to CQC recommendations for safeguarding training and competencies, and development of internal and multi-

agency relationships and networks. The Committee recognised the exemplary support the team provided to the Trust's staff and the high regard the City have for the safeguarding team. The report provided reasonable assurance.

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

Infection Prevention and Control (IPC) annual report

The Committee received the annual report on healthcare associated infections (HCAI) within Leeds Community Healthcare NHS Trust. The report provided information on IPC arrangements and activities, HCAI statistics and the proposed IPC programme for 2018/19, which the Committee was asked to approve. The Committee was advised that the key risks were: major infection/outbreak, ensuring the environment is maintained in good physical repair and condition, and ensuring there is robust documentation for legionella control. The Committee discussed the two sites which had failed the legionella test in 2017/18, and was advised that for both incidents, processes had been followed correctly. The Committee was reasonably assured by the IPC annual report and approved the 2018/19 programme.

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

NHS
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AGENDA ITEM 2018-19 (50cii)

Report to: Trust Board 5 October 2018
Report title: Business Committee 26 September 2018: Committee's Chair assurance report
Responsible Director: Chair of Business Committee **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 26 September 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service Support Session: Community Dental Service
Representatives from Community Dental Service attended Business Committee for the service support session agenda item, which replaces the services presentation item. This was the first session using the Committee's new approach, which aims to shift the emphasis from a mere description of a service and the challenges it faces, to a shared problem-solving session, and to understand how the Committee can support the service. The service provided the Committee with a briefing paper in advance of the meeting, which described the problems with achieving waiting time targets, the attempts to resolve this so far, and asked the Committee for support with ideas and suggestions. The Committee was advised about the very recent good news that the Community Dental Service had secured a five-year contract to deliver services. This was welcome news for the service but posed additional problems for achievement of waiting time targets. The Committee and the service representatives discussed a number of means of tackling the waiting list issue, with some new ideas and some forward commitments coming out of the discussion.

Workplace Race Equality Standard (WRES) performance update
The Committee had previously examined performance against the nine WRES indicators at its meeting in July 2018 and had noted that the report provided only limited assurance as there was no agreed plan of action. The update in the September 2018 Business Committee meeting included a preliminary action plan, which was produced following feedback at workshops held with Black, Asian, and Minority Ethnic staff, the Trust Board workshop and from discussions at the July 2018 meeting of the Business Committee. The Committee noted that the action plan was extensive, and asked about the areas that would be given priority, which were given as: resource for completing the work, conducting analysis of the WRES data and planning and delivering an equality event. The Committee agreed that this update provided it with reasonable assurance.

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

Operational plan priorities update
The operational plan update provided the Committee with an overview at the end of month five of progress towards achieving the Trust priorities and also provided a forecast for the year-end. The Committee agreed that the report was an accurate account and provided it with reasonable assurance that the plan was progressing satisfactorily. The Committee requested additional narrative about recovery plans to be included in future reports.

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

Emergency Preparedness Annual Report 2017/18
The report presented to the Committee provided an overview of emergency preparedness, resilience and response (EPRR) activity over the last year and identified priorities for 2018/19. The Committee was asked to review the Trust's new EPPR policy statement and the Trust's self-assessment score against the national core standards, a process overseen by NHS England. The Committee discussed the areas in which the Trust is currently partially compliant and was content with the actions being taken to improve these areas. The Committee agreed with the overall self-assessment score of 'substantially compliant' against the standards and with the policy statement and recommends that the Trust Board should approve these.

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

Workforce Strategy
The Committee was provided with a briefing paper and a supporting presentation of the progress being made to develop a successor workforce strategy to replace the existing organisational development strategy in 2019. The Committee heard that the draft workforce strategy aimed to be more people-focussed, putting people before process where possible. The draft strategy aligns with strategic goals, corporate priorities, extreme risks on the risk register, and Board Assurance Framework strategic risks. The next steps for the draft strategy is for it to be received by the Board in October 2018 for comment, and to be reviewed at staff engagement events. The Committee was supportive of the draft strategy, recognising the more transformational approach this strategy took, when compared to the previous one. The Committee suggested that there should be additional focus on the structure of the workforce including roles, responsibilities and staff numbers, and that there should be positive communication about what the strategy means to individual staff. They were also concerned that there should be a more direct and obvious link to the overarching Trust Strategic direction.

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

Projects:
Productivity
An update from the Productivity Group was presented to the Committee, which described the Trust's approach to productivity. The Committee was advised that the Productivity Group has now been established, with membership from each business unit and from corporate services. The Committee was keen to understand how the Productivity Group determined which services it should review and was advised the Productivity Group is focussing on services where a number of measures were a cause for concern (Did not attend rates, first to follow-up ratios etc) and considers whether these services require additional support. The aim of the Productivity Group is to support services through engagement and to avoid a 'top down' approach. Additional work streams that the Productivity Group have agreed are to compare team performance with the findings of the Carter Review, and to complete work around corporate benchmarking. The Committee agreed the report provided them with reasonable assurance.

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

E-rostering
The Committee learned that since it approved the business case for the procurement of the 'Allocate' e-rostering system in June 2018, the project has been in mobilisation phase in readiness for early implementation of the system to CLASS, Armley Neighbourhood Team, Police Custody Suites and CAMHS inpatients. The initial draft of the project initiation document has been provided to the Change Board for comment. The Committee was advised that discussions have taken place with the early implementing teams around the risks of implementing the system during times of 'winter' pressure. The teams' response was that the benefits of the system will support them through such times. The Committee asked how staff within the four early implementer teams felt and was advised that some were very enthusiast, others were not as enthused as yet. The Committee agreed that the project initiation document should be reviewed by a non-executive director (RG), who would feedback back to the Committee. The Committee agreed that the update gave it reasonable assurance.

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

CAMHS Tier 4 build
The Committee received an update on the proposed new CAMHS building including a range of commercial items and detail.

Performance Brief
The Committee were satisfied with most areas of progress in the Performance Pack. They did discuss, with concern, the activity figures and trends, and further clarification work was promised.

NHS
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AGENDA ITEM 2018-19 (51)

Meeting: Trust Board 5 October 2018	**Category of paper**	
Report title: Chief Executive's report	**For approval**	
Responsible director: Chief Executive **Report author:** Chief Executive	**For assurance**	✓
Previously considered by Not applicable	**For information**	

Purpose of the report

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

Main issues for consideration

The main features of the report are:

- Annual General Meeting held 18 September 2018
- Community Dental Services (CDS) contract
- Emergency planning major incident response
- Winter planning – agreed winter plan

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

Recommendation

The Board is recommended to:

- Note the contents of this report

Chief Executive's report

1. Trust news

1.1 Annual General Meeting

The Trust held its annual general meeting on 18 September 2018. It was hosted by the Trust's Vice Chair, Brodie Clark. Around 100 attendees (comprising Board members, staff and members of the public) heard presentations from myself and Bryan Machin, Executive Director of Finance and Resources which reflected on the previous year's challenges and successes, with opportunities for attendees to ask questions of the Board. Members of the public who asked questions were keen to learn about how health and social care service providers will further integrate care pathways to provide a more seamless service.

Key messages at the AGM were:

- Our staff have provided excellent care amidst significant service pressures and, in doing so, demonstrating the Trust's vision, values and behaviours
- We value partnership working and aim to provide joined up care for everyone
- The Trust had achieved all its financial targets and achieved excellent performance across a whole range of national and local performance indicators

The AGM drew to a close with a showing of an innovative animation, created by a member of our Communications Team, which described a number of services LCH provides, through the eyes of a typical family who would access our services.

1.2 Community Dental Services (CDS) contract

We have been informed that we are to continue to deliver CDS services for Leeds for the next five years, under a new specification, which is to be developed within the next 12 months. The new specification will ensure collaborative working between NHS England and organisations within the West Yorkshire and Harrogate Health and Care Partnership, for a more joined up approach. This is excellent news and demonstrates the high regard that our services are held in. We are delighted for our staff who have worked diligently through multiple procurements which have started and then been halted. We recognise that this has had a significant and damaging effect on staff wellbeing and morale in this service and we are extremely pleased to be able to give them and the people of Leeds this stability.

1.3 Emergency planning

The Trust tested its Major Incident Planning response on 14 September 2018 through a table top exercise. The event was coordinated by the Resilience Manager and attended by representatives from the first and second on-call managers. The scenario centred around a suspected poisoning in the vicinity of the Merrion Centre and involved the immediate evacuation of staff from Merrion House. The initial situation occurred at 6.30pm on a Saturday evening and continued into the working week enabling to look at emergency planning processes over a prolonged period. A number of services were affected by the scenario including the Night Nursing Service, Neighbourhood Teams, the Leeds Sexual Health Service and services based in Merrion House (Single Point of Access (SPUR) and MindMate SPA).

The event evaluated well and produced a number of learning points. One specific area for further testing is the evacuation and relocation of SPUR. This will be subject to a live exercise in the next few months.

The Board should be assured that the Major Incident Plan provided robust and appropriate guidance for on call managers to follow in an emergency.

1.4 **Winter planning**

The system has agreed a winter plan (immediate response to pressures in this year) as well as a longer term plan based on the findings of the Newton Europe work. A second summit showcased the good progress made on the six key work streams which now have assigned Senior Responsible Officers:

Workstream	**SRO**
Decision making: A. The right pathway, every time B. Responsive services i) Community Care Beds ii) Recovery & Independence Services (LCC & LCH)	Julian Hartley
Stroke A. Community 'Pull' B. In-hospital discharge planning	Thea Stein
Social Work input Appropriateness of demand, timeliness of allocation, assessment, decision etc.	Cath Roff
Patient/Family Delays Transfer of care policy and implementation	Phil Corrigan
Mental Health Long Term Placements Ensuring the process for selecting and being assessed by providers is swift and patients/families are supported	Sara Munro
Mental Health Funding for Placements Ensuring funding decisions are made in a consistently timely way	Phil Corrigan

Sara Munro is the overall SRO for the programme, with a particular focus on cross-system leadership behaviour and culture. The second summit showcased the good progress to date in each work stream.

In readiness for winter, the system has agreed a winter plan and established a winter room where representatives from all organisations will meet each week to review the previous seven days and plan for the week ahead. Escalation processes have been agreed and in times of pressure representatives will meet up to three times per week to manage flow. Work is almost complete on the mutual aid arrangements between organisations (to be finalised in next two weeks).

Internally the winter steering group has been re-established and meets monthly (fortnightly from 1 December 2018). A Project Manager has been appointed to create capacity and coordinate the Trust's response to increased system pressure.

1.5 **Newton Europe work update**

There continues to be great engagement across the city in implementing the recommendations from the Newton Europe analysis of flow. We are completely engaged in this work and in particular are working on pathways out of the hospital and new approaches – led by Sam Prince, Director of Operations, and work on developing the stroke pathways both in the hospital and in to community – led by myself. We continue to look at how we can best respond across all of our services to both increase our work on admissions avoidance and ensuring swift discharge as we get ready for winter.

1.6 **Safety Huddles**

Safety huddles are focused meetings about one or more agreed patient harms and many of our teams now frequently 'huddle'. The Wetherby neighbourhood team has been accredited by Yorkshire and Humber Improvement Academy. Significantly LCH is the first community trust to make this level of progress with safety huddles in community integrated teams.

1.7 **CQC review of Children Looked After and Safeguarding**

From 4th - 8th June 2018 the CQC undertook an unannounced review of health services for Children Looked After and Safeguarding in Leeds. As this review was of services across the health economy, no judgement was issued. No improvement notices were issued, 35 recommendations were made, of which 10 were identified directly for LCH.

There is much in the report for which we can be proud, with many of our services being commended by the CQC. Here is a snapshot:

- *"Children with emotional and mental health needs are well supported through the CAMHS commissioned service"*
- *"Safeguarding risk assessment within the Leeds Sexual Health Service is strong"*
- *"*[Infant Mental Health case records] *demonstrated comprehensive, explicit documentation with a child focus"*
- *"Effective professional challenge to children's social care was evident in health visitor records"*
- *"... in the school nursing service we saw that the "voice of the child" was evident in assessments and reports"*
- *"*The allocation of Children Looked After to Specialist Nurse from 13yrs through to leaving care] *ensures that young people can have their health interventions planned and co-ordinated dynamically without having to wait for the next health assessment and it promotes good continuity of care",*
- *"Leadership provided by safeguarding professionals across Leeds is good"*

The recommendations relate to e.g. improvement in depth of analysis in assessments; evidence of supervision being reflected in case records, and audit/review of processes to ensure GPs are enabled to input to Children Looked

After health assessments. Action planning is underway to address the recommendations.

1.8 **Staff engagement**

Work continues across the organisation to ensure that staff are always engaged and involved in all aspects of our work. Much involvement happens at a local level with staff involved within their local teams talking about local issues that effect them. This is monitored to ensure that staff are being involved regularly through a variety of means including the quarterly presentations to SMT about progress on business plans from each of the business units.

At an organisational level I continue to run 50 Voices as a network for conversation and involvement and at recent meetings have been discussing leadership development, the Well Led Framework self- assessment. Leaders network continues to meet and recent forums included updates from myself on strategic issues across the Trust and West Yorkshire and conversations on leadership development, working with unions, preparing for winter, understanding our strategy and a presentation on innovation from the dietetics team which stimulated a lot of debate about the use of digital to aid efficiency and productivity.

I am trialling a new way of talking and engaging with leaders in the organisation about the work of the Integrated Care System (ICS), Leeds Plan, Committees in Common and other strategic groups in Leeds with an open meeting once a month for all to attend who can, rather than written information which it is often difficult for people to have time to read and understand.

1.9 **Quality Improvement update**

Providing the best possible care is our most important priority. There are great examples of great practice and innovation happening right across the organisation every day, and we want to build on this by supporting all our staff to contribute to improvements, wherever they work. There is a lot of work going on across the Trust at the moment to embed this as a way of working. We have four Quality Improvement Learning Projects which are: CUCs service review: improving patient experience and service performance, Improving attendance, health and wellbeing, Improving the transfer of patients from community beds to acute hospital care, and Young People with Continuing Care Needs. We also have Quality Improvement Training, the development of a resource pack to support local improvement and a simple guide to Quality Improvement

1.10 **Child and Adolescent Mental Health In-Patient Unit public engagement event**

The Trust held a drop-in information session on 13 September 2018 where proposals for a new in-patient Child and Adolescent Mental Health unit were provided to give the public an opportunity to view and comment on plans prior to a submission of a planning application. The unit is proposed to be located at St Mary's Hospital site in Armley and will provide specialist support to young people with mental health problems being supported by the Children and Adolescent Mental Health service (CAMHS).

42 local residents attended and put forward their questions. The feedback received from a number of residents, following the event, was that they felt more reassured.

1.11 **Awards and Innovation**

The Trust continues to receive external acknowledgement in respect of its many excellent services:

- The CAMHS team has been shortlisted for a Medipex NHS Innovation Award for the StepUp! App. StepUp! was designed to support clinical work and allows young people to access useful resources whilst they wait for an appointment or between sessions, keep a track of their care, complete questionnaires, record notes and set goals on their device. As finalists, the team have been invited to an award ceremony and showcase which will take place on Thursday 4 October 2018 where the winner will be announced.

- Our Nutrition and Dietetics service, supported by the Service Improvement Team and in collaboration with healthcare IT specialists AireLogic Ltd, have successfully been shortlisted for two awards. Together they have developed the electronic Functional Gut Disorder (FGD) form which is an electronic pre-assessment tool for patients seeking dietary treatment for Irritable Bowel Syndrome (IBS).Patients can complete the tool online and the dietician will then review the information prior to their first appointment.

- The Integrated Children's Additional Needs (ICAN) service has been nominated for a Medipex NHS Innovation Award. This is in recognition of the ground breaking mobile app LMSU! (LetMeShowYou) which is designed to support young people with complex specialist needs through transition to adult services. The app was developed in partnership with digital health design specialists mHabitat, Leeds and York Partnership Foundation Trust (LYPFT) and technical firm ADI. The service has also been shortlisted in the Patient Digital Participation category of the HSJ awards, which take place in November 2018.

2. Local activity

2.1 CQC Local System Review of Health and Social Care in Leeds

The CQC is reviewing Leeds as a system during September and October 2018. The local system review will look at how people move between health and social care, with particular focus on people over 65 years old. It will also include an assessment of commissioning across the interface of health and social care and of the governance systems and processes in place in respect of the management of resources. The review will not include mental health services or specialist commissioning, but the CQC will look at the experiences of people living with dementia through case tracking. The CQC team of inspectors will be speaking with people who use services, their families and carers, and organisations that represent people, including local Healthwatch. On 15 to 19 October 2018 the CQC team will on site for a week and will be holding focus groups with staff, interviews and visit services. On completion of the system review, the CQC's findings will be reported to the Leeds Health and Wellbeing Board, with copies to all relevant partners across health and social care. Following this the CQC expect all system leaders to agree to a joint action plan to progress any recommendations they may make.

3. National information and involvement

3.1 **NHS England and** and the National Lottery announced in September 2018 that they have awarded £450k to the Building Health Partnerships programme to help patients have their say on health services. The funding will provide tailored support for co-production to 10 areas. The areas receiving the support will take part across two cohorts; West Yorkshire and Harrogate Health and Care Partnership is included in the first cohort.

4. Recommendations

4.1 The Board is recommended to:

- Note the contents of this report

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (52)

Meeting: Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title: Leeds Providers Integrated Care Collaborative Draft Memorandum of Understanding	**For approval**	✓
Responsible director: Thea Stein **Report author:** Katherine Sheerin	**For assurance**	
Previously considered by: Leeds Providers Integrated Care Collaborative Committees in Common meeting 13 September 2018	**For information**	

Purpose of the report: The draft Memorandum of Understanding (MOU) for Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common is being presented to the Board for discussion and approval.

Main issues for consideration

Leeds Community Healthcare, Leeds and York Partnership Foundation Trust, Teaching Hospitals Trust and Leeds GP Confederation have together committed to establishing a Committees in Common. A draft Memorandum of Understanding (MOU) has been developed to describe the relationship between the four organisations in the context of a programme of work.

The MOU is not a legal contract, but it is a formal agreement between all of the partners.

It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations.

The MOU was reviewed and agreed with minor amendments at the first meeting of the LPICC Committees in Common on 13 September 2018. The revised version is attached. The Committees in Common are recommending that their respective Boards should approve the MOU.

Recommendations

The Board is recommended to:

- Approve the Memorandum of Understanding

Leeds Providers' Integrated Care Collaborative

Committees in Common

Memorandum of Understanding

1. Summary

The purpose of this paper is to present the draft Memorandum of Understanding for Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common for approval.

2. Background

Leeds Community Healthcare, Leeds and York Partnership Foundation Trust, Teaching Hospitals Trust and Leeds GP Confederation have together committed to establishing a Committees in Common to better integrate health services across the city, in order to improve care and outcomes for people and make best use of resources. This Committees in Common is operating under the name Leeds Providers' Integrated Care Collaborative (LPICC).

These four organisations together represent the major NHS providers of health care in the city, and whilst there has been a strong sense of collaboration for many years, this is the first time formal governance arrangements have been put in place to facilitate and underpin co-ordinated decision making. In order to reflect that people's health care needs are met through more providers than the NHS, the Local Authority Adults and Health Directorate (as a provider) and third sector representative will also be attending the CIC, to take part in discussions and to inform direction.

The arrangement will be reviewed after six months to ensure that it adds value to existing structures, and really does facilitate change in services across organisations.

3. Proposed Memorandum of Understanding

A draft Memorandum of Understanding (MOU) to describe the relationship between the four organisations named above in the context of this programme of work has been developed.

It should be highlighted that the MOU is not a legal contract, but it is a formal agreement between all of the partners. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration. It allows delegated authority from Boards to their sub-committee to support the shared work programme of LPICC.

The Committees In Common will operate in just the same way as any other committee of the Board (i.e. within its terms of reference and in line with any delegated authority limits) and will be required to make an account to each Board. The Boards will receive the minutes from the bi-monthly Committees In Common meetings along with a summary report which will provide assurance to the Boards of the work being undertaken by the committees. The gateway decision making process set out in the MOU will ensure time for full engagement and discussion with trust boards before any decisions are made regarding future service delivery. Should any Board require added assurance or have concerns with any decision, it would have an opportunity to refer matter back to the Committees in Common for further discussion and assurance.

The draft MOU is included in appendix A. It was developed by the Company Secretaries of each of the Parties in LPICC, using the West Yorkshire Association of Acute Trusts and the West Yorkshire Mental Health Collaborative documents as reference points. It was reviewed at the shadow meeting of the Committees in Common on 13th September, and with amendments, was recommended for approval by Boards.

It should be highlighted that the progress of LPICC will be actively reviewed; whilst this is the only forum which formally brings together all four major NHS care providers in Leeds, it is recognised that there are a number of existing groups in the city whose aim is to promote integration of services. As such, the value of LPICC will be dynamically assessed and changes to governance proposed if and when necessary.

In light of this, it is proposed that the MOU is fit for purpose for now and provides a framework for us to work within; however, this may need to be refined as the programme develops. Subject to approval by the Board, the MOU will be signed at the next Committees in Common meeting which is being scheduled for early November 2018.

4. Financial Implications and Risk

One of the key drivers for establishing LPICC is to ensure best use of resources across organisations. Directors of Finance are engaged in the process, and will be key to working through how contractual models can be deployed to support change, whilst securing system stability overall.

In terms of individual projects, there is a five step process to developing the LPICC Programme which is set out in Schedule 2. These are as follows –

- Describe the case for change
- Design the future operating model
- Develop the options
- Evaluate and select the preferred option
- Implementation

This will enable the CIC to have a full understanding of the risks (including financial) of each element of the work programme, and to gain assurance regarding their mitigation and management.

5. Communication and Involvement

5.1 Strategically

A key issue for LPICC is to describe its purpose and how this fits with existing forums across the city which aim to improve the integration of services. This will be addressed through regular briefings to partners, including through the Health and Wellbeing Board, PEG and third sector organisations.

As part of clarifying responsibilities, it was suggested at the shadow Committees in Common meeting that the existing Provider Partnership Board, which brings together clinicians and others from across the system to develop ideas and review proposals, is used as the 'stakeholder' forum for LPICC.

In terms of effective on-going engagement of Board members and Governors, the agenda for the next Committees in Common meeting will include an item on how this is ensured.

5.2 Operationally

It is essential that projects which comprise the work programme are developed in an inclusive way, involving clinicians, other professionals and citizens in their design and implementation. This will be built into the project management process, with assurance mechanisms developed for the CIC.

6. Equality Analysis

A key driver for LPICC is to support the city's ambition to improve the health of the poorest the fastest. As such, full equality analyses will be included as part of the development of projects for inclusion in the Committees in Common work programme.

7. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

8. Recommendation

The Board is asked to approve the MOU and the establishment of the Committees in Common.

9. Supporting Information

The following papers make up this report:

Appendix A - Leeds Providers' Integrated Care Collaborative Memorandum of Understanding

Katherine Sheerin

September 2018

Appendix A

LEEDS PROVIDERS' INTEGRATED CARE COLLABORATIVE

DATE TBC

1. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
2. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
3. **LEEDS TEACHING HOSPITALS NHS TRUST**
4. **LEEDS GP CONFEDERATION**

DRAFT MEMORANDUM OF UNDERSTANDING

FOR LEEDS PROVIDERS INTEGRATED CARE COLLABORATIVE

No	Date	Version Number	Author
1	18.7.2018	01	K Sheerin
2	22.8.2018	02 Incorporating discussions with Company Secretaries	K Sheerin J Bray C Hill D Allison J Barwick
3	28.8.2018	03 Incorporating further comments from Company Secretaries	K Sheerin J Bray C Hill D Allison J Barwick
4	04.09.2018	04 Incorporating comments on draft Discussion Paper from CEOs	K Sheerin
5	18.09.2018	05 Incorporating comments from shadow CIC meeting (13.9.2018)	K Sheerin

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(2) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(3) **LEEDS TEACHING HOSPITALS NHS TRUST** of Beckett Street, Leeds, West Yorkshire L”9 7TF

(4) **LEEDS GP CONFEDERATION** of Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.

(B) The Parties together form the Leeds Providers Integrated Care Collaborative ("**LPICC**") and have agreed to collaborate in delivering city-wide efficient and sustainable primary, community, and secondary care hospital services (including mental health services in the community and hospital) for patients. The Parties have formed Committees in Common ("**LPICC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for primary, community and secondary care hospital services (including mental health) for the city. The intention being to deliver a system model that is integrated, consistent (reducing unwarranted variation) and focused on ensuring services are delivered in the best way to optimise health and resources across organisations.

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the LPICC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the LPICC service area.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. A Committees in Common is a mechanism to facilitate co-ordinated decision making across organisations.

1.2. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.3. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.4. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for primary, community and secondary care hospital services (including mental health services in the community and hospital) in Leeds. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the LPICC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the LPICC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the LPICC Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2. The Parties acknowledge the current position with regard to the LPICC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the LPICC Programme (the "**Principles of Collaboration**"):

4.1.1. address the vision - in developing LPICC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable primary, community and secondary care hospital services (including mental health services in the community and in hospital) for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider Leeds health and care system for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues, risks or opportunities relating to LPICC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014), and Managing conflicts of interest in the NHS: Guidance for staff and organisations (NHS England, June 2017) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the LPICC Programme development and delivery and respond accordingly to requests for support;

4.1.7. effectively involve Boards in the work of the Committees, ensuring input at all appropriate stages

4.1.8. manage wider stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.
4.1.9. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and
4.1.10. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the LPICC Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;
5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the LPICC Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the LPICC Programme in accordance with the Key Principles; and
5.2.3. underpinned by the following principles:
(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and
(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within LPICC:

LPICC Committees in Common ("LPICC C-In-C")

6.1. The LPICC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;
6.1.2. decisions required by the LPICC C-In-C;
6.1.3. issues and risk being managed;
6.1.4. issues requiring escalation to the LPICC C-In-C; and
6.1.5. progress planned for the next period.

Under a standing agenda item, LPICC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the Programme Director will be circulated promptly to all LPICC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Programme Director will provide a summary for sharing in the public domain.

LPCC Programme Executive

6.2. The LPCC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored work streams within the LPICC Programme via the LPICC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the LPICC Programme in line with the Key Principles:

LPICC Committees in Common

7.1. The LPICC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the LPICC Programme. It is chaired on a rotational basis by a Chair from one of the Parties, with the chair rotating after each meeting.

7.2. The LPICC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

LPICC Executive Group

7.3. The LPICC Executive Group will provide assurance to the LPICC C-In-C that the key deliverables are being met and that the development of the LPICC Programme is within the boundaries set by the LPICC C-In-C. It will provide management at programme and work stream level.

8. DECISION MAKING

8.1. The Parties intend that LPICC C-In-C individual Members will each operate under a model scheme of delegation whereby each LPICC C-In-C individual Member shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the LPICC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;

- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the LPICC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the LPICC C-In-C.

8.2. The Parties intend that LPICC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the LPICC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the LPICC Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the LPICC, the matter shall be promptly referred to the LPICC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the LPICC Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the LPICC Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the LPICC Programme but it is intended that other providers to the LPICC service area population may also come to be involved with the work of the programme (including for example independent sector and third sector providers). Further organisations may where appropriate be invited to meetings of the LPICC C-In-C as observers or through an additional stakeholders' forum. It is intended that Leeds City Council as a provider of care services and a representative of the third sector in Leeds are invited as standing attendees at the C-In-C. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Regulators and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the LPICC C-In-C shall take place 6 months after the date of implementation of this MoU (date to be inserted) or sooner if deemed as required by the Parties.

13.2. The LPICC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the Collaborative Programme and individual work streams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on date to be inserted (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the LPICC Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the LPICC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and
14.4.2. the affected Party is first given the opportunity to address the LPICC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legally binding partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS TEACHING HOSPITALS NHS TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS GP CONFEDERATION	))	DATE:

SCHEDULE 1

THE KEY PRINCIPLES FOR THE LPICC PROGRAMME

1. Through the LPICC Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective primary, community and secondary care hospital services (including mental health services in the community and hospital) across Leeds, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

1.1. Achieving clinical and financial stability across the LPICC service areas.

1.2. Enhancing collaborative working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

1.3. The approach to collaboration:

- The Parties will work on the greatest challenges together to ensure high quality, sustainable health services now and in the future.

- Take a collaborative approach to the delivery of primary, community and secondary care hospital services (including mental health services in the community and in hospital) via clinical pathways and networked services (rather than individual place/provider led developments).

- Work as part of the Leeds Health and Care Academy, ensuring flexibility of the workforce which is skilled to meet the changing needs of people and corresponding changing service models.

- Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing

- Ensure there is appropriate public engagement and involvement in the work programme, including developing the overall strategic direction and how service changes are designed, and to advise Boards on the requirement for statutory consultations for major service changes.

SCHEDULE 2

LPICC PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to improve integration of services across organisations, to improve outcomes and to make best use of resources. In developing this programme the Parties will be designing services across organisations and settings, thinking of different models of care and making collective efficiencies where the potential exists.

2. The LPICC Programme Approach

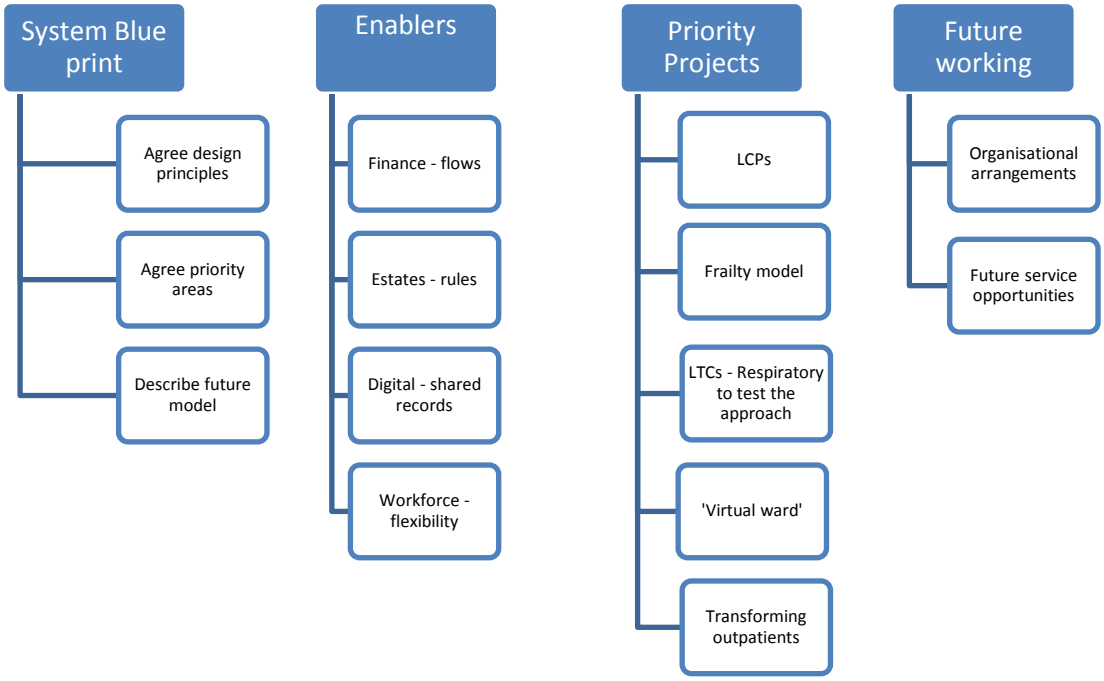
The Key Principles and five key steps to developing the LPICC Programme approach are set out in Schedule 1.

3. LPICC Programme Priorities

The LPICC Programme priorities are expected to be generated as a result of the following internal and external drivers;

- LPICC clinical and operational sustainability priorities.
- LPICC analysis of opportunities for improving services through integration.
- Leeds Health and Wellbeing Strategy.
- The Leeds Health and Care Plan

The structure of the programme will reflect these priorities as shown in the work streams below (date to be confirmed):



4. Key Work Stream Stages

4.1 Work stream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of work stream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2 The table below illustrates the sequence of stages of the work stream development process, this will be a scalable process and proportionate to the work stream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and Clinical Senate involvement
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce	

Stage	Outputs	Key Requirements
	Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

The LPICC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable work streams (some work streams may not require this approach) and that the work stream pipeline is managed within defined timescales.

4.3 Each work stream will have a LPICC Director (identified by the LPICC Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments

- Use of external scrutiny

- Appropriate commissioner engagement

- Appropriate public/patient engagement

- Governor engagement

4.4 The LPICC Executive and LPICC C-In-C will make decisions on the prioritisation and progressing of work streams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some LPICC projects developed under the work streams will have the potential to disproportionately benefit participating LPICC organisations at the expense of others. The potential impact of the implementation of a project through a work stream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective LPICC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the LPICC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the LPICC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

- equal gain share;

- proportional gain share; and/or

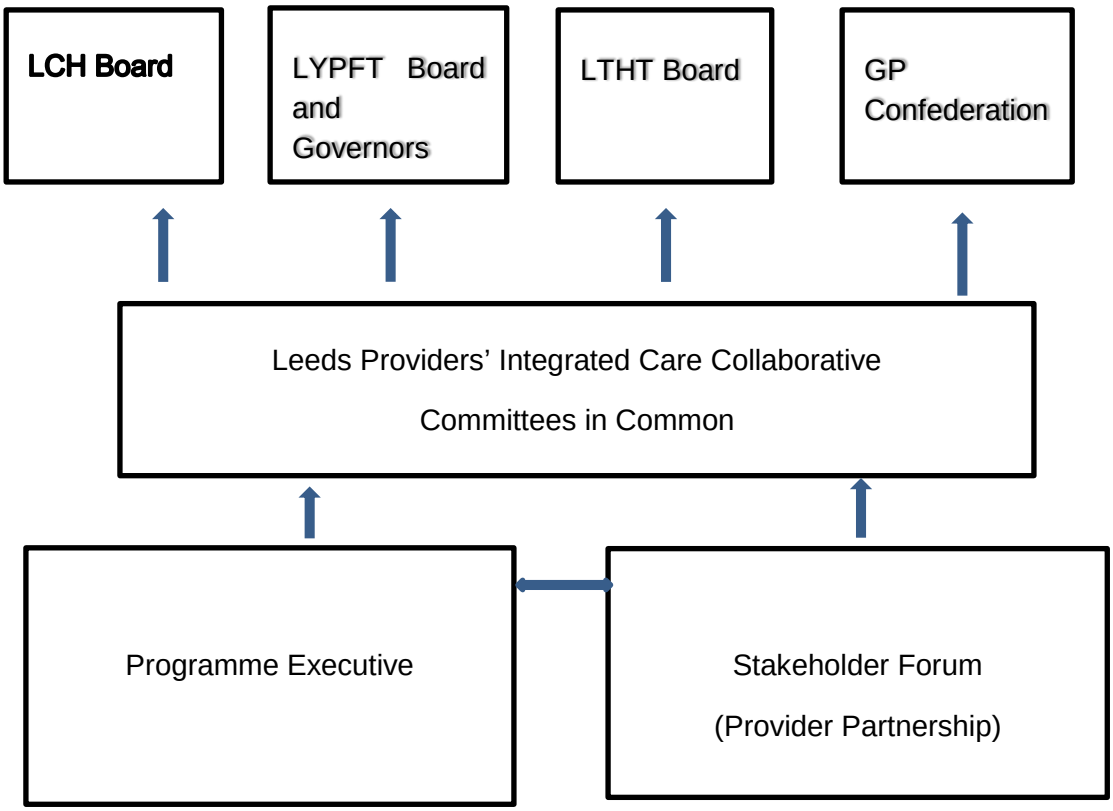
- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan, is shown below:



SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the LPICC Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the LPICC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the LPICC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the LPICC C-In-C for resolution.

1.5 The LPICC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the LPICC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This

MoU is not intended to be legally binding save as provided in paragraph 2.4 of the MoU and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the LPICC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the LPICC C-In-C reached in accordance with the above, it shall inform the LPICC C-In-C within 10 Business Days and request that the LPICC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the LPICC C-In-C, on a "Best for Meeting the Key Principles" basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the LPICC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the LPICC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

Leeds Providers' Integrated Care Collaborative Committees In Common Decision Making

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the LPICC Committee in Common (LPICC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the LPICC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the LPICC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the LPICC service area in accordance with the Key Principles when making decisions at LPICC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The LPICC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the LPICC C-In-C will require a detailed case for change. At this stage the LPICC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

6. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the LPICC Programme.

7. Bilateral and Tripartite Agreements between Individual Trusts

7.1. The LPICC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in LPICC outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other LPICC trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the LPICC Programme.

7.2. Recognising that being part of the LPICC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

7.3. Parties may wish to invite other organisations to be party to initiatives agreed by the LPICC C-In-C.

8. Forum for engaging with the wider system

8.1 The LPICC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the LPICC) on specific issues.

SCHEDULE 5

LEEDS PROVIDERS' INTEGRATED CARE COLLABORATIVE COMMITTEES IN COMMON (LPICC CIC)

TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE LPICC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

1.1. The LPICC C-In-C will be responsible for leading the development of the LPICC Programme and the work streams in accordance with the Key Principles, setting overall strategic direction in order to deliver the LPICC Programme.

2. Standing

2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. Commitments

3.1 Parties have agreed the following commitments for how to work together in this Committees in Common. Members will -

a) Demonstrate leadership and commitment to delivering the vision
b) Be honest where this is difficult – and why
c) Carefully think through the issues so that sound discussions can be held
d) Follow through on decisions and commitments made

4. General Responsibilities of the LPICC C-In-C

4.1. The general responsibilities of the LPICC C-In-C are:

(a) providing overall strategic oversight and direction to the development of the LPICC Programme;

(b) ensuring alignment of all Parties to the vision and strategy;

(c) formally recommending the final form of the collaborative programme, including determining roles and responsibilities within the work streams;

(d) reviewing the key deliverables and ensuring adherence with the required timescales;

(e) receiving assurance that work streams have been subject to robust quality impact assessments

(f) reviewing the risks associated with the performance of any of the Parties in terms of the impact to the LPICC Programme- recommending remedial and mitigating actions across the system;

(g) receiving assurance that risks associated with the LPICC Programme are being identified, managed and mitigated;

(h) promoting and encouraging commitment to the Key Principles;

(i) formulating, agreeing and implementing strategies for delivery of the LPICC Collaborative Programme;

(j) seeking to determine or resolve any matter referred to it by the LPICC Programme Executive or any individual Party and any dispute in accordance with the MoU;

(k) approving the appointment, removal or replacement of key programme personnel;

(l) reviewing and approving the Terms of Reference of the LPICC Programme Executive;

(m) agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

5. Members of the LPICC C-In-C

5.1. Each Party will appoint their Chair and Chief Executive as LPICC C-In-C Members and the Parties will at all times maintain a LPICC C-In-C Member on the LPICC C-ln-C.

5.2. Each LPICC C-In-C member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the LPICC C-ln-C Member is not personally present and do all the things which the appointing LPICC C-ln-C Member is entitled to do.

5.3. Each Party will be considered to be one entity within the collaborative.

5.4. The Parties will all ensure that, except for urgent or unavoidable reasons, their respective LPICC C-ln-C Member (or their Nominated Deputy) attend and fully participate in the meetings of the LPICC C-ln-C.

6. Proceedings of LPICC C-In-C

6.1. The LPICC C-In-C will meet bi-monthly, or more frequently as required.

6.2. The LPICC C-In-C shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the LPICC C-In-C into the Parties' Trust Boards.

6.3. The C-in-C will be chaired by one of the Party Chairs on a rotational basis, with the chair rotating following each meeting.

6.4. The LPICC CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

6.5. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one LPICC C-In-C Member present.

6.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

6.7. A meeting of the LPICC C-In-C may consist of a conference between the LPICC C-In-C Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

6.8. Each LPICC C-In-C Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the LPICC Collaborative Programme.

6.9. The LPICC C-In-C will review the meeting effectiveness at the end of each meeting.

7. Decision making within the LPICC C-In-C

7.1. Each LPICC C-In-C Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions

which are permitted under their organisation's Scheme of Delegation.

7.2. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, LPICC C-In-C Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the LPICC service area in accordance with the Key Principles when making decisions at LPICC C-In-C meetings.

7.3. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all LPICC C-In-C Members reaching an agreed consensus decision in common in accordance with the Key Principles.

7.4. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the LPICC Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

8. Attendance of third parties at LPICC C-In-C meetings

8.1. The LPICC C C-In-C shall be entitled to invite any person to attend but not take part in making decisions at meetings of the LPICC In-C. It is intended that a representative from Leeds City Council as a provider of social care services and a representative from the third sector in the city are invited to attend on a standing basis to take part in discussions. It is expected that there will be continuity in attendance by the standing representatives in order to ensure progress of issues. Whilst all CIC meetings will be held in private and therefore all business will be confidential, there may be some business which is for discussion by full LPICC C-in-C members only.

9. Administration for the LPICC C-In-C

9.1. Meeting administration for the LPICC C-In-C will be provided by the LPICC Programme Office, maintaining the register of interests and the minutes of the meetings of the LPICC C-In-C.

9.2. The Company Secretary / Governance lead of the Chair will have responsibility for providing governance advice and finalising agendas and minutes with the Chair.

9.3. The agenda for the meeting will be agreed by the LPICC C-In-C Chair. Papers for each meeting will be sent from the Programme Office to LPICC C-In-C Members no later than five working days prior to each meeting. By exception, and only with

the agreement of the Chair, amendments to papers may be tabled before the meeting.

9.4. The minutes, and a summary report from the Programme Director will be circulated promptly to all LPICC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Programme Director will provide a summary for sharing in the public domain.

10. Review

10.1. The LPICC C-In-C will review these Terms of Reference at least annually for approval by the Parties.

AGENDA ITEM 2018-19 (53)

Meeting: LCH Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title: GP Confed/LCH Committees in Common Memorandum of Understanding	**For approval**	✓
Responsible director: Thea Stein **Report author** Company Secretary, Leeds Community Healthcare NHS Trust	**For assurance**	
Previously considered by GP Confed/LCH (shadow) Committees in Common 14 September 2018	**For information**	

Purpose of the report

The Leeds GP Confederation and Leeds Community Healthcare NHS Trust have agreed to support the principle of shared governance and the establishment of a Committees in Common (CiC) structure.

This paper details the proposed Memorandum of Understanding for the committees in common, which is a governance mechanism to support the Leeds Primary Healthcare Collaborative (LPHC).

Main issues for consideration

The model of a CiC provides a recognised framework for the two organisations to formalise, strengthen and build upon existing partnership working through collaborating on an agreed set of work priorities.

The MoU is not a legal contract, but is a formal agreement between both of the partners.

It is proposed that an agreement is made by the two parties in the Collaborative that the CiC has delegated approval to commit up to £500,000 for any business case that the CiC is considering and the individual trust's scheme of delegation will reflect this.

It is proposed that the MOU is fit for purpose and provides a framework to work within; this may need to be refined as the programme develops. Subject to approval by the Boards, the MoU will be signed at the Committees in Common meeting scheduled for 27 November 2018.

Recommendations

The Executive is recommended to:

- Agree to the request for a delegated financial approval limit
- Approve the Memorandum of Understanding

GP Confed/ Leeds Community Healthcare Collaborative
Memorandum of Understanding

1. Introduction & Background

1.1 The Collaborative is the coming together of the GP Confederation and Leeds Community Healthcare NHS Trust to work together to build stronger working relationships and collaborate on a shared work programme

1.2 The two organisations' boards have agreed to support the principle of shared governance and the establishment of a Committees in Common (CiC) structure. The attached draft Memorandum of Understanding (MoU) set out in Appendix A is based on the established MoU for the West Yorkshire Association of Acute Trusts (WYAAT).

2. Memorandum of Understanding and Committees in Common

2.1 The MoU is not a legal contract, but is a formal agreement between the two parties. It does not replace or override the legal and regulatory frameworks that apply to statutory NHS organisations. Instead, it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration. It allows delegated authority from Boards to their sub-committee to support the shared work programme of the Collaborative.

2.2 The way the parties work together in line with their shared values and behaviours will be critical to the success of the collaborative and realising the collective ambition. There may at times be tensions between priorities for organisations, these will have to be worked through in an open and honest way and it is only though strong relationships and collective leadership that this will be achieved.

2.3 The CiC will operate in just the same way as any other committee of the Board (i.e. within its terms of reference and in line with any delegated authority limits) and will be required to make an account to each Board. The Boards will receive the minutes from the CiC meetings along with a summary report which will provide assurance to the Boards of the work being undertaken by the committees. The gateway decision-making process set out in the MOU will ensure time for full engagement and discussion with Boards before any decisions are made regarding future service delivery. Should any Board require added assurance or have concerns with any decision, it would have an opportunity to refer matter back to the CiC for further discussion and assurance.

2.4 Each organisation is already required to have a document known as a 'Scheme of Delegation' which sets out what matters are reserved specifically to the Board and what matters the Board has delegated to be done on its behalf elsewhere in the organisation. This includes financial approval limits. It is proposed that an agreement is made by the two parties in the Collaborative that matters reserved to the Board in relation to the work programme will be £500k and the individual trust's scheme of delegation will reflect this. It is anticipated that approval of matters over

the financial limit of £500k, requiring specific Board sign-off, will only occur occasionally.

2.5 It is proposed that the MOU is fit for purpose and provides a framework to work within; this may need to be refined as the programme develops. Subject to approval by the Board, the MoU will be signed at the CiC meeting scheduled for 27 November 2018.

3. Recommendations

The Executive is recommended to:

- Agree to the request for a delegated financial approval limit
- Approve the Memorandum of Understanding

Appendix A

LEEDS PRIMARY HEALTHCARE COLLABORATIVE
(or another name?)

DATE

XX XXX XXXX

1. LEEDS GP CONFEDERATION

2. LEEDS COMMUNITY HEALTHCARE NHS TRUST

MEMORANDUM OF UNDERSTANDING

Version 3

Date	Version number	Author	Amendment
10/09/2018	1	Diane Allison, LCH Company Secretary	
14/09/2018	2	Diane Allison, LCH Company Secretary	Page 18 schedule 1 bullet point 5 amended: reworded to read 'integration with Social Care' rather than 'Integration of jointly held services with Social Care'
20/09/2018	3	Diane Allison, LCH Company Secretary	Page 18 schedule 1 bullet point 5 amended: reworded to read ' integrated working with social care rather than ' integration with Social Care'

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **Leeds GP Confederation (address- Stockdale House?)**

(2) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme, including ownership and commitment to collaboration, as set out in the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan, and the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP).

(B) The Parties together form the Leeds Primary Healthcare Collaborative ("**LPHC**") and have agreed to collaborate in delivering city-wide seamless and efficient primary care and community health services for patients. The Parties have formed Committees in Common ("**LPHC CiC**") which have the specific remit of overseeing a comprehensive system-wide collaborative programme to deliver the objective of a more collaborative model of primary care in the City of Leeds. The intention being to deliver a system model that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population of Leeds.

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the LPHC CiC; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the Leeds area.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for primary care and community health services in Leeds. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the LPHC in this MoU, which sets out the framework for collaborative decision-making by the parties.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the LPHC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. PRIMARY OBJECTIVE AND APPROACH TO COLLABORATION

3.1 The continued challenge of ensuring the quality and financial sustainability of primary care and community health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in Leeds making best use of the collective resources.

3.2 Through the LPHC Programme, the Parties primary objective is to achieve sustainable, safe, high quality and cost effective primary care and community health services across Leeds, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be

collectively managed. This will be achieved through addressing the following:

3.3 Achieving the clinical and financial stability across the primary care and community health service areas.

3.4 Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

3.5 The approach to collaboration:

- The Parties will work on the greatest challenges together to ensure high quality, sustainable primary care and community health services now and in the future.

- Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in Leeds.

- Take a collaborative approach to the delivery of primary care and community health services via clinical pathways and networked services (rather than individual place/provider led developments).

- Delivering economies of scale in primary care and community health service support functions

- Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing

- Ensure there is appropriate engagement on those matters which need to be communicated more widely.

4.0 PRINCIPLES OF COLLABORATION

4.1 The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the LPHC Collaborative Programme (the "**Principles of Collaboration**"):

4.1.1 address the vision - in developing LPHC, the Parties seek to establish a model of collaborative care, to provide high quality, sustainable primary care and community health services for the population of Leeds, enabled by ambitious, integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2 collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3 hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider Leeds health and care system for performance of the respective roles and responsibilities set out in this MoU;

4.1.4 at all times act in good faith towards each other, with honesty and integrity - communicate openly with each other about major concerns, risks, issues or opportunities relating to LPHC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5 adhere to statutory requirements - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6 share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost;

4.1.7 learn from best practice of other collaborations and seek to develop as a collaborative to achieve the full potential of the relationship;

4.1.8 undertake shared analysis of problems and issues as the basis of taking action;

4.1.9 act in a timely manner - recognise the time-critical nature of the LHPC Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.10 work proactively with service users, staff, the public, and other stakeholders, seeking their engagement at all stages ensuring communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives, and

4.1.11 deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU.

5. GOVERNANCE

5.1 The governance structure (summarised below in Schedule 1) of this MoU provides a structure for the development and delivery of the LPHC Programme. The governance arrangements will be:

5.1.1 based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.1.2 shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the LPHC Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the Collaborative Programme in accordance with the Key Principles; and

5.1.3 underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6 ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within LPHC:

LPHC Committees in Common ("LPHC CiC")

6.1 The LPHC CiC will receive reports at each meeting from the Programme Executive responsible for the workstreams, highlighting but not limited to:

6.1.1 progress throughout the period;
6.1.2 decisions required by the LPHC CiC;
6.1.3 issues and risk being managed;
6.1.4 issues requiring escalation to the LPHC CiC; and
6.1.5 progress planned for the next period.

Under a standing agenda item, LPHC CiC will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the CiC Chair will be circulated promptly to all LPHC CiC Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The CiC Chair, supported by the Company Secretary, will provide a summary for sharing in the public domain.

LPHC Programme Executive

6.2 The LPHC CiC will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the LPHC Programme via the LPHC Programme Executive

7 ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the LPHC Programme in line with the Key Principles:

LPHC Committees in Common

7.1 The LPHC CiC comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the LPHC Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2 The LPHC CiC shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 4.

LPHC Executive Group

7.3 The LPHC Executive Group will provide assurance to the LPHC CiC that the key deliverables are being met and that the development of the LPHC Programme is within the boundaries set by the LPHC CiC. It will provide management at programme and workstream level**.**

8 DECISION MAKING

8.1 The Parties intend that LPHC CiC individual Members will each operate under a model scheme of delegation whereby each LPHC CiC individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the LPHC CiC and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 1;
- the devolving of the Key Principles set out in section 4; and,
- in accordance with the LPHC Gateway Decision Making Framework set out in Schedule 3 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the LPHC CiC.

8.2 The Parties intend that LPHC CiC Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the LPHC Key Principles and facilitating these functions in a timely manner.

ESCALATION

8.3 If any Party has any issues, concerns or complaints regarding the LPHC Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

8.4 Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 2 (Dispute Resolution Procedure).

8.5 If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the LPHC, the matter shall be promptly referred to the LPHC CiC Chair, in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

9 CONFLICTS OF INTEREST

9.1 The Parties agree that they will:

9.1.1 disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the LPHC Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the LPHC Programme; and

9.1.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

9.1.3 Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.3 above.

10 FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the LPHC Programme but it is intended that other providers to the LPHC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the LPHC CiC as observers or through an additional stakeholders forum. If appropriate to achieve the

key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

11 COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

12 REVIEW

12.1 A formal review meeting of the LPHC CiC shall take place 12 months after the date of implementation of this MoU (DATE) or sooner if deemed as required by the Parties.

12.2 The LPHC CiC shall discuss and agree as a minimum:

12.2.1 the principles of collaboration;
12.2.2 the governance arrangements as set out in Section 5;
12.2.3 the scope of the LPHC Programme and individual workstreams;
12.2.4 the progress against the key deliverables; and
12.2.5 key decisions required in support of Schedule 3.

13 TERM AND TERMINATION

13.1 This MoU shall commence on (DATE) (having been executed by all the Parties)

13.2 This MoU may be terminated in whole by:

13.2.1 mutual agreement in writing by all of the parties
13.2.2 in accordance with paragraph 15.2; or
13.2.3 in accordance with paragraph 1.5 of Schedule 2.

13.3 Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 15.

13.4 In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the LPHC Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the LPHC CiC for the removal of the relevant Party from the MoU on a majority basis provided that:

13.4.1 reasonable notice shall have been given of the proposed resolution; and

13.4.2 the affected Party is first given the opportunity to address the LPHC CiC meeting at which the resolution is proposed if it wishes to do so**.**

13.5 This MoU shall be terminated in accordance with the provision at paragraph 14.2.

14 CHANGE OF LAW

14.1 The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 15.

14.2 In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

15 VARIATION

15.1 This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

16 CHARGES AND LIABILITIES

16.1 Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

16.2 No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

17 NO PARTNERSHIP

17.1 Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

18 COUNTERPARTS

18.1 This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

18.2 The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

18.3 No counterpart shall be effective until each Party has executed at least one counterpart.

19

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS GP CONFEDERATION	)	
	)	DATE: XX XXX 2018

SIGNED by	)	……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	)	
	)	DATE: XX XXX 2018

(This needs Boards' approval prior to signing)

SCHEDULE 1

LPHC PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to further integrate primary care and community health services, improve outcomes and make best use of resources. In developing this programme the Parties will be designing services across organisations and settings, creating integrated pathways of care and making collective efficiencies where the potential exists.

2. The LPHC Programme Approach

The primary objective and approach to developing the LPHC Programme are set out in section 3.

3. LPHC Programme Priorities

The LPHC Programme priorities are expected to be generated as a result of the following internal and external drivers;

- clinical and operational sustainability priorities.
- analysis of opportunities for improving services through integration.
- Leeds Health and Wellbeing Strategy
- The Leeds Health and Care Plan
- West Yorkshire and Harrogate Health and Care Partnership
- Regulatory requirements.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at DATE):

- Integration of primary care and community health services to work as “one voice” in pathway redesign to improve patient care
- Development of services with a focus on prevention and proactive care
- Review and understand the workforce implications of greater integration and collaboration as well as the ways in which this can be leveraged in workforce terms, including the provision of back office support where appropriate
- Identify of shared incentive schemes and the potential to focus resources jointly on these
- Integrated working with social care

4. Key Workstream Stages

4.1 Workstream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2 The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement External Experts and **Clinical Senate** involvement
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3 The LPHC Programme Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4 Each workstream will have a LPHC Director (identified by the LPHC Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments
- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement

4.5 The LPHC Executive and LPHC CiC will make decisions in line with each Party's standing orders and standing financial instructions, consulting with and seeking approval from each Party's respective Board as required, on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 3).

5. Risk and Gain Sharing Principles

5.1. Some LPHC projects developed under the workstreams will have the potential to disproportionately benefit participating LPHC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective LPHC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the LPHC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the LPHC CiC can be clear when selecting the preferred option where the costs will be

met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

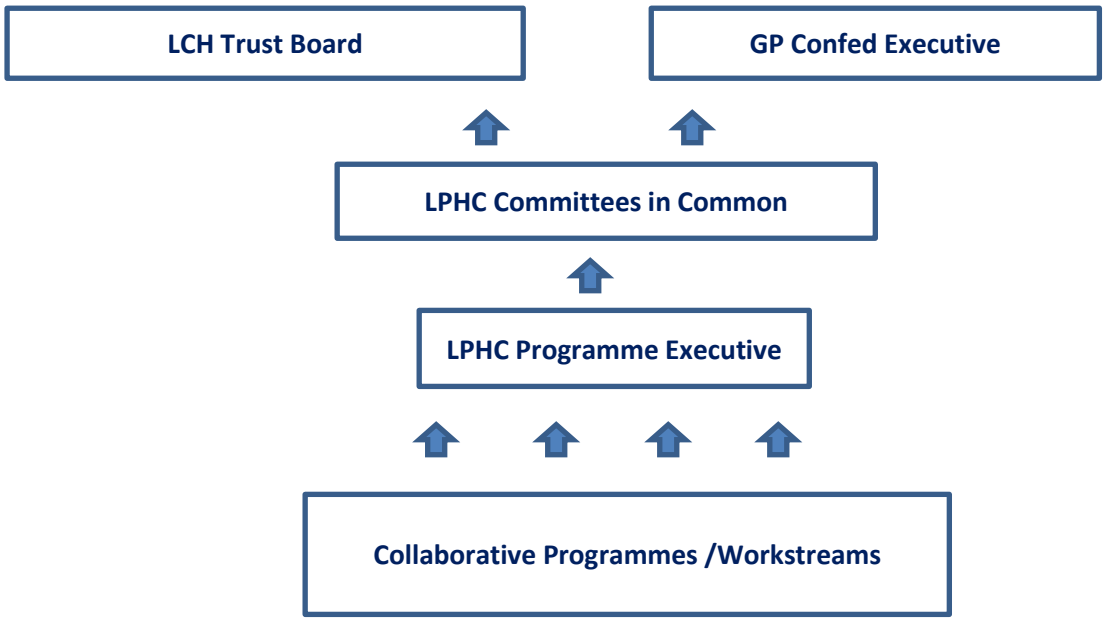
- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. Governance Structure

The governance structure is shown below**:**



SCHEDULE 2

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the LPHC Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the LPHC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the LPHC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the LPHC CiC for resolution.

1.5 The LPHC CiC shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the LPHC CiC reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the LPHC CiC or the independent facilitator, they may withdraw from the MoU at any point in accordance with section X of the MoU.

1.6 If a Party does not agree with the decision of the LPHC CiC reached in accordance with the above, it shall inform the LPHC CiC within 10 Business Days and request that the LPHC CiC refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the LPHC CiC, on a “Best for Meeting the Key Principles” basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the LPHC CiC cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the LPHC CiC may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 3

LEEDS PRIMARY HEALTHCARE COLLABORATION COMMITTEES IN COMMON DECISION MAKING

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the Leeds Primary Healthcare Collaboration Committees in Common (LPHC CiC) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the LPHC CiC may not be of obvious benefit to all Parties, it is anticipated that the LPHC CiC will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the LPHC service area in accordance with the Key Principles when making decisions at LPHC CiC meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The LPHC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the LPHC CiC will require a detailed case for change. At this stage the LPHC CiC will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6. The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Seek unanimous support by all parties eligible to make decisions	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the LPHC Collaborative Programme.

8. Bilateral and Tripartite Agreements between Individual Trusts

8.1. The LPHC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other organisations outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other LPHC trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the LPHC Collaborative Programme.

8.2. Recognising that being part of the LPHC CiC does not preclude Parties alliances or existing relationships with other organisations.

8.3. Parties may wish to invite other organisations to be party to initiatives agreed by the LPHC CiC.

9. Forum for engaging with the wider system

9.1. The LPHC CiC could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the West Yorkshire and Harrogate Health and Care Partnership) on specific issues.

SCHEDULE 4

LEEDS PRIMARY HEALTHCARE COLLABORATION COMMITTEES IN COMMON TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE LEEDS PRIMARY HEALTHCARE COLLABORATION COMMITTEES IN COMMON (LPHC CiC) MEMORANDUM OF UNDERSTANDING. DEFINITIONS AND TERMINOLOGY ALIGN WITH THE MEMORANDUM OF UNDERSTANDING

1. Scope

1.1. The LPHC CiC will be responsible for leading the development of workstreams in accordance with the principles of collaboration, setting overall strategic direction in order to deliver the key objectives of the LPHC.

2. Standing

2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. General Responsibilities of the LPHC CIC

3.1. The general responsibilities of the **LPHC CiC** are:

(a) providing overall strategic oversight and direction to the development of a collaborative programme;

(b) ensuring alignment of both Parties to the vision and strategy;

(c) formally recommending the final form of the collaborative programme, including determining roles and responsibilities within workstreams;

(d) reviewing the key deliverables and ensuring adherence with the required timescales;

(e) receiving assurance that workstreams have been subject to robust quality impact assessments

(f) reviewing the risks associated with the performance of any of the Parties in terms of the impact to the collaborative programme - recommending remedial and mitigating actions across the system;

(g) receiving assurance that risks associated with the collaborative programme are being identified, managed and mitigated;

(h) promoting and encouraging commitment to the principles of collaboration;

(i) formulating, agreeing and implementing strategies for delivery of the collaborative programme;

(j) seeking to determine or resolve any matter referred to it by either individual Party and any dispute in accordance with the MoU;

(k) approving the appointment, removal or replacement of key programme personnel;

(l) agreeing the collaborative programme budget and financial contribution (in line with each Party's standing orders/standing financial instructions – and use of resources in accordance with the Risk and Gain Sharing Principles;

4. Members of the LPHC CiC

4.1. Each Party will appoint **four** members to its own **LPHC CiC** and the Parties will at all times maintain its membership on the **LPHC CiC**.

4.2. Each LPHC CiC member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the LPHC CiC member is not personally present and do all the things which the appointing LPHC CiC member is entitled to do.

4.3. Each Party will be considered to be one entity within the collaborative.

4.4. The Parties will all ensure that, except for urgent or unavoidable reasons, their respective LPHC CiC member (or their Nominated Deputy) attend and fully participate in the meetings of the LPHC CiC.

5. Proceedings of the LPHC CiC

5.1. The LPHC CiC will meet bi-monthly, or more frequently as required.

5.2. The LPHC CiC shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the LPHC CIC members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the LPHC CiC into the Parties' Trust Boards.

5.3. The Parties will select one of the Parties' Chairs to act as the Chair of the LPHC CiC meetings on a rotational basis for a period of twelve months. There shall also be a Deputy Chair nominated. The Deputy Chair will be the succeeding chair of the CiC at the end of the incumbent Chair’s term.

5.4. The LPHC CiC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.5. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless each Party has at least two LPHC CiC members present.

5.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

5.7. A meeting of the LPHC CiC may consist of a conference between the LPHC CiC members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.8. Each LPHC CiC member will have an equal say in discussions and will seek to agree recommendations and actions in line with the principles of collaboration.

5.9. The LPHC CiC will objectively review the meeting effectiveness at the end of each meeting, seeking feedback from members and attendees.

6. Decision making within the LPHC CiC

6.1. Each LPHC CiC party will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

6.2. CiC members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the LPHC service area in accordance with the principles of collaboration when making decisions at LPHC CiC meetings.

6.3. In respect of matters which require decisions where both Parties are affected, the Parties will seek to make such decisions on the basis of both LPHC CIC parties reaching an agreed consensus decision in common in accordance with the principles of collaboration.

7. Attendance of third parties at LPHC CiC meetings

7.1. The LPHC CiC shall be entitled to invite any person to attend but not take part in making decisions at meetings of the LPHC CiC.

8. Administration for the LPHC CiC

8.1. Meeting administration for the LPHC CiC will be provided by the Company Secretary of one of the Parties, maintaining the register of interests and the minutes of the meetings of the LPHC CiC.

8.2. The Company Secretary will have responsibility for providing governance advice and finalising agendas and minutes with the Chair.

8.3. The agenda for the meeting will be agreed by the LPHC CiC Chair. Papers for each meeting will be sent to LPHC CiC Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4. The minutes, and a summary assurance report from the LPHC CiC Chair will be circulated promptly to all LPHC CiC members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Company Secretary will provide a summary, agreed with the Chair, for sharing in the public domain.

9. Review

9.1. The LPHC CiC Chair will review these Terms of Reference at least annually for approval by the Parties.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (54i)

Meeting: Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 19 September 2018 Quality Committee, 24 September 2018 Business Committee, 26 September 2018	**For information**	

Purpose of the report

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

Safe Domain
Safe Staffing Fill Rate is presented for the first time this financial year in this report. It is reported as 104.3% in August and was discussed fully at Trust Board 3 August 2018.

The 269 patient safety incidents reported in July 2018 has reduced to 259 in August 2018. This may be explained by data recording and quality due to records being update/amended or rejected as duplicates or 'not incidents'.

There were no avoidable Category 3 or 4 pressure ulcers reported in August 2018.

There were nine admissions that qualified for a VTE Risk Assessment in August with all nine recorded as complete.

Caring Domain
LCH has inpatient beds in both the Specialist and Children's Business Units. The percentage of Inpatient respondents recommending care has regained its 100.0% positon from a dip in June. The percentage of patients recommending Community Care remains above target.

Effective Domain
The measures in this domain are reported quarterly. The next time this domain will be updated will be September's Performance Brief published in October 2018.

Responsive Domain
The Trust has performed well in its indicators relating to waiting lists with all rated as green for August. There were 0 patients waiting more than 52 weeks for consultant led services. 98.5% of patients were waiting under 6 weeks for a diagnostic test. 3 patients were waiting 6 or more weeks for a test. No patients are waiting more than 12 weeks. A more in depth view of waiting list breaches can be found in section 1.2 of this document.

Patient Contacts are reported as -14.0% below profile in August and -7.6%% below the position reported in August 2017.

99.8% of patients in the IAPT service are treated within 18 weeks of referrals. This measure has been consistently above target (95%) and remains a positive story. However, in August there was an increase to 80.3% of patients, from 79.2% in July, being treated within 6 weeks of referral.

Well Led Domain
The overall trend in this area continues to be a positive one, with turnover and stability rates better than the same period in 2017.

Appraisal rates have demonstrated an improvement of 4.7% this month, achieving an overall organisational level of 83.26%. All areas have improved, with a significant increase in the Corporate Directorate from 69.03% to 81.63%.

The sickness absence rate for August 2018 is 5.64%, (1.57% short term and 4.07% long term), which remains below the outturn 2018/19 target of 5.8%.

Finance Domain
The Trust is £0.2m underspent at the end of August. Pay costs are higher than last month mostly as a result of the pay award arrears. There are 117 WTE vacancies for the month; temporary staffing is in place to mitigate the impact on service delivery. The Trust remains 15% below the agency cap for the year to date. Cost savings plans continue to be 4.5% below expected levels however savings in procurement occur as the year progresses. Cash is running £0.4m less than planned. The use of resources risk rating is 1.

The major risks at this time is the £1.2m unidentified savings in respect of the CCG decommissioning plan and any shortfall in the delivery of planned cost savings.

Recommendations
The Committee is recommended to:

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

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, August 2018

Quality Committee – 24th September 2018
Business Committee – 26th September 2018
Trust Board – 5th October 2018

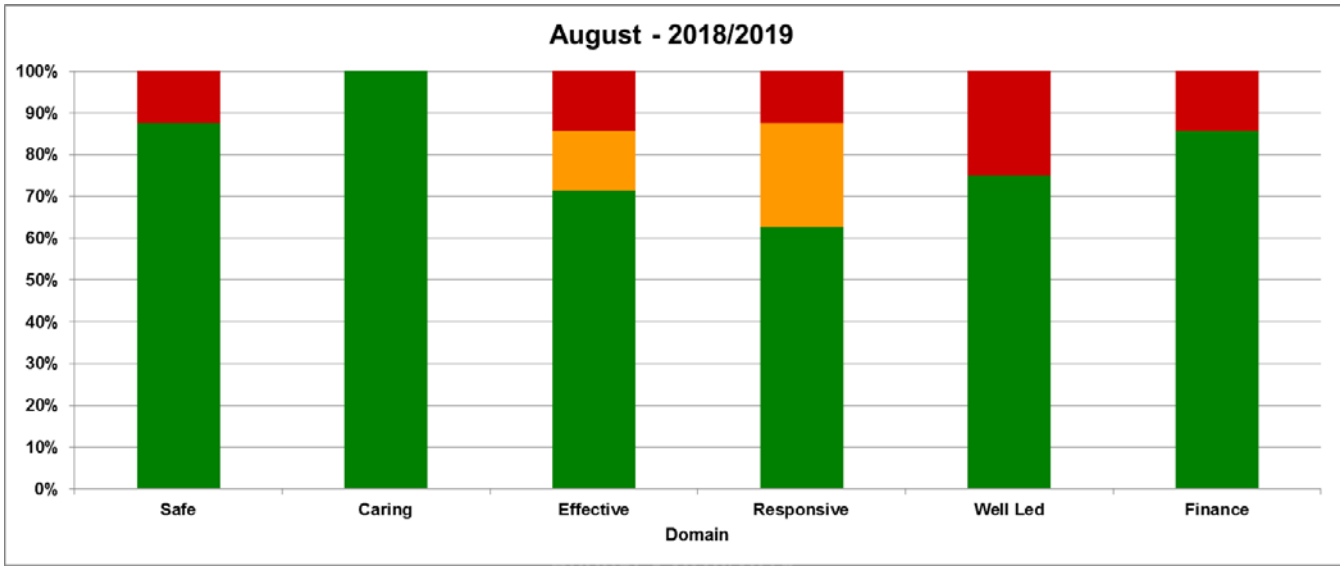
1. High Level Performance Summary

1.1 Summary of Performance Against High Level Indicators

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

1.1.1 Getting to Good

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



The measures in the Effective domain are reported quarterly and represent Q1.

1.1.2 Safe Domain

Safe Staffing Fill Rate is presented for the first time this financial year in this report. It is reported as 104.3% in August and was discussed fully at Trust Board 3rd August 2018.

The 269 patient safety incidents reported in July 2018 has reduced to 259 in August. This may be explained by data recording and quality due to records being update/amended or rejected as duplicates or 'not incidents'.

There were no avoidable Category 3 or 4 pressure ulcers reported in August 2018.

There were 9 admissions that qualified for a VTE Risk Assessment in August with all 9 recorded as complete.

1.1.3 Caring Domain

LCH has inpatient beds in both the Specialist and Children's Business Units. The percentage of Inpatient respondents recommending care has regained its 100.0% positon from a dip in June. The percentage of patients recommending Community Care remains above target.

1.1.4 Effective Domain

The measures in this domain are reported quarterly. The next time this domain will be updated will be September's Performance Brief published in October 2018.

1.1.5 Responsive Domain

The Trust has performed well in its indicators relating to waiting lists with all rated as green for August. There were 0 patients waiting more than 52 weeks for consultant led services. 98.5% of patients were waiting under 6 weeks for a diagnostic test. 3 patients were waiting 6 or more weeks for a test. 0 patients are waiting more than 12 weeks. A more in depth view of waiting list breaches can be found in section 1.2 of this document.

Patient Contacts are reported as -14.0% below profile in August and -7.6%% below the position reported in August 2017.

99.8% of patients in the IAPT service are treated within 18 weeks of referrals. This measure has been consistently above target (95%) and remains a positive story. However, in August there was an increase to 80.3% of patients, from 79.2% in July, being treated within 6 weeks of referral.

1.1.6 Well Led Domain

The overall trend in this area continues to be a positive one, with turnover and stability rates better than the same period in 2017.

Appraisal rates have demonstrated an improvement of 4.7% this month, achieving an overall organisational level of 83.26%. All areas have improved, with a significant increase in the Corporate Directorate from 69.03% to 81.63%.

The sickness absence rate for August 2018 is 5.64%, (1.57% short term and 4.07% long term), which remains below the outturn 2018/19 target of 5.8% Whilst this is an encouraging level of performance, it remains some way from the target of 95% compliance.

1.1.7 Finance Domain

The Trust is £0.2m underspent at the end of August. Pay costs are higher than last month mostly as a result of the pay award arrears. There are 117 WTE vacancies for the month; temporary staffing is in place to mitigate the impact on service delivery. The Trust remains 15% below the agency cap for the year to date. Cost savings plans continue to be 4.5% below expected levels however savings in procurement occur as the year progresses. Cash is running £0.4m less than planned. The use of resources risk rating is 1.

The major risks at this time is the £1.2m unidentified savings in respect of the CCG decommissioning plan and any shortfall in the delivery of planned cost savings.

1.2 Statutory Breaches

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

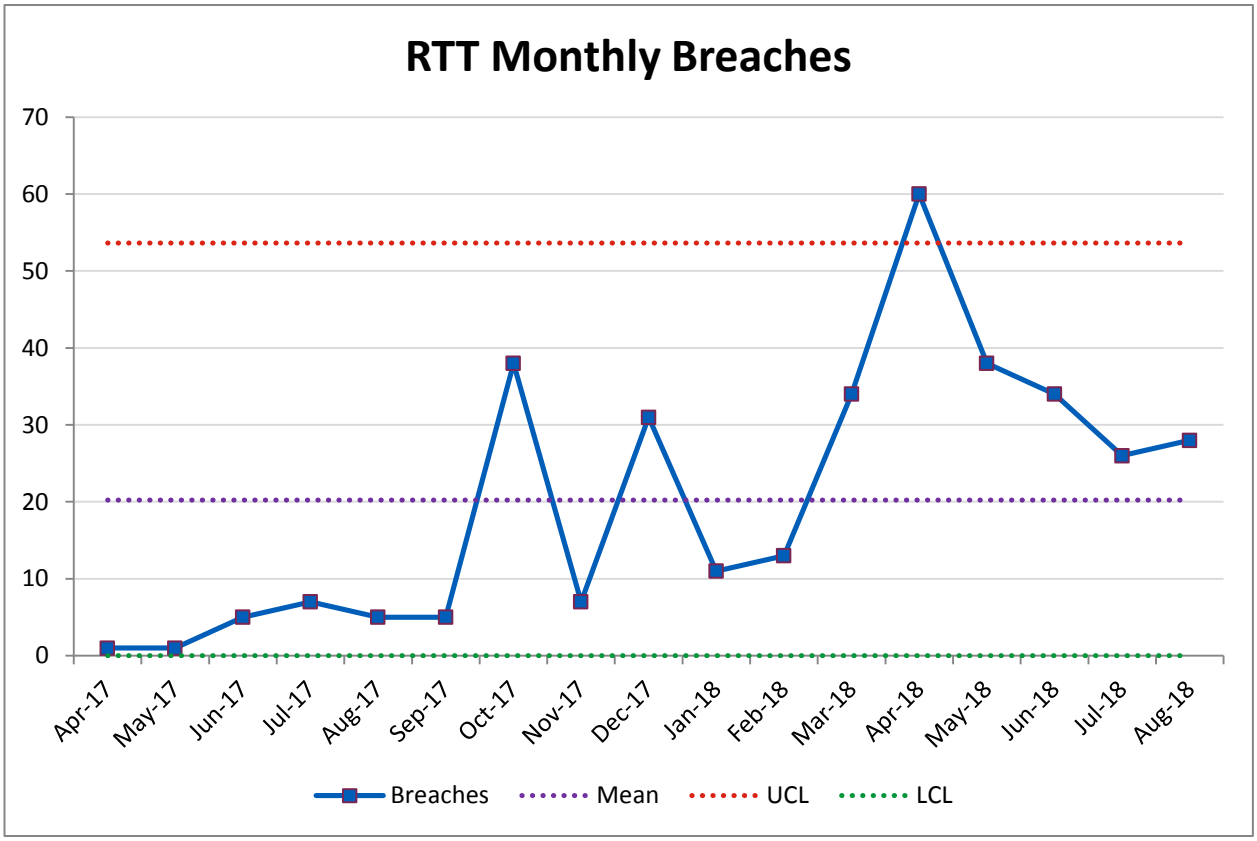
At the end of August 2018, 28 patients were waiting more than 18 weeks for treatment in consultant-led services. This is an increase of 2 from the previous month. In the 2018-2019 Financial Year to date there have been a total of 186 breaches compared with 158 for the whole of FY 2017-2018.

There were 26 waiters within the Children's Development Centre (CDC) service. All patients, except 2 have now received an appointment or have been seen.

There were 2 waiters within the Child Protection Medical Service (CPC) service. Both patients have now been seen.

There were 0 waiters in the Paediatric Neuro Disability (PND) service.

The graph below shows a 17 month position for RTT Breaches. There was an upward trend peaking in April 2018. The 3 months since April 2018 have shown an improving position but since March 2018 there are now 6 data points above the mean which means there is a 1 in 64 chance that this change is happening by chance.



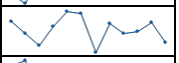
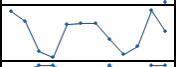
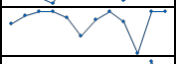
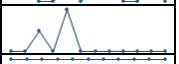
2. Contract Related Performance Highlights

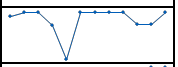
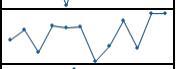
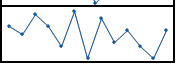
No contract related performance issues this month

Leeds Community Healthcare NHS Trust

Director of Nursing Report

Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		Target	YTD	Q1	Jul	Aug	Sep	Forecast	Rolling 12 Month Trend
Overall Safe Staffing Fill Rate - Inpatients	2018/19	>=97%	-	101.1%	104.0%	104.3%		●	
	2017/18		-	97.7%	102.5%	97.5%	96.1%		
Patient Safety Incidents Reported in Month Reported as Harmful	2018/19	0.56 to 1.1	0.90	0.86	0.92	0.76		●	
	2017/18			0.92	0.71	0.95	0.93		
Potential Under Reporting of Patient Safety Incidents	2018/19	1.22 to 2.67	1.91	1.85	2.00	1.45		●	
	2017/18			2.22	2.24	2.22	2.14		
Serious Incident Rate	2018/19	0 to 1.44	0.05	0.04	0.08	0.06		●	
	2017/18			0.05	0.00	0.08	0.08		
Percentage VTE Risk Assessment Completed*	2018/19	>=95%	100.0%	79.2%	100.0%	100.0%		●	
	2017/18			-	-	-	-		
20% Reduction in Avoidable Category 3 Pressure Ulcers	2018/19	10	4	1	3	0		●	
	2017/18			2	1	4	1		
0 Avoidable Category 4 Pressure Ulcers	2018/19	0	0	0	0	0		●	
	2017/18		12	0	0	0	0		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2018/19	100%	100.0%	100.0%	100.0%	100.0%		●	
	2017/18		100.0%	100%	100%	100%	100%		

Caring - staff involve and treat people with compassion, kindness, dignity and respect		Target	YTD	Q1	July	Aug	Sept	Forecast	Rolling 12 Month Trend
Percentage of Staff Recommending Care (Staff FFT)	2018/19	>=73%	-	83.0%				●	
	2017/18		-	81.0%	75.0%				
Percentage of Respondents Recommending Inpatient Care (FFT)	2018/19	>=95%	-	91.7%	100.0%	100.0%		●	
	2017/18		-	100.0%	100.0%	100.0%	90.0%		
Percentage of Respondents Recommending Community Care (FFT)	2018/19	>=95%	-	95.9%	96.8%	96.8%		●	
	2017/18		-	95.3%	94.5%	96.1%	95.8%		
Written Complaints - Received	2018/19	<211	33	44	10	17		●	
	2017/18			50	23	18	16		

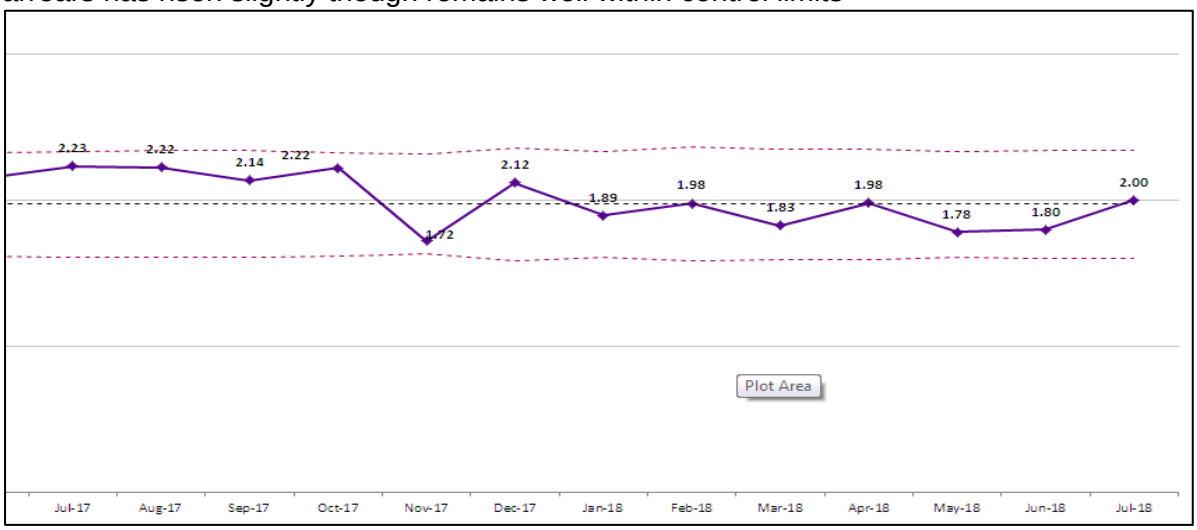
1. Patient Safety Incidents (LCH only)

1.1 Patient safety incident data has been captured from Datix for incidents reported within the month of August 2018. There were a total of 177 LCH PSIs reported in August 2018.

1.2 July figures previously reported have been amended following data cleansing (e.g. removing duplicate records) and there were 259 incidents reported (269 stated in previous months report).

1.3 The number of incidents reported has reduced significantly this month. It is unclear if this is due to fewer incidents occurring or incidents not being reported. This will be monitored and work will be undertaken to remind staff of the importance of reporting incidents.

1.4 The LCH Patient Safety incidents per 1000 contacts SPC chart which runs a month in arrears has risen slightly though remains well within control limits



**data available to July 2018 only*

2. Incidents causing harm (LCH only)

2.1 There were 26 fewer low harm incidents reported in August than in July. However the percentage remained unchanged due to a decline in the overall incidents reported.

2.2 There were 93 (53.0%) LCH PSI incidents reported as causing harm during August 2018. This is an increase of around 5% from the previous month's verified figures. This will be monitored to establish if this is a trend or remains within normal variation limits

2.4 SPC charts broken down by Business unit are not available as 25 points of data are required to produce a meaningful chart. Currently only 20 points exist; therefore expected date for production of SPCs by business unit will be January 2019.

2.5 Four incidents were submitted to the CCG via STEIS in August 2018.

Moderate & Major Harm Incidents

3. Harm incidents

3.1 The August ratio on moderate/major incidents to minimal/no harm incidents for LCH Patient Safety Incidents was 1:3.6 during August. This ratio is lower than previous months and attributable to a fall in no harm reporting this month and a rise in major harm reporting.

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
No Harm	163	151	186	140	140	119	113	133	126	116	108	135	80
Minimal Harm	81	79	62	73	66	82	62	45	66	75	70	83	57
Moderate Harm	39	39	48	36	[1]36	51	45	32	43	33	37	31	28
Major Harm	5	6	8	4	5	4	9	7	5	6	4	5	8
Death	5	9	9	10	7	0	2	13	8	12	16	5	4
Total	293	284	313	263	254	256	231	230	248	242	235	259	177
Ratio	1:5.5	1:5.5	1:4.4	1:5.3	1:5	1:3.7	1:3.2	1:4.6	1:4	1:4.9	1:4.3	1:5.4	1:3.6

4. No Harm incidents

4.1 31 teams/services reported no harm patient safety incidents in August – this is 16 teams fewer than the previous month. This is likely to be the reason for fewer incidents overall being reported and teams are being contacted to remind them of the importance of reporting no harm incidents.

5. Overdue Incidents

5.1 As of 11/09/2018 153 LCH Patient safety incidents and have breached the 15 or 30 day investigation time. 18 of these are moderate harm and above and the remaining 135 are low and no harm incidents.

5.2 A full narrative on this will be available in the next Director of Nursing report.

6. Never Events

6.1 There were no Never Events reported in August 2018.

7. Safety Alerts (CAS)

7.1 There were 8 Safety alerts issued which were due to be closed in August 2018. All were responded to and closed within the timescales set.

8. Duty of Candour

8.1 In the month of August 2018 there was one incident closed that was attributable to LCH of moderate harm or above.

8.2 Duty of Candour was enacted for this incident with the exception of a written Duty of Candour letter; which was declined by the patient and family.

9. Infection Prevention Control (IPC)

9.1 MRSA bacteraemia and C difficile Infection:

During August there were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to LCH.

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

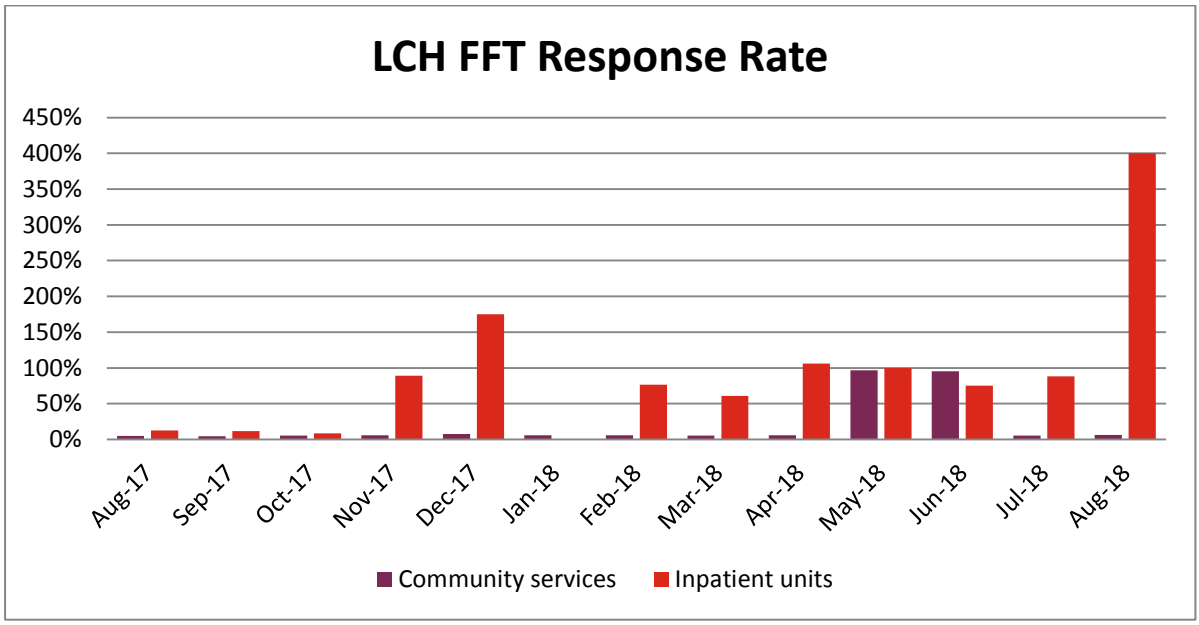
9.3 During August there were 5 sharps injuries (2 using patients own devices), IPCG suggested deep dives of these cases and individuals are being contacted to have a face to face meeting.

10. Patient Experience

10.1 Friends and Family Test (FFT) Performance Dashboards

10.1.1 Response rates (Community and Inpatient)

The number of completed FFT surveys fluctuates on a monthly basis due to variation in when surveys are received in the month by the Clinical Governance Team. Overall 96.79% of Community patients and 100% of Inpatients for August would recommend LCH services.



10.1.2 FFT Performance by Business Unit

Aug-18	% recommended	Response rate	Comments
ABU services	93.19%	5.23%	134
CBU services	98.13%	5.69%	428
CBU inpatients	100%	400%	5
SBU services	96.93%	6.57%	696
SBU inpatients	0%	0%	0

11. Complaints, Concerns, PALS and Claims

11.1 17 complaints were received in August 2018. Of these, 2 did not have a corresponding incident reported through Datix. This has been addressed with the teams concerned and will be picked up for further discussion at the PSEGG meeting.

11.2 No other exceptions to report

Leeds Community Healthcare NHS Trust

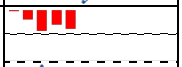
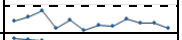
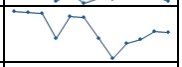
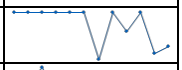
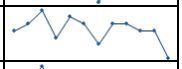
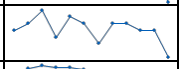
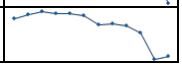
Effective Domain Report

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

This domain is reported quarterly. The next update will appear in the Performance Brief detailing September performance which will be published in October 2018.

Leeds Community Healthcare NHS Trust

Responsive Domain Report

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		Target	YTD	Q1	July	Aug	Sept	Forecast	Rolling 12 Month Trend
Patient Contacts - Variance from Profile*	2018/19	0 to ± 5%	-9.8%	-8.0%	-10.1%	-14.9%		●	
	2017/18			-5.9%	-6.9%	-10.3%	-5.2%		
Patient Contacts - Variance from 2017/2018	2018/19	-	-	-4.3%	-5.9%	-7.6%		●	
	2018/19		-	392,416	129,452	121,697			
	2017/18		-	409,858	137,564	131,728	132,999		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2018/19	>=92%	-	97.0%	98.1%	98.0%		●	
	2017/18		-	99.6%	99.4%	99.6%	99.6%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2018/19	0		0	0	0		●	
	2017/18		0	0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2018/19	>=99%	-	99.7%	98.1%	98.5%		●	
	2017/18		-	99.5%	100.0%	100.0%	100.0%		
% Patients waiting under 18 weeks (non reportable)	2018/19	>=95%	-	98.9%	98.8%	98.4%		●	
	2017/18		-	98.8%	98.6%	99.0%	98.8%		
IAPT - Percentage of people treated within 18 weeks of referral	2018/19	>=95%	-	98.9%	99.4%	99.8%		●	
	2017/18		-	100.0%	98.7%	98.9%	98.2%		
IAPT - Percentage of people treated within 6 weeks of referral	2018/19	>=75%	-	98.9%	79.2%	80.3%		●	
	2017/18		-	96.1%	93.5%	95.6%	94.1%		

Patient contacts are currently running 14.9% below the current profile – this is mainly attributed to activity in neighbourhood teams. It has been acknowledged that the current profile, based solely on patient contacts does not reflect the work of the neighbourhoods and the performance and business team is currently working with their counterparts in the CCG to review and amend the profile.

Performance in terms of waiting times is strong. The Trust routinely meets the national expectation of providing 95% first appointments within eighteen weeks of referral, both for nationally mandated consultant-led appointments and also for all other referrals into the Trust. There are a small number of services where this standard is challenging:

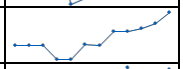
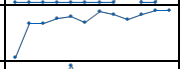
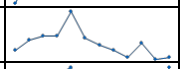
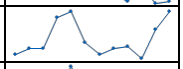
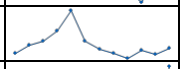
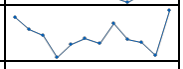
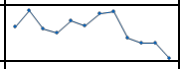
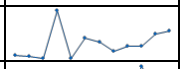
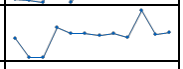
CAMHS – the majority of young people are seen within 12 weeks – parent requests to defer appointments during exam periods and summer holidays account for the breaches. The Trust and CCG have submitted a bid to become a trailblazer in reducing the wait to four weeks – if successful funding will be available from 2019/20

Integrated Services for Children with Additional Needs (ICAN) – the current breaches are a direct consequence of the extraordinary levels of absence in the paediatrician workforce over the last six months. Work is underway to manage demand, refine pathways and ensure the standard is routinely achieved.

The six-week diagnostic standard has not been met in the last months. This has been due to unexpected short term sickness which has meant clinics have had to be cancelled on the day and the small numbers entering the service.

Leeds Community Healthcare NHS Trust

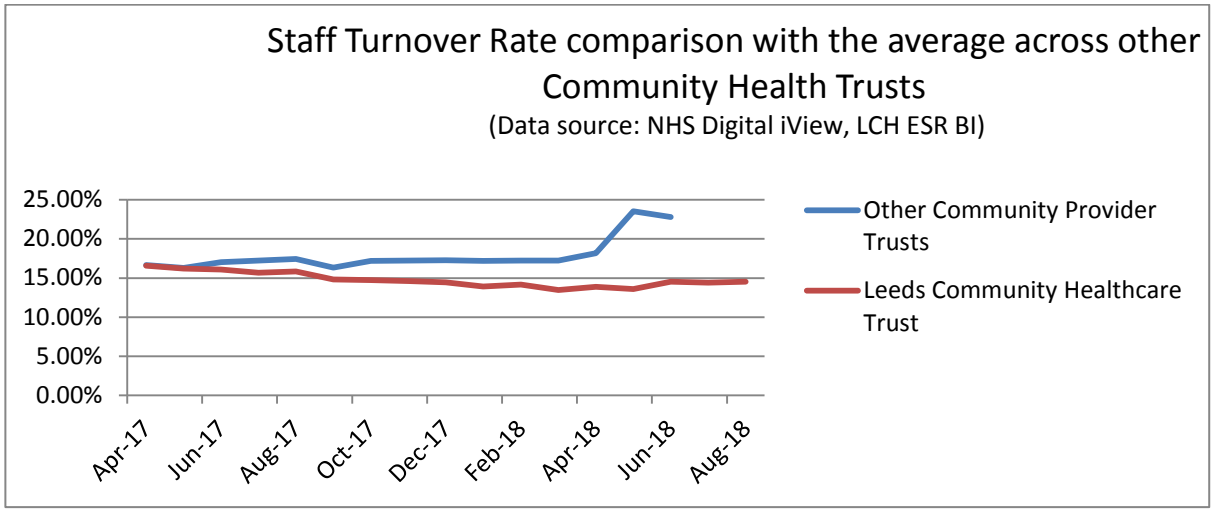
Well Led Domain Report

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		Target	YTD	Q1	July	Aug	Sept	Forecast	Rolling 12 Month Trend
Staff Turnover	2018/19	<=15.0%	-	14.0%	14.4%	14.5%		●	
	2017/18		-	15.2%	15.2%	15.1%	14.4%		
Reduce the number of staff leaving the organisation within 12 months	2018/19	<=20.0%	-	13.1%	13.6%	14.4%		●	
	2017/18		-	16.3%	14.2%	13.5%	12.0%		
Executive Team Turnover	2018/19	<=14.5%	-	0.0%	0.0%	6.4%		●	
	2017/18		-	0.0%	0.0%	0.0%	0.0%		
Stability Index	2018/19	>=85%	-	85.5%	85.9%	85.9%		●	
	2017/18		-	83.8%	83.8%	83.8%	82.5%		
Short term sickness absence rate (%)	2018/19	<2.2%	-	1.9%	1.5%	1.6%		●	
	2017/18		-	1.8%	2.0%	1.9%	1.9%		
Long term sickness absence rate (%)	2018/19	<3.6%	-	3.5%	3.8%	4.1%		●	
	2017/18		-	3.5%	3.8%	3.6%	3.4%		
Total sickness absence rate (%)	2018/19	<5.8%	-	5.3%	5.3%	5.6%		●	
	2017/18		-	5.2%	5.8%	5.5%	5.4%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2018/19	>=95%	-	80.7%	78.5%	83.6%		●	
	2017/18		-	86.6%	86.7%	85.0%	82.5%		
Medical staff appraisal rate (%)	2018/19	100%	-	100.0%				●	
	2017/18		-	100.0%		100.0%			
WRES indicator 1 - Percentage of BME staff in the overall workforce	2018/19	-	-			10.1%			
	-		-						
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2018/19	-	-			3.1%			
	-		-						
6 universal Statutory and Mandatory training requirements	2018/19	>=95%	-	90.3%	89.6%	88.7%		●	
	2017/18		-	91.0%	91.0%	91.5%	90.5%		
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2018/19	>52.0%	-	63.0%				●	
	2017/18		-	54.0%		53.9%			
Percentage of staff who are satisfied with the support they received from their immediate line manager	2018/19	>52.0%	-	64.0%				●	
	2017/18		-	62.0%		60.0%			
Sustain the time between placing adverts									
	Qualified Nurses	<= 112 Days	-					●	
	Administration	<=83 Days	-					●	
	Police Custody	<=145 Days	-					●	
Response Rate for Staff FFT	2018/19	>22.0%	-	24.0%				●	
	2017/18		-	22.2%		21.0%			
Response Rate for Inpatient FFT	2018/19	23.1%	-	38.9%	88.2%	100.0%		●	
	2017/18		-	15.4%	8.0%	12.6%	11.8%		
Response Rate for Community FFT	2018/19	6.8%	-	7.4%	5.6%	6.1%		●	
	2017/18		-	6.9%	6.6%	5.2%	4.6%		
Total agency cap	2018/19	£534k	£2,670k	£1,403k	£394k	£462k		●	
	2017/18		£6,089	£1,544k	£416k	£625k	£538k		
Percentage Spend on Temporary Staff	2018/19		7.1%	7.8%	5.0%	7.0%			
	2017/18		8.0%	8.1%	6.8%	9.1%	8.7%		

1. Retention

The overall trend in this area continues to be a positive one, with turnover and stability rates better than the same period in 2017.

The Trust's turnover rate continues to benchmark favourably against its Community Trust peers who are seeing a steep rise in turnover to 22.81% at June 2018. (Fig. 1)



In August 2018, turnover was 14.51%, slightly above the 2018/19 outturn target of 14.5%.

The stability index in August was 85.87%. Whilst slightly above the Trust target of 85%, this remains within tolerance.

The incidence of staff leaving the Trust within the first 12 months of employment remains slightly lower than overall turnover, at 14.39% at August 2018. The first year attrition rate has seen an increase from 12.47% at April 2018 and further analysis is needed to help identify any opportunities for improvement.

The overall number and distribution of leavers across the Trust's Business Units in August 2018 continues to remain consistent with a higher proportion leaving due to promotion.

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

2. Recruitment

To improve our recruitment we have been analysing the establishment, vacancy rate and recruitment activity to support development of a resourcing plan. This will increase efficiency in matching workforce demand and supply; and to assist the trust in planning ahead for this Winters resourcing needs.

A series of winter resourcing meetings have been planned in until end of month 7. These will focus on the resourcing needs of core services in advance of winter.

Separately to the winter resourcing meetings, an organisation wide Resourcing Steering group is being established to direct and measure outputs of the Resourcing plan

Background detail associated with recruitment and retention is at Appendix 1.

3. Health and Wellbeing

The sickness absence rate for August 2018 is 5.64%, (1.57% short term and 4.07% long term), which remains below the outturn 2018/19 target of 5.8%.

Improving staff's health and wellbeing (HWB) and reducing sickness absence remains one of the Trust's key priorities. Recent progress includes:

A HWB Steering Group has been formed, co-chaired by the Executive Medical Director and the Director of Workforce, which will meet for the first time in September 2018.

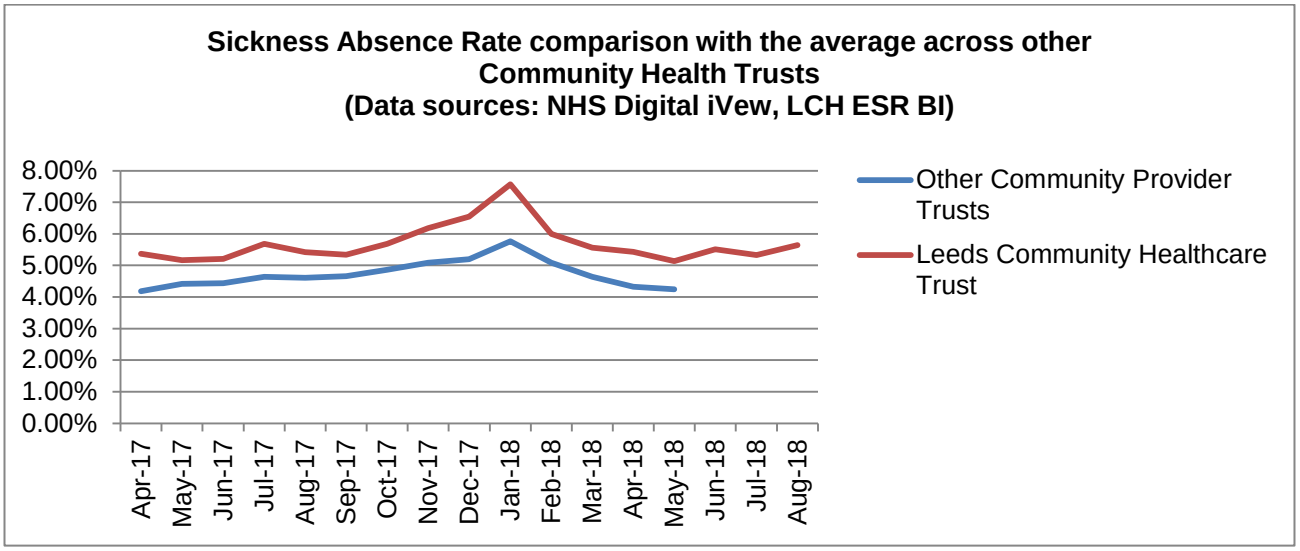
One of the Steering Group's first tasks is to consider the outputs from the self-assessment HWB Diagnostic tool completed by the HWB Engagement Group (see below) – to identify which 1 or 2 elements will make the greatest impact to the health and wellbeing of our staff. Those elements will then be the subject of extensive work with the Yorkshire and Humber Improvement Academy, who as will work with the Trust on 4 projects; HWB being one of them.

The inaugural meeting of the HWB Engagement Group took place in August 2018, in the form of a workshop. One of the tasks was the completion of a self- assessment HWB Tool, designed by NHS England, to produce an organisational dashboard on the following enablers and health interventions:

- Leadership & Management
- Data & Communications
- Healthy Working Environment
- Mental Health
- MSK
- Healthy Lifestyles

One of the areas at discussion at the Group, was whether an alternative and more positive way to report on the HWB of staff, could be to report on attendance rather than absence. This is currently being researched and will be subject to further debate in due course.

NHSi HWB programme – dialogue continues with NHSi and they will be visiting the Trust 11/10/18, to hear of our progress and offer support.



4. Appraisal

Appraisal rates have demonstrated an improvement of 4.7% this month, achieving an overall organisational level of 83.26%. All areas have improved, with a significant increase in the Corporate Directorate from 69.03% to 81.63%.

	Target	April 18	May 18	Jun 18	July 18	Aug 18
833 Overall	Imp Traj to 95%	81.88%	80.23%	79.89%	78.53%	83.26%
833 Adult Business unit		85.71%	82.02%	80.83%	78.64%	82.14%
833 Children's Business Unit		83.38%	84.91%	83.57%	79.12%	83.42%
833 Corporate Directorate		56.40%	57.35%	64.76%	69.03%	81.63%
833 Operations		88.46%	90.82%	90.24%	87.89%	89.16%
833 Specialist Business Unit		80.70%	77.14%	76.65%	77.58%	84.31%

Whilst this is an encouraging level of performance, it remains some way from the target of 95% compliance. 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
- Continued weekly compliance reports for SMT; for circulation to senior managers

- Team level performance reports have been developed for senior managers to access; these are currently subject to consultation and refinement with stakeholders

5. Statutory and Mandatory training

Performance against the target for compliance with universal statutory and mandatory training requirements has reduced again this month and currently stands at 88.66%.

		April	May	June	July	August
833 Overall	**Imp Traj to 95%**	**91.44%**	**89.89%**	**89.60%**	**89.57%**	**88.66%**
833 Adult Business unit		89.43%	87.94%	88.80%	89.43%	88.50%

833 Children's Business Unit		93.35%	92.58%	92.21%	91.71%	89.72%
833 Corporate Directorate		86.06%	92.55%	92.32%	92.56%	91.15%
833 Operations		82.93%	86.99%	84.20%	82.39%	83.48%
833 Specialist Business Unit		92.74%	90.32%	89.24%	89.91%	89.67%

This is a cause for concern and there are a number of key actions which have been initiated:

- Team level performance reports (alongside Appraisal information)
- Weekly update on performance to SMT, for circulation to senior managers
- Establishment of a Statutory & Mandatory Training Monitoring Group to focus on enabling actions to improve compliance rates

6. Staff Friends and Family Test (FFT)

The Q2 Friends and Family Test was launched on 3 September 2018 and will be live until 27 September. This is the first test of the new survey which is titled 'The Working Lives We Want' and includes new questions to provide a more regular pulse measure of engagement (details were provided in the July Well-Led report). Work is underway to boost response levels which stand at over 500 responses at 14 September (17%).

Analysis of results, including the new questions, will take place in early October and results will be distributed to all relevant stakeholders and organisational leaders in quick succession.

7. WRES Indicator

The Workforce Race Equality Standard has 9 indicators upon which each Trust can measure their progress on improving inclusion and equality of treatment for BAME staff, to enable pro-active and sustained action to be taken and for Trusts to be monitored at a national basis on their progress. The Trust is in the process of developing a WRES Action plan with specific areas to improve upon this important agenda.

At the last Business Committee, it was agreed to include one of the Indicators within the regular monthly reporting process, to ensure continued visibility of this agenda. The selected indicator is: *WRES indicator Percentage of BME staff in Bands 8-9, VSM (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce.*

As can be shown below, the Trust needs to make significant progress in this area:

% of BME staff in the overall workforce = 10.13%
% of BME staff in Bands 8-9, VSM = 3.13%

Within the WRES Action Plan there will be a number of initiatives, which have been shown to be successful elsewhere in increasing BAME representation within the workplace, such as reverse mentoring, career development, BAME champions etc.

Leeds Community Healthcare NHS Trust

Finance Report

Finance		Target	YTD	Q1	July	Aug	Sept	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2018/19	£0.6m	£0.8m	£0.3m	£0.7m	£0.8m		●
	2017/18		-£3.3m	-£0.9m	-£1.2m	-£1.9m	-£2.1m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2018/19	£2.5m	£2.5m	£2.5m	£2.5m	£2.5m		●
	2017/18		-£3.3m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	
Forecast underlying surplus	2018/19	£1.4m	n/a	n/a	n/a	n/a		●
	2017/18		-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	
Capital expenditure in comparison to plan (£k) - YTD	2018/19	£107k	£478k	£303k	£85k	£90k		●
	2017/18		£1.4k	£0.2m	£0.2m	£0.3m	£0.3m	
Capital expenditure in comparison to plan (£m) - Forecast	2018/19	£3.4m	£3.4m	£3.2m	£3.2m	£3.4m		●
	2017/18		£1.4m	£1.8m	£1.8m	£1.8m	£1.8m	
CIP delivery (£m) - YTD	2018/19	£0.3m	£1.6m	£1.0m	£0.3m	£0.3m		●
	2017/18		£2.8m	£0.6m	£0.9m	£1.0m	£1.2m	
CIP delivery (£m) - Forecast	2018/19	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m		●
	2017/18		£2.8m	£3.4m	£2.8m	£2.9m	£2.9m	
Use of Resources Risk Rating (from Oct 2016)	2018/19	2	1	1	1	1		●
	2017/18		1	1	1	1	1	

1. Income & Expenditure

The Trust continues to run £0.2m ahead of plan at August. All un-committed reserves have been released into the position. Contract income is running slightly behind plan due to £0.15m of penalties in respect of the police custody contract and £0.06m as a result of 6 community care beds not being available for the CCBS contract. Non contract income is on plan. The CQUIN income has been accrued as it is paid in arrears. Income assumes the allocated PSF monies for 2018/19.

Forecast income is £0.3m less than planned this will be mitigated by underspending on non-pay and reserves expenditure. The Trust continues to forecast delivery of the £2.5m control total surplus for the year.

Mitigation of the loss of £1.2m CCG income remains financial risk as the Trust works with Commissioners to identify decommissioning opportunities.

2. Pay and Non-pay Expenditure & Vacancies

Pay expenditure is £0.4m underspent at the end of August, this is after the pay award arrears. The main driver for the underspending is the level of vacancies which are 117 wte (118 wte Jul), or 4.4% of establishment; this is after the planned vacancy factor reduction. There has been an increase in the temporary staffing expenditure in month to £625k most likely in response to annual leave cover.

The Trust continues to be 15% below the agency cap target; the in-month expenditure on agency staff has returned to the expected run rate. Expenditure on medical agency staff is forecast to reduce as the year progresses.

Other non-pay costs include the as yet un-identified corporate and Trust-wide CIPs which are resulting in the year to date overspending. Drugs costs have returned to the expected run-rate.

3. Delivery of Cost Improvement Plans

CIP delivery is consistent with last month; there is a 4.5% (£75k) shortfall in respect of the procurement savings at the end of month 5. Specific corporate support savings have not been identified however corporate pay is underspent at the end of August so these savings are being made.

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

4. Capital Expenditure

The Trust had planned for capital expenditure of £3.241m, since April an additional national allocation of £127k has been made to spend on enabling public WiFi access in the Trust's premises; this brings the total planned expenditure to £3.368m. The Trust's forecast is to spend all of this. The year to date position is an overspending of £0.2m in respect of IT expenditure. This is a timing matter and will resolve as the year progresses.

5. Cash

The Trust's cash position remains very strong at £25.4m. Trade receivables total £6.8m at the end of August (£6.3m last month). Trade payables total £10.5m at the end of July which is £1.6m less than plan (£12.3m July). As a result of the above the cash position is £0.4m less than planned.

6. Better Payment Practice Code

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

7. Use of Resources Risk Rating

The Trust's risk rating at the end of August continues to be 1 overall, which is the lowest risk.

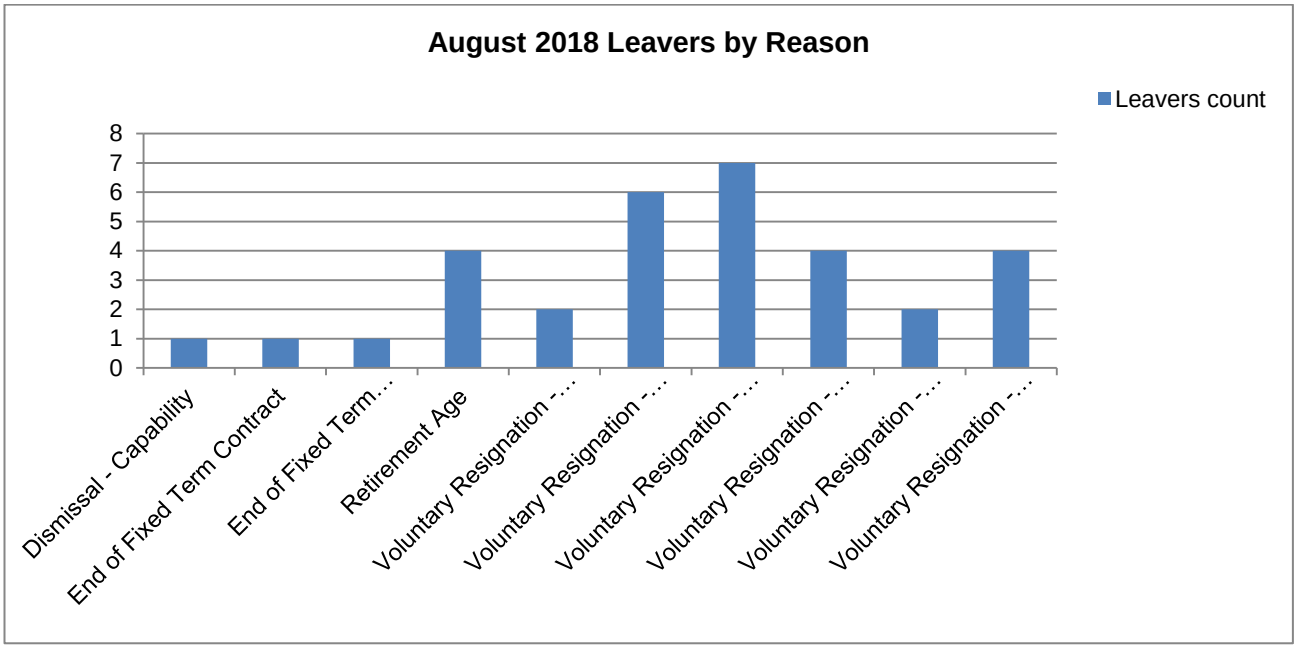
Agency expenditure has increased again in month however expenditure remains 15% below the cap set by NHS Improvement.

Appendix 1: Recruitment / Retention background data

In August 2018 there were 32 leavers across the Trust. Their distribution by Business Unit, staff group and reason for leaving is set out below:

Business Unit	August 18 Leavers
Adult Business unit	13
Children's Business Unit	3
Corporate / Operations	7
Specialist Business Unit	8
Executive	1
Grand Total	**32**

Staff Group	August 18 Leavers
Clinical Services and Scientific/medical	8
Administrative and Clerical	11
Allied Health Professionals	4
Estates	1
Nursing and Midwifery Registered	8
Grand Total	**32**



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

Resourcing plan: A single resourcing plan to address systemic and periodic recruitment and retention challenges has been developed. Discussions with General Managers are taking place to further develop the plan for each of the business units. Success measures have been established for first time fill rates and for hard to recruit posts. We are in the process of validating the data to inform the time to recruit success. Once systems are aligned the data will provide insight as to how the resourcing team are performing and where there are delays in the recruitment process. This will also provide valuable data to support workforce planning.

Retention plan (2018/19): Work continues to progress key retention initiatives. A working group has been established and is progressing the 'itchy feet' / internal transfer's initiative.

Redesign of the leadership & management offer: Design and content of the new leadership offer is now in place, ready for consultation and is on track to be offered to the first cohort from Quarter 3. The offer incorporates a leadership competency framework, linked to our Behaviours, and a 3 day leadership development programme which will run parallel to the Manager as Coach programme. The Management Essentials programme is also being redesigned and will be in place by Quarter 4.

Creating positive team cultures: All business units now have action plans in place which focus on employee engagement. There will be a focus on re-engaging teams in the Trust's values and behaviours during Quarters 4 and 5, together with a focus on listening and acting on feedback from our staff, through FFT, staff survey and local discussions.

Apprenticeships: At the end of month 5 we have a total of 40 apprentices (10 are part of a national pilot to introduce the new role of Nursing Associate, level 5 and a Nurse Apprentice, level 6). Work has been progressing to establish the number / type of apprenticeships the Trust can support.

Appendix 2: Detailed Financial Data Tables

Appendix 1 Detailed Financial Data Tables

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	£0.8m	£0.2m	£2.5m	G
Remain with EFL of (£3.708m)			-£3.7m	G
Remain within CRL of £2.039m	£0.5m	£0.2m	£3.4m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	100%	5%	95%	G
BPPC Non NHS Invoices Number 95%	97%	2%	95%	G
BPPC Non NHS Invoices Value 95%	96%	1%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.2m recurrent in year	£1.3m	-6%	£3.2m	R
CIP Savings £1.5m planned non recurrent in year	£0.3m	-	£1.5m	G

Table 2 Income & Expenditure Summary	August Plan WTE	August 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			(57.9)	(57.8)	0.2	(138.7)	(138.4)	0.3	0.2
Other Income			(4.2)	(4.2)	(0.0)	(10.1)	(10.1)	0.0	0.0
Total Income			***(62.1)***	***(62.0)***	***0.1***	***(148.9)***	***(148.5)***	***0.3***	***0.2***
Expenditure									
Pay	2,664.9	2,547.3	44.4	44.1	(0.4)	105.9	106.0	0.1	0.2
Non pay			15.4	15.4	0.1	36.6	36.5	(0.0)	(0.1)
Reserves & Non Recurrent			0.7	0.6	(0.1)	1.4	0.9	(0.4)	(0.3)
Total Expenditure	***2,664.9***	***2,547.3***	***60.5***	***60.0***	***(0.5)***	***143.8***	***143.4***	***(0.4)***	***(0.2)***
EBITDA	**2,664.9**	**2,547.3**	**(1.6)**	**(1.9)**	**(0.3)**	**(5.0)**	**(5.1)**	**(0.1)**	**(0.0)**
Depreciation			0.8	0.8	(0.0)	1.9	1.9	0.0	0.0
Public Dividend Capital			0.3	0.3	0.0	0.7	0.7	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.1	0.1	0.0	0.1	0.1	0.0
Interest Received			(0.1)	(0.0)	0.0	(0.1)	(0.1)	0.0	0.0
Retained Net Surplus	**2,664.9**	**2,547.3**	**(0.6)**	**(0.8)**	**(0.2)**	**(2.5)**	**(2.5)**	**(0.0)**	**(0.0)**
	Variance =	**(117.7)**							

Table 3 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	YTD Actuals £k
Directly employed staff	7,886	7,829	7,898	8,247	8,688	40,550
Seconded staff costs	88	51	109	86	83	417
Bank staff	176	218	224	45	163	825
Agency staff	438	417	549	394	462	2,259
Total Pay Costs	**8,588**	**8,515**	**8,781**	**8,772**	**9,396**	**44,051**

Table 4 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	336	332	(4)	12	
Clinical Supplies & Services	4,182	4,009	(173)	(101)	
General Supplies & Services	2,176	2,139	(36)	(25)	
Establishment Expenses	2,795	2,700	(95)	(48)	
Premises	5,184	5,261	78	115	
Other non pay	681	966	284	198	
Total Non Pay Costs	**15,353**	**15,407**	**53**	**150**	**(47)**

Table 5 Savings Scheme	2018/19 YTD Plan £k	2018/19 YTD Actual £k	2018/19 YTD Variance £k	2018/19 Annual Plan £k	2018/19 Forecast Outturn £k	2018/19 Forecast Variance £k	2018/19 Forecast Variance %
Estates	292	292	0	700	700	0	0%
Admin Review	104	104	0	250	250	0	0%
Corporate Support	125	125	0	300	300	0	0%
Procurement	75	0	(75)	180	180	0	0%
Non Pay Inflation	183	183	0	440	440	0	0%
CQUIN	188	188	0	452	452	0	0%
Contribution to overheads / fixed costs	346	346	0	831	831	0	0%
Release of Reserves	31	31	0	75	75	0	0%
IT Kit	125	125	0	300	300	0	0%
Discretionary spending	208	208	0	500	500	0	0%
Decommissioning cost reduction	0	0	0	700	700	0	0%
Total Efficiency Savings Delivery	**1,678**	**1,603**	**(75)**	**4,728**	**4,728**	**0**	**0%**

Table 6 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.2	0.1	(0.1)	0.7	0.7	0.0
Equipment/IT	0.0	0.2	0.2	0.5	0.5	0.0
Electronic Patient Records	0.1	0.1	(0.0)	0.5	0.5	0.0
CAMHS Tier 4	0.0	0.0	0.0	1.5	1.5	0.0
Public WiFi				0.1	0.1	0.0
Totals	**0.3**	**0.5**	**0.2**	**3.4**	**3.4**	**0.0**

Table 7 Statement of Financial Position	Plan 31/08/2018 £m	Actual 31/08/2018 £m	Variance 31/08/2018 £m	*Opening 01/04/17 £m*	Planned Outturn 31/03/19 £m	Forecast Outturn 31/03/19 £m	Forecast Variance 31/03/19 £m
Property, Plant and Equipment	28.8	28.9	0.1	*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**	**0.1**	*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	6.8	(0.1)	*8.8*	7.9	7.9	0.0
Cash and Cash Equivalents	25.8	25.4	(0.4)	*23.2*	27.3	27.3	0.0
Total Current Assets	**32.7**	**32.2**	**(0.5)**	*32.1*	**35.2**	**35.2**	**0.0**
TOTAL ASSETS	**61.6**	**61.2**	**(0.4)**	*61.5*	**65.8**	**65.8**	**0.0**
Current Liabilities							
Trade and Other Payables	(12.1)	(10.5)	1.6	*(12.1)*	(13.4)	(13.4)	0.0
Provisions	(0.4)	(1.3)	(0.9)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.5)**	**(11.8)**	**0.7**	*(13.4)*	**(13.8)**	**(13.8)**	**0.0**
Net Current Assets/(Liabilities)	**20.2**	**20.3**	**0.1**	*18.7*	**21.4**	**21.4**	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**49.1**	**49.3**	**0.2**	*48.0*	**52.1**	**52.1**	**0.0**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	*0.0*	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**49.1**	**49.3**	**0.2**	48.0	**52.1**	**52.1**	**0.0**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	1.8	1.8	0.0
Retained Earnings Reserve	18.3	18.5	0.2	*17.2*	19.7	19.7	0.0
General Fund	18.5	18.5	(0.0)	*18.5*	18.5	18.5	0.0
Revaluation Reserve	12.0	12.0	(0.0)	*12.0*	12.0	12.0	0.0
TOTAL EQUITY	**49.1**	**49.3**	**0.2**	48.0	**52.1**	**52.1**	**0.0**

Table 8 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	97%	95%	G
By Value	96%	95%	G

Table 9 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	51	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	8.2	1	20%	0.2
Underlying performance	I&E margin	2%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-15%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (55)

Meeting Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title Report on Delivery of 2018/19 Operational Plan Priorities	**For approval**	
Responsible director Executive Director of Finance and Resources **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by Business Committee 26 September 2018	**For information**	

Purpose of the report

This report provides an overview of progress towards achieving the Trust priorities set out in the 2018/19 operational plan at the end of month 5 and provides a forecast for the year-end.

Main issues for consideration

The 2018/19 Operational Plan sets out 14 priorities which will drive achievement of the Trust's 4 strategic goals. Each priority has one or more success measures, defined in SMART terms wherever possible / appropriate. There has been progress in defining some of the workforce measures that have not yet been defined. An overall RAG status is indicated which reflects an overall assessment of progress and performance in relation to the priority, not solely the component success measure RAG ratings.

There has been good progress across most priorities, most notably success in being awarded the contract for 0-19 services. Turnover continues to be low relative to most other community trusts and we are confident that the resourcing plan being finalised, will enable us to better address systemic recruitment and retention challenges. Sickness absence is below the year to date target but the significant challenge to reduce it to an acceptable level long term remains.

We continue to engage fully with partners to develop system resilience and progress key city-wide and West Yorkshire and Harrogate Integrated Care System sustainability and transformation agendas. We have flexed resource within Adult Business Unit to enable this and to respond to service pressures.

We are confident that the slippage in the development of our quality improvement approach due to competing organisational pressures will be recovered over the rest of the year.

We expect to achieve a green rating on all our 14 priorities by the end of the year.

Recommendations

The Board is recommended to:

- Note the assessment of progress at the end of August and the forecast for the year-end
- Consider whether sufficient assurance has been provided that plans to support achievement of priorities are robust and effective.

Strategic Goal: Recruit, retain and develop the staff we need now and for the future

Priority 1:	**Improve retention**			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan

- Implement retention plan
- Engagement – teams / services act on staff survey, continue focus on 'creating the working life we want' and 'Building the workplace we want'
- Develop Leadership and management throughout the Trust

Other key focuses indicated in our internal delivery plan

- Develop and promote apprenticeships that meet Trusts current and future workforce requirements

Progress update

The Trust's turnover rate remains on target at 14.5%.Key initiatives supporting reduction in turnover:

- **Resourcing plan:** a single resourcing plan to address systemic and periodic recruitment and retention challenges has been developed. Discussions with General Managers are taking place to further develop the plan for each of the business units.
- **Retention plan (2018/19):** work continues to progress key retention initiatives. A working group has been established to progress the 'itchy feet/internal transfers initiative and the first meeting was held in month 5. Initiatives may need to be reprioritised based on the development of the resourcing plan.
- **Redesign of the leadership & management offer:** design and content of the new leadership offer is now in place, ready for consultation and on track to be offered to the first cohort from quarter 3. The offer incorporates a leadership competency framework, linked to our Behaviours, and a 3 day leadership development programme which will run parallel to the Manager as Coach Programme. The Management Essentials programme is also being redesigned, and will be in place by quarter 4.
- **Creating positive team cultures:** all business units now have action plans focussed on employee engagement. There will be a focus on re-engaging teams in the Trust's values and behaviours during quarters 4&5, together with a focus on listening and acting on feedback from our staff, through FFT, staff survey and local discussions.
- **Apprenticeships:** at the end of month 5 we have a total of 40 apprentices (10 are part of a national pilot to introduce the new role of Nursing Associate, level 5 and a Nurse Apprentice, level 6). Work has been progressing to establish the number/type of apprenticeships the Trust can support. Further work is needed with each of the business units so this can be included within the Resourcing plan. SMT will be updated of progress and strategy for progressing this agenda by end of Quarter 2.
- **Medical engagement:** to repeat the survey in 2019/20

Success Measures	**Month 5 RAG status**	**Year-end Forecast RAG**
Turnover reduces to 14.5% by end of FY18/19		
Increase in national staff survey score for staff engage-ment	Not known till March 2019	
Determine medical engage-ment		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 2:	Improve recruitment with a particular focus on recruiting in hard to recruit areas			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan • Review recruitment and selection process, systems and methodologies	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
Progress update To improve recruitment we have been analysing the establishment, vacancy rate and recruitment activity to support development of a resourcing plan. This will increase efficiency in matching workforce demand and supply and assist the Trust in planning for this winter's resourcing needs. Winter resourcing meetings scheduled to focus on core services resourcing needs in advance of winter. An organisation-wide resourcing steering group is being established to direct and measure outputs of the Resourcing plan.	75% of vacancies recruited to 1st time:	72%	
Increase in number of vacancies recruited to 1st time: a review of past performance shows consistently high 1st time fill rate of over 70%: at end of Q1 reported 78%. End of month 5 is reporting below target but this is due to a shorter reporting period and full data not being available due to the recruitment life cycle.	60% fill rate for hard to recruit posts	Band 5 nurses: – 80%; Police Custody HCP's: 103%	
Improve recruitment in hard to recruit areas: Hard to recruit areas are being defined through the analysis of the establishment and vacancy rates and through consultation with the business units and development of the resourcing plan. This work has shown nursing band 5/6 and specialist nurse vacancies to be the most difficult to recruit. Progress at end of month 5: • 24 newly qualified nurses recruited to commence September/October 2018 - target of 30 (80% fill rate). We are working to maintain this number of nurses through good onboarding / induction experience. Planning has commenced to recruit newly qualified adult nurses qualifying in 2019. • 31 band 6 healthcare professionals recruited to Police Custody - target of 30. • April – August 18: 258 vacancies advertised, 175 new starters			
Improve time to hire (measured from the date of advert to the start date). We are validating the data to inform the success measure and will present this to Business Committee in September 18. We need to align our systems (ESR/NHS Jobs) so that meaningful data is available. This work will provide insight as to how the resourcing team are performing, where there are delays in the recruitment process and will provide valuable data to support workforce planning.	Improve time to hire – TBA		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 3:	Reduce sickness absence			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focus • Develop a Sickness Absence project	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
Progress update Sickness absence continued below target in July and August: 5.3% and 5.6% respectively. The inaugural meeting of the Health and Well-Being Engagement Group took place in August 2018. One of the outputs was the completion of NHS England's Health and Well-Being diagnostic tool, to identify areas of focus. The Steering Group will meet in September 2018 to consider the above and determine which 1 or 2 areas to use a Quality Improvement approach, facilitated by the Yorkshire and Humber Improvement Academy. NHSi Health and Well-Being programme – dialogue continues with NHSi. NHSi will visit the Trust 11 October to hear of our progress and offer support.	Reduction in sickness absence rate: target 5.8%	5.6%	

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Strategic Goal: Provide high quality services

Priority 4:	**Achieve or maintain good or outstanding rating for all services (CQC and internal Quality Challenge +)**			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan

- By end June '18 complete QIP actions identified from February '17 CQC inspection
- Roll out refreshed Quality Challenge + by May 2018
- Implement our approach to ensure adequate focus on quality governance and ensure appropriate support to small isolated services

Other key focuses included in our internal delivery plan

- Share good practice identified through quality visits and self-assessments across teams and services
- Ensure quality impact assessment completed prior to any service change and effective governance structures are in place to provide the necessary assurance
- Progress work to ensure enabling systems such as ESR and training are effective and responsive to services requirements

Success Measures	**Month 5 RAG status**	**Year-end forecast**
70% of services rate themselves good or outstanding in the Quality Challenge self-assessment		
80% of services rated good or outstanding following Quality Challenge Quality Visit		
Services currently rated 'requires improvement' by CQC, achieve good or outstanding rating if re-inspected		

Progress update

CQC good / outstanding rating: overall status remains amber reflecting:

- further improvements and consolidation in clinical governance, operational processes and staff morale however continued concerns about Hannah House. All CQC actions completed by May 2018. Additional senior level support is being maintained.
- slight delay in completing QIP actions: the CQC also rated Little Woodhouse Hall and the Sexual Health service 'requires improvement'. The Sexual Health service has now completed all actions. Little Woodhouse Hall will complete the 1 outstanding action relating to staff compliance for Childrens Safeguarding training by the end of September.

Quality Challenge Plus: as reported in quarter 1, refreshed Quality Challenge+ rolled out on time, 82% of service self-assessments (34 of 41) rated good. Only 1 peer Quality Visit completed July – August (5 in quarter 1), service rated requires improvement. Low number of quality visits reflects focus on ABU in quarter 2 – agreed to reduce the number of visits because of service pressures – plus insufficient availability of Quality Visit assessors. Scheduling will be reviewed and comms campaign developed.

Business Unit senior management and SMT have increased their focus on understanding and escalating quality, operational and people concerns at team / service level through monthly performance review meetings and Business Unit's quarterly progress review meetings with SMT. Performance Brief Review will include improving triangulation of service level information to provide early warning / signal adverse performance and / or pressure in services.

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to achieve

Priority 5:	Develop LCH's quality improvement approach which engages staff, service users & the public			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan

- By the end of quarter 1 develop a clear appropriate evidence-based QI model and improvement methodology for use across the organisation
- By the end of quarter 1 identify up to 4 QI projects at organisational and business unit level to implement in 2018/19
- Encourage QI projects to be undertaken at team / service level

Other key focuses included in our internal delivery plan

- Engage SMT, Board and the leadership community in understanding our QI approach and its role as a key enabler for organisational success
- Successfully engage an external Improvement partner to support development and implementation of our approach
- Support leaders, staff and service users involved in QI projects with access to QI training and improvement coaching
- Communicate, share and spread QI work undertaken and its impact through a QI communication and engagement strategy

Progress update

Whilst good progress has been made this year, there has been slippage June - July due to other organisational priorities / pressures. There will be a strong re-focus to ensure there is more awareness and support for services around the quality improvement agenda.

4 organisational QI learning projects: identified, scoped; project teams identified, work commenced:

- Improving staff attendance, health & well-being
- Improving the coordination of care for children with continuing care needs
- Improving the quality of patient transfer from community bed to hospital with a focus on transfer of information
- Improving the effectiveness of the CUCs service offer

The Improvement Academy are supporting the learning projects and offering coaching and development to Trust Improvement Coaches, through action learning and mentoring. The QI projects have taken longer to establish than anticipated and may continue beyond March 2019.

Local QI projects: work has commenced on the development of a resource pack to support local quality improvement work; this will be actively promoted during Q3

QI Training: 4 QI training sessions planned during Q3 and Q4 for Trust leaders, together with workshops for the 4 project teams, focussing on QI methodologies and measurement, applied to the specific areas of improvement.

QI communications and engagement: a significant communications focus on quality improvement is planned for Q3 and Q4 – encouraging engagement, sharing improvement stories, providing updates.

Success Measures	Month 5 RAG status	Year-end forecast
Recognising the importance of QI as a priority in LCH (national staff survey)		
Able to make improvements and changes in their service area (national staff survey)		
Complete up to 4 QI projects with good outcomes and service user involvement		
Further 100 staff trained in QI		

	On track		Slight under performance &/or risk of not achieving priority	Not achieved/expected to achieve

Priority 6:	Provide harm-free evidence based care		
Overall RAG Status	**Month 5**		**Year-end forecast**

Key Focuses indicated in Board approved plan	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**

• Further develop use of tools and provision of information supporting quality improvement to front line staff:
  ○ formal accreditation of safety huddles in the ABU by the Quality Improvement Academy
  ○ PIP 2 roll-out and subsequent development
  ○ embed use of Quality Boards in specialist services: 11 services using the Boards by the end of quarter two, fully embedded by the end of quarter 3
  ○ make better use of data to identify and understand variation in practice, inform service improvement and reporting
  ○ strengthen use of benchmarking through agreed organisational approach
• Reduce the incidence of avoidable harms through implementing pressure ulcer, falls and CAUTI work plans
• Further develop clinical outcomes work in line with the agreed plan
Additional key focuses included in our internal delivery plan
• Continue to improve compliance within 2 years with NICE guidance
• Implement the Trust's refreshed Research Strategy with a clear focus on research that relates directly to and can benefit our services and practice			

Progress Update No Cat 4 pressure ulcer targets for the year to date. Three Cat 3 pressure ulcers in July: 4 for the year to date. Pressure ulcer work plan implementation on track. Chapeltown NT participating in the NHSi Pressure Ulcer Collaborative, using QI methodology and Statistical Process Control to drive improvement in pressure ulcer management. Falls work plan is being refreshed informed by output from PSEG workshop. Revised CAUTI policy to be signed off. Quarter 1 report flagged investigation of low VTE risk assessments in June. Investigation confirmed this reflected data quality following change of reporting system. VTE risk assessments 100% in July and August. Other workstreams developing use of tools and provision of information supporting quality improvement to front line staff are progressing well: • ABU safety huddles have gained national accreditation • all Specialist BU services that requested a Board have received them. Plans on how they will be used in place. 1 additional service has now requested a Quality Board: will be implemented in quarter 3. Evaluation of use of Quality Boards to be undertaken in quarter 3. • As reported in quarter 1, benchmarking information now available on PIP • Develop clinical outcomes: engagement with corporate and clinical staff about the proposed organisational approach: to be presented to Quality Committee in September	Aim: 0 avoidable Cat 4 pressure ulcers. Minimum target: 50% reduction 20% reduction in Cat 3 pressure ulcers	0 YTD 4 YTD	

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Strategic Goal: Work in partnership to deliver integrated care and care closer to home

Priority 7:	**Engage fully in the development and implementation of the Leeds Health and Care Plan and West Yorkshire and Harrogate H&CP Plan under-pinned by an effective relationship with all partners**			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses

- Ensure the necessary governance, capacity, capabilities and systems are in place to support the development and testing of new models of care
- Develop our relationship with primary care with a particular focus on developing integrated nursing
- Play a full part in the development and implementation of the WY & Harrogate Leeds HCP Plan
- Ensure robust project management and governance of the West Yorkshire and Harrogate CAMHS NMoC project and deliver to key milestones, quality and financial parameters

- **Partnership governance**: Approach strengthened to ensure early and ongoing focus on quality governance in relation to partnership business developments. A checklist of questions is being developed to be used when entering partnership arrangements/collaborations (will be used to determine appropriate actions in respect of financial and contractual governance) and will underpin all CIC agreements. Partnership Internal Audit review to go to Audit Committee in October 2018. Plans progressing for the 1st meeting of the Provider Committees in Common (CIC) in autumn 2018. First meeting of the LCH / GP Federation CiC 14 September.
- **Developing our relationship with primary care**: continues to be a key focus. Agreement to trial integrated nursing post winter, to explore development of a home visiting service and NMoC with First Care Practitioners. Through collaboration, standardising NT tasking to GPs to improve communications with GP practices, increased capacity for matron prescriber training and arranged honorary GP practice contracts for community nurses to enable community nurses to do staff flu immunisation for housebound practice patients on LCH caseload.
- **Leeds Health and Care Plan development**: continue to be actively engaged in developing and implementing key workstreams e.g. LCP development, involvement in citywide strategic developments for frailty (1st Population Health Management pathway), diabetes, urgent care and cancer care in the community–see priority 8. To develop city-wide health & social care careers site
- **WY & Harrogate HCP Plan**: joined the Integrated Care System programme in May. This attracted over £8m of transformation funding. Leeds will benefit from its share of this resource in providing greater resilience to A & E plans this winter, developing primary care networks and other ICS priority programmes. Funding secured to establish integrated health and care ambassadors to work with schools and deliver an integrated internship programme for students across WY and H.
- **WY CAMHS NMoC**: crisis service being implemented funded from savings delivered by the NMoC. CCG seeking funding to extend the service out of hours.

Success Measures	**Month 5 RAG status**	**Yr-end forecast**
Active engagement in the development of governance in relation to PHM & NMoC e.g. risk-sharing, costings, contract management, quality governance, operational protocols		
Meet agreed time-frames & require-ments for developing and implementing the 1st PHM pathway & CAMHS NMoC		
LCH involvement in NMoC pathway and pilots being developed or recurrently funded		
Achieve 1% WY & Harrogate engagement CQIN		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 8:	Engage fully as a key partner in the development of Local Care Partnerships and their plans and ensure service responsiveness in implementing new models of care and pathway redesign			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focus
Work actively with partners to develop and implement Local Care Partnership plans and more integrated ways of working across all locality areas

Progress update

LCP development: key developments July – August have been development of staff comms about LCPs and development and submission of a proposal to the West Yorkshire and Harrogate Health and Care Partnership to secure funding from the notional allocation of £844k from ICS transformation monies to support LCPs in Leeds to progress further faster.

The 1st first Children's Hub pilot (childrens community care clinical MDT) is operating in Pudsey. 2 further pilots to be established.

NMoC and pathway redesign

- Virtual Respiratory Ward: service went live in June with phased implementation (service limited to lower risk patients) due to LTHT not yet having signed off the medical model.
- MSK: The First Contact Practitioner (FCP) model has been agreed as the future model to improve access to musculoskeletal expertise in localities. Recruitment has taken place to start provision of the model in 2 localities October 2018 funded initially by the CCG.
- Diabetes: LCH is fully involved in the Task and Finish Groups to develop a citywide diabetes strategy.
- CIVAS Pathway Development: 2nd clinic established in quarter 1 at St James; working with LTHT to increase referrals. From 1st August the services has provided line care for Oncology patients (currently provided by NTs). Model evaluated in September. Commissioners agreed to extend the pilot for a further 6 months and add new pathways.
- ABU senior management fully engaged in planning for the roll-out of city-wide development of Urgent Treatment Centres

Success Measures	Month 5 RAG status	Year-end forecast
Active engagement and influence in all 18 LCPs		
New models of care (NMoC) implemented to agreed time-frames and specifications		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 9:	Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
• Evaluation of NT self-care trial and adoption of principles into business as usual. Understand the impact of the model on staff capacity by September 18. • Embed health coaching / restorative practice approach in Children's, Specialist and Adult Business Units ***Additional key focuses included in our internal delivery plan*** • Work with LTHT to identify pathways where early intervention may result in a self-care approach • Use of Quality Improvement methodology to support culture/behaviour • Exploit use of digital technology to support self-care			
Progress update **NT self-management model**: NT self-management pilot continues to deliver impact in Armley and Chapeltown. Initial reporting demonstrates 84% of patients have increased skills, confidence and knowledge to manage their health. 54% moved up 1 or more levels (using validated outcome tool). The 2nd stage of the pilot goes live on 1 October 2018 and aims for self-management to become an embedded function for all NT staff. Clinical Pathway Lead seconded to support leadership of the team plus a Self-Management Lead. Recruiting 26 self-management facilitators: 18 recruited so far. Staff from Live Well Leeds project Band 4 level now working with the Self-Management Team. The Better Conversations Team will support the 2nd stage. **Rolling-out and embedding health coaching and restorative practice**: • Training dates scheduled for October-December 2018 – 60 places across the 3 business units. Dates for Jan-March in the pipeline • Adults Business Unit – to train 60 Neighbourhood Team staff in health coaching • Childrens Business Unit – to complete roll-out of health coaching within ICAN and SLT: 115 staff • Specialist Business Unit - Long Term Conditions team offered priority training for October 2018. • Health Coaching Steering Group re-focused around responsibility for identifying staff for training; pre-training preparation and post –training embedding and support and evaluation of impact. Exploration of link between LCH outcomes work and health coaching through CEG **Exploit use of digital technology to support self-care**: • Developed and evaluating the StepUp! app with a view to rolling it out in CAMHS to support service users aged 14+. Implementation team nominated for a Medipex award. • The Infant Mental Health Service has been working with BabyBuddy app developers to include video resources and other information that promotes infant mental health.	NT staff trained to enable roll-out and embedding of NT self-management model in line with the agreed plan		
	Embedded self-management approach in NTs		
	Roll-out and embed health coaching and restorative practice in services and align to the city-wide plan		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 10:	Ensure LCH is at the forefront of the development of the Leeds Primary Care Provider Partnership (was known as the Alliance)			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses • Pro-actively support the development of the Leeds Primary Care Provider Partnership • Maximise the role of LCH services and corporate teams in service, pathway and new model of care development and provision by the Partnership, in line with our business development strategy	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
This priority is superseded by development of our integration work with the GP Federation	Robust governance in place for Primary Care Provider Partnership contracts e.g. risk-sharing arrangements, clinical governance framework, contract management framework, operational protocols		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Strategic goal: Create sustainable services

Priority 11:	**Establish a project team and implement the project plan for developing the CAMHS Tier 4 new building and service offer**					
Overall RAG Status	**Month 5**		**Year-end forecast**			
Key Focused indicated in Board approved plan Ensure the capacity, skills and experience are in place to develop and implement the PID and business case for the new build ***Other key focuses included in our internal delivery plan*** • Establish robust project governance by April 2018 • Engage fully CAMHS in-patient team with corporate services to develop models for the delivery of high quality, efficient patient services				**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
Progress update Progress continues to be made towards the key milestone of a guaranteed minimum price from the P22 partner and submission of a planning application. An engagement event with local people and councillors took place 12 September. Key risk: total projects costs unlikely to be within the original £13m bid: LCH and LYPFT working together have mitigation plan in place				Approvals received and work starts on sit		
				Progress made on developing the service offer in line with the project implementation plan		
	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved	

Priority 12:	Implement year 1 of the business development strategy: proactively generate income, scope opportunities to provide services in neighbouring areas and support the Leeds Primary Care Provider Partnership in developing business development propositions			
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
• In Q1 and 2 develop a corporate infrastructure that ensures we can generate income effectively, to include costing, marketing, payments processes • In Q 3 and 4 complete / refresh service annual self-assessments to support understanding about the market and service competitiveness, agree priority actions to improve competitiveness and review the service strategy ***Other key focuses included in our internal delivery plan*** Q1 and 2: • Review lessons to understand fully why previous out of area bids have not been progressed and review bid no-bid documentation to ensure it is fit for purpose • Provide business development expertise to the Leeds Primary Care Partnership Q3 and 4: • Map commissioning stakeholders in neighbouring areas and start proactive engagement to raise the profile of LCH and develop intelligence about future tenders			
Progress update **Traded services**: project on track: priority projects moving forward, costings agreed, traded service infrastructure agreed and framework being developed. Arranging financial sign-off system for payment, booking and marketing packages. LCH Marketplace to be included in LCH corporate website development. Surplus targets to be considered by Business Development Board in September. **Developing out of area business**: currently assessing whether to bid for 1 out of area tender. **Providing business development expertise to the Leeds Primary Care Provider Partnership**: due to the significant expansion of the Leeds Primary Care Provider Partnership it is no longer appropriate to offer business development support. Our focus is now providing business development support to our developing relationship with Leeds GP Federation	Surplus created from traded services projects – *target TBA*		
	Number of out of area bids submitted - not appropriate to RAG rate	0	
	Number of bids awarded - not appropriate to RAG rate	0	

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 13:		Develop an innovative and viable model for the 0-19 pathway that meets commissioners' requirements		
Overall RAG Status	**Month 5**		**Year-end forecast**	

Key Focuses indicated in Board approved plan	**Success Measures**	**Month 5 RAG status**	**Year-end forecast**
• Close working with commissioners to influence the specification • Development and implementation of engagement plan with staff, young people and other stakeholders to maximise the users voice in our submission • Establishment of bidding team with clear capacity and capability to write a winning bid ***Additional key focus included in our internal delivery plan*** • Work with mHabitat to ensure a digitally optimised submission			
Progress update Contract award notification announced 17 September further to successful bid submission. Mobilisation planning and Transformation Assurance process started ahead of notification. Transformation Assurance key components are: monitoring the programme plan, ensuring there is the necessary resource in both the programme team and corporate support and completing the 2nd phase of the QIA. Programme governance structure agreed; the 1st programme board sits 24 September. Consultation period re leadership structure concluded October 1st 2018. Process being developed to track and mitigate risk in relation to financial penalties. Mobilisation begins October 2018.	Viable response to invitation to tender within price constraints and that does not compromise quality		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

Priority 14:		Work on productivity within agreed services with clear expectations regarding workload and efficiency requirements			
Overall RAG Status	**Month 5**		**Year-end forecast**		
Key Focuses • Establish a working group to prioritise services and areas to be explored by May 2018 • Use of Quality Improvement methodology to support productivity gains, to include developing capability and use by services of capacity and demand tools and analysis				**Success Measures Baseline / 17-18**	**Month 5 RAG status**	**Year-end forecast**
Progress update Workplan developed for the 1st phase of work: • agreed to focus on services that are internal outliers across a number of productivity measures e.g. Did Not Attend / Child Not Brought, first to follow up ratios. Initial analysis highlighted Podiatry, MSK (including Spinefit), Health Visiting and the Continence and Colorectal Service (CUCs). Data is being reviewed with service teams to understand the local context; patient engagement will add to this intelligence. Initial analysis also highlighted CAMHS, however there is an established workstream looking at productivity in CAMHS so it was decided not to include CAMHS in this project. • comparing the findings of the Carter Review with performance in the Neighbourhood teams focusing on 4 key metrics. • corporate benchmarking: will be informed by the results of the 2017/18 national audit, expected to be published in October.				Prioritised services achieve target productivity improvements – target TBA		

	On track		Slight under performance &/or risk of not achieving priority		Not achieved/expected to be achieved

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM (56)

Meeting: Trust Board 5 October 2018	**Category of paper**	
Report title: Organisational Development refresh update	**For approval**	
Responsible director: Director of Workforce **Report author:** Director of Workforce	**For assurance**	
Previously considered by: Business Committee 27 September 2018	**For information**	✓

Purpose of the report

This paper provides the Board with an update on development of the LCH Workforce Strategy, which will be the successor to the existing LCH Organisational Development Strategy (2017-19).

It outlines the context and framework for the Workforce Strategy, which will come to the Board in final draft for approval in early 2019.

Recommendation

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

LCH Workforce Strategy: update and draft framework

September 2018

1. Background

1.1 The fundamental purpose of the LCH Workforce Strategy will be 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.

1.2 In August 2018, the Board received and noted a paper describing broad details of the review and refresh of the existing LCH Organisational Development Strategy 2017-2019.

1.3 This paper builds on those broad details, introducing the context and framework for the document that will be referred to as the LCH Workforce Strategy 2019 – 2021.

1.4 The context and framework for the LCH Workforce Strategy were presented to the Business Committee on 26 September 2018 who were content and welcomed the direction of travel as well as noting it provided a level of "reasonable assurance".

1.5 It is proposed that a full draft of the LCH Workforce Strategy is brought to the Board in early 2019, for approval prior to its implementation.

2 Context and alignment

2.1 The strategy will align with the **external** context that LCH operates in; referencing a range of research and policy direction, including:

2.1.1 Secretary of State for Health Matt Hancock's focus on workforce; technology and prevention (July 2018)

2.1.2 Next Steps on the NHS Five Year Forward View (March 2017)

2.1.3 Leeds Health & Wellbeing Strategy 2016-2021

2.1.4 West Yorkshire & Harrogate Health & Care Partnership Workforce Strategy (April 2018)

2.1.5 *Employee Engagement and NHS Performance* (West, M & Dawson, J, King's Fund, 2012)

2.1.6 *A Year of Integrated Care Systems* (Charles, A et al, 2018)

2.2 The strategy continues its line of sight through LCH's **internal** context: its strategic objectives, corporate priorities and significant risks, maintaining a clear focus on the recruitment, retention and attendance challenges articulated in them.

2.3 Intrinsic to the strategy is LCH's **cultural** context; anchored by its Vision, Values and Behaviours; and its aspirations towards a culture based on genuine engagement and a people centred approach celebrating diversity and inclusion.

2.4 The strategy draws on successful cultural transformation initiatives introduced in comparable organisations including MerseyCare NHSFT.

2.5 Partnership with other organisations is an important contextual element, notably the GP Confederation, and also other health and care partners across the city and the broader integrated care system. The workforce journey is one of increasing integration and it is imperative that this strategy delivers the foundations to facilitate the LCH role in partnership working across the city of Leeds.

2.6 Simplicity, alignment and clarity are core to the strategy, to facilitate meaningful engagement and communication throughout its development and implementation.

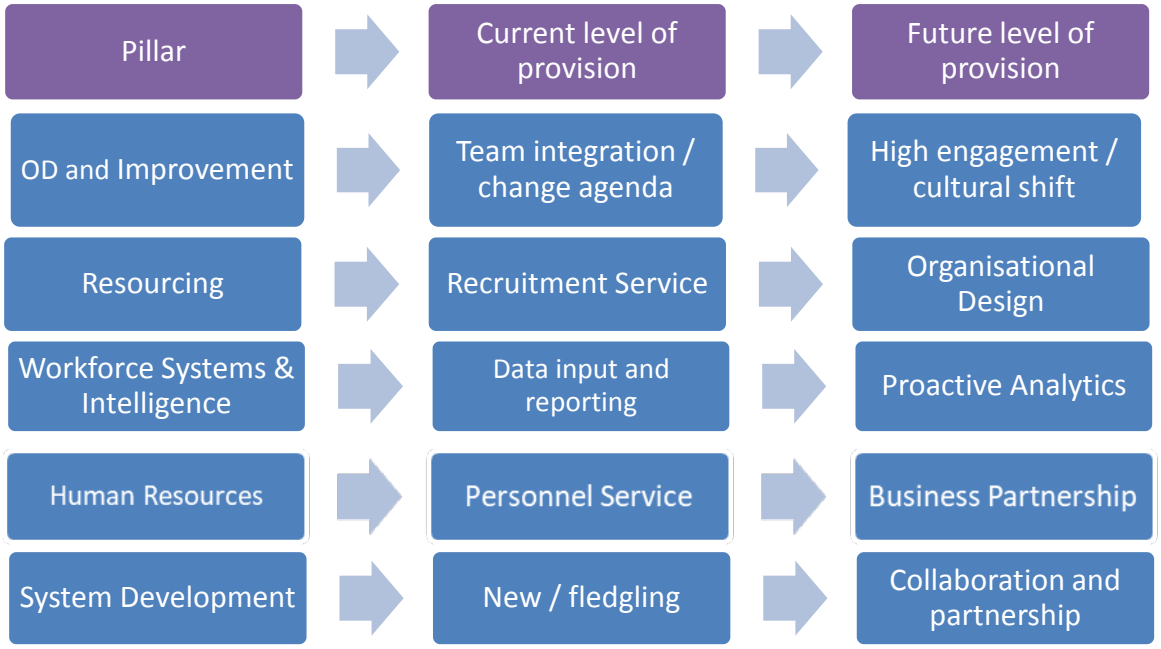
3 LCH Workforce Directorate

3.1 The scope and ambition of the strategy must be set within the resources and capabilities of the LCH Workforce Directorate, aligning organisational aspiration with achievable deliverables.

3.2 To maximise the Workforce Directorate's potential to add value over the lifespan of the strategy, a core theme in the strategy is to develop the Workforce Directorate's offer to the organisation: from primarily transactional towards primarily transformational.

3.3 A summary of this development is in Fig 1, below: more detail will be incorporated into the strategy itself:

Fig 1: Development of the Workforce Directorate offer



4. Workforce Strategy Framework

4.1 In conceiving the Workforce Strategy, the Workforce Directorate has developed a framework setting out the primary pillars of its portfolio, and its key priorities (Appendix 1)

4.2 Each pillar holds responsibility for a key theme of the strategy, specifically:

4.2.1 Organisational Development and Improvement - Leadership & skills

4.2.2 Resourcing – Resource plan for LCH

4.2.3 Workforce Systems and Intelligence - Proactive analytics

4.2.4 Human Resources – Health and Wellbeing

4.2.5 System Development - Integration

4.3 A set of objectives is in development for each of the pillars. An example, for the Organisational Development and Improvement (ODI) pillar, is attached at **Appendix 2.**

4.4 **Engagement** stretches across the framework, a cross-cutting theme permeating all elements of the strategy. This links to the well-regarded Kings Fund research attributed to Michael West, *Employee Engagement and NHS Performance* (2012), which draws links between levels of engagement and organisational performance in a range of areas.

4.5 In developing the strategy and objectives, case studies are being sourced from across the organisation, of people's lived experience of LCH. Case studies from

staff, managers and patients, including both positive and negative experiences, will ensure the strategy's focus is rooted in engagement.

5 Deliverables underway

5.1 Whilst the Workforce Strategy continues to be developed, deliverables linked to the strategy's key themes are already underway, including:

5.1.1 Launch of new Leadership & Management programme

5.1.2 Introduction of refreshed "Working Lives We Want" (FFT) survey

5.1.3 Production of first stage Resourcing Plan

5.1.4 Launch of Health & Wellbeing Programme focussing on a QI approach

5.1.5 Introduction of new leadership to Workforce Systems & Intelligence

5.1.6 Establishment of profile and relationships with partner organisations

5.1.7 Instigation of HR case conferences and professional development

5.1.8 Review of HR service offering to the organisation

6 Next steps

6.1 Engagement has commenced on the development of the Workforce Strategy, including within the Workforce Directorate itself; with SMT; with Business Committee; with trade union partners at the JNCF; and with Business Unit colleagues, beginning with the Specialist Business Unit Development Forum (September 2018).

6.2 Feedback to date is positive, with multiple offers of case studies to inform the strategy's objectives and deliverables.

6.3 Further engagement is planned for Q3, including at Leaders Network, Senior Ops and Community Talk.

6.4 Pillar objectives will be finalised towards the end of the engagement process; and underpinned by KPIs.

6.5 The draft LCH Workforce Strategy (2019-21) will be brought to Board for approval in January 2019.

7 Conclusion

7.1 Since the August Board, work has continued on the development of the new LCH Workforce Strategy (2019-21), aligning it with the external, internal and cultural context relevant to LCH.

7.2 The draft Workforce Strategy Framework (**Appendix 1**) encapsulates the strategy's proposed pillars and themes.

7.3 Development of the strategy continues, with case studies and direct engagement with staff and managers key to finalising its content.

7.4 The draft strategy will be brought to the Board for approval in January 2019.

8 Recommendations

8.1 The Board is invited to note the progress made in the development of the LCH Workforce Strategy (2019-21); and its schedule for engagement and completion.

8.2 Board members are invited to comment upon the content of the draft Workforce Strategy Framework.

Jenny Allen and Laura Smith
Director of Workforce
27th September 2018

Appendix 1: Draft Workforce Strategy Framework

Workforce Strategy on a page

Cross-cutting themes: *Engagement. Professionalism. Service. Succession.*

	ODI	RESOURCING	SYSTEMS & INTELLIGENCE	HUMAN RESOURCES	SYSTEM DEVELOPMENT
Priorities	**Leadership & Management redevelopment** Leadership Competency Framework L&D strategy & approach Organisation of Adults Cultural mapping	**Resourcing plan** NHSI Retention programme Induction & on-boarding review	**Proactive analytics** Automated management reports E-Rostering Safeguarding project Bank re-launch Temporary Staff Induction / On-boarding	**Health & Wellbeing Project** Pay Deal implementation HR Service Offer WRES and WDES Gender pay gap	**Confederation plan** Cementing stakeholder relationships Confed employer set-up Workforce offer scoping Professional networks
Core functions	Learning & Development Staff Survey Cultural Mapping Talent Management System OD Freedom to speak up Stat & Mand Quality appraisal QI Approach & Projects	Recruitment Retention Service provision to organisation Apprenticeships Induction On-boarding	CLaSS: Temporary Staffing services External suppliers / contracts Performance & trends ESR administration Data quality E-learning Workforce Planning	Casework Organisational Change Employment policies & procedures Equality & Diversity Partnership working Terms & conditions Medical staffing GDPR	Primary Care CIC Integration journey System relationships H&SC Academy Leeds WF Work stream ICS Workforce Plan LWAB

Appendix 2: Exemplar Pillar Objectives (work in progress)

Organisational Development & Improvement

Cross-cutting themes: *Engagement. Professionalism. Service. Succession.*

	Objectives & deliverables		Any big changes needed to enable delivery?
18/19	To redesign the leadership & management development offer To develop a systematic approach to staff engagement, rooted in values & behaviours and connected to Quality improvement approach To support the development of the Organisation of Adults To develop our approach to talent management, linking closely with the competency framework and appraisal process To review & improve the Learning & Development system and infrastructure across the organisation To work effectively as a system partner in the development of L&D and OD via the Leeds Health & Care Academy To continue implementation of Health Coaching as part of the self management agenda	**18/19**	• More joined up internal approach to L&D • Shift in leadership / management culture towards "letting go safely": greater opportunities for staff engagement • Time for staff engagement & QI • Development of middle and senior leaders in their confidence of the organisation's support for a "people not policy" focus • Pump priming funding around Leeds H&C Academy to progress city working, whilst Trusts deliver on short term L&D objectives (insufficient capacity for both)
19/20	Embed leadership programme Training needs analysis undertaken informing clear training strategy Greater delivery of L&D with partners via LH&C Academy Proactive engagement of staff as part of an improvement culture Implementation of approach to talent management & succession planning	**19/20**	• Better workforce planning information to inform TNA and training plans • Strong comms around the benefits of engagement and QI at team level

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (57i)

Meeting: Trust Board Meeting: 5 October 2018	**Category of paper**	
Report title: Workforce Race Equality Standard (WRES) - update	**For approval**	
Responsible director: Director of Workforce **Report author:** Assistant Director of Workforce and Equality and Diversity Manager	**For assurance**	√
Previously considered by: Business Committee 26 September 2018	**For information**	√

Purpose of the report

This paper contains an overarching WRES action plan, with supporting detailed action plans to help achieve the organisational vision in terms of this area of work and is provided by way of update to the Board.

Main issues for consideration

- Acknowledge the progress to date around the BAME agenda
- Note that SMT are supporting additional dedicated resources to help drive the agenda
- Endorse the overarching approach as well as the WRES action plan together with the supporting detailed action plans.

Recommendations

The Board is recommended to:

- Endorse the over-arching plan which sets the direction of travel, and to offer their support to the detailed action plans.

1.0 Purpose of paper

1.1 We want to be an organisation, where all of our staff thrive regardless of race, where diversity is celebrated and acknowledged as an enormous advantage in forming high performing teams, and crucially where our staff do not suffer or perceive any detriment to their race or ethnicity.

1.2 This paper contains an overarching WRES Action plan, with supporting detailed action plans to help achieve this vision, which also recognises that this is a shift in organisational culture and therefore a critical transformational change piece for LCH.

2.0 Background

National context

2.1 In 2015, when the Workforce Race Equality Standard (WRES) was introduced as part of the NHS standard contract, it was the first time that workforce race equality had been made mandatory in the NHS. The WRES was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. This is vital as evidence shows that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

2.2 On an annual basis, all NHS Trusts are required to report to NHS England and publish against nine indicators; four relate specifically to workforce data, four are based on the NHS staff survey and one considers BME representation on boards.
Local context

2.3 The table below details LCH status on the indicators 2-9 over the last 3 years. The 2018 data is our information submitted – we await the full WRES Data Analysis Report for all NHS Trusts, which is expected towards the end of the 2018.

2.4 WRES Metric 1 is the percentage of staff in each of the Agenda for change staff bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Following discussion at a recent Business Committee, the percentage of BME staff in the overall workforce and percentage of BME staff in Bands 8-9 and VSM, now form part of the KPIs within the well- led domain report. The longer term goal is to have a workforce that broadly reflects the population of Leeds, at all levels.

Indicator Type	WRES Indicator	Metric Description	2016 Score	2017 Score	2018 Score
WORKFORCE	2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts	1.7	1.7	1.69
	3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	1.57	3.4	3.4
	4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff	1.07	0.7	1.01
STAFF SURVEY	5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	25% (34%)*	25% (27%)	31% (25%)
	6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	24% (22%	15% (16%)	21% (15%)
	7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	80% (91%)	78% (94%)	73% (91%)
	8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team	12% (6%)	9% (4%)	12% (5%)
BOARD	9	Percentage of BME Board membership	0	0	0

** The figure in brackets relates to the percentage of White staff*

3.0 Progress to date

3.1 Over the last 12-18 months, working with our BAME staff, there has been an increasing focus within the Trust around the agenda of Race, particularly. We have spent our time to date, equipping ourselves to become better informed, by increasing our knowledge together with our presence and participation at external networking events as follows:-

Workshops held with BAME staff

3.2 Staff workshops were held during late 2016, to understand what it feels like to be a BAME member of staff within LCH and what we could do to improve this experience. A couple of follow-up workshops were held during the Summer of 2017, with an external facilitator, Beverley Powell, from the Yorkshire & Humber leadership academy, who is an experienced equality and diversity professional and the winner of multiple national awards for her contribution towards equality, diversity and inclusion, to explore this in more detail.

WRES Expert Programme

3.3 The Executive Director of Nursing has supported the E & D Manager to be part of this National Programme, in order to enhance our understanding and increase knowledge around WRES. This is an extensive resource commitment from LCH, with participation requiring 14 days compulsory attendance.

Diversity and Inclusion Partners Programme

3.4 Our application was successful to be one of NHS Employers Diversity and Inclusion Partners, with the aim to embed and integrate diversity and inclusion into the culture and structures of the organisation. This application was co-sponsored by the Executive Director of Nursing and former Interim Director of Workforce. Attendance at 4 modules is compulsory for the E & D Manager, together with one of these Directors.

Staff survey results

3.5 Analysis has been undertaken around the staff survey comparing "BAME" results compared to "White" results. This was shared with the BAME staff network, and feedback sought to better understand the results, which has been fed into the areas of focus within the WRES Action Plan.

BAME Staff network

3.6 One of the outputs from the staff workshops was to establish a BAME staff network. Formal terms of reference were agreed, appointments made to key roles, and the network has been operational since November 2017.

BAME Project Officer

3.7 Following the outputs from the workshops, it was clear that to help us understand how to start addressing some of the issues raised, that we needed help from our BAME workforce and offered a secondment opportunity to join us. A part time BAME Project officer was recruited in March 2018, from one of our members of staff to work 2 days per month. In supporting the work identified within the overarching WRES plan and wider E & D agenda, SMT have recently approved recurrent funding for a BAME Project Officer for 3 days per week.

4.0 Over-arching WRES Action plan, with supporting detailed action plans

4.1 We are now at the stage where we have the foundations in place, ready to progress and help embed this work to be "just the way we do things around here" and become the fabric of LCH. However to do so, requires additional resources to drive this. SMT are fully supportive of this and have recently approved recurrent funding of 3 days per week for BAME Project Officer role and in addition, internal discussions are to take place around aligning some of the Equality and Diversity Manager's time and for the Chair of the BAME staff network group to have a dedicated period of time per month on this agenda.

4.2 Therefore we now have additional resources, increased knowledge, commitment and dedication to drive the BAME agenda forward, and are pleased to share with you our over-arching WRES action plan, together with supporting detailed action plans, which outlines the key areas of focus across the indicators. These plans have been designed based on good practice and with input from the NHS WRES team. These are live plans, and as such will be subject to refinement, with regular updates provided to the Business Committee.

5.0 Recommendation

5.1 The Board is asked to endorse the over-arching plan which sets the direction of travel, together with the supporting detailed action plans, and to offer their support to drive this agenda.

WRES - Overarching action plan

	Initiative/Action	Lead	Desired outcome	WRES Metric	Delivery date
1	Design and implement a WRES Comms Plan	E&D Manager	Increase awareness of the WRES and its purpose Highlight key messages of the WRES Engage with colleagues Promote good practice and processes Increase awareness and access to the Trust BAME staff network Facilitate an inclusive approach towards workforce management across the Trust Increase awareness of the role of the BAME project officer	2, 4,5,6,7,8	30.9.18
2	Design and implement a Reverse mentoring programme for Board members and BAME staff	BAME Project Officer and E&D Manager with support from Asst. Director of Workforce	Educate leaders about diversity issues, by exposing them to challenging dialogue, which they might otherwise never encounter. Facilitate BAME staff access to Board Members to provide an understanding of their role and responsibilities in the Trust	4, 7	Launch Programme 1.11.18 to start 2.1.19
3	Conduct analysis of the Trust WRES indicators data	ODI lead and E&D Manager	Understand the WRES data in order to identify actions to be included in the WRES action plan to create a level playing field where the treatment of staff is not unfairly affected by their ethnicity.	4,5,6,7,8	March 2018 NHS staff survey indicators, 5,6,7,8 and September 2018, Workforce Indicators 1, 2,3,4,9
4	Plan and deliver an equality event - #InclusiveLCH	Asst.Director of Workforce	The target audience is aware of the good work that has already happened in the areas of Race Raise supervisor/managers awareness of the inequality of experience by BAME staff compared to white staff A commitment by the target audience to improve the BAME staff experience and subsequently the Trusts WRES performance	3,6,7,8	1.11.18
5	BAME Talent Management	ODI Lead and Asst. Director of Workforce	An increase in BAME staff employed in Senior and Board level roles	1,2,7,9	3.6.19
6	Create and implement a sustainable process to enable the Trust to hold recruitment & selection panels comprising of a diverse staff group	Resourcing Manager and Asst. Director of Workforce	The probability of BAME applicants being shortlisted and selected for posts is comparable to that of White applicants	1,2,7,9	31.7.19
7	Design and implement a management process to ensure that recording of staff applications for and outcomes of the application for non mandatory training can be accessed through the ESR	ODI Lead and Asst.Director of Workforce	Provide robust data to inform the WRES action planning	4	31.3.19
8	Research and design a Cultural Competence (Race) awareness programme	ODI Lead & E & D Manager	Assist in equipping managers with a set of attitudes, behaviours and skills to enable success management of teams and individuals.	2,3,4,6,7,8	3.4.19

WRES - Communications Plan

Action		Lead	Key message	Delivery date (s)	Progress
1	Create and maintain a WRES section on the Elsie Equality page	E&D Manager	WRES what it is what it does, latest news.	31.12.18	
2	Provide current WRES information and Trust performance contained on the E&D page of the LCH website	E&D Manager	WRES what it is what it does, latest news.	31.12.18	
3	Create a WRES FAQ and share with the Trust services and departments	E&D Manager	Raising awareness of the WRES in services & departments, creating discussion and providing answers to questions	31.12.18	
4	Write a WRES & WRES Expert promotional piece for Community Health Matters	E&D Manager	What is a WRES expert?	31.12.18	
6	Create an informative WRES article for Community Talk	E&D Manager	WRES what it is what it does, latest news.	15.11.18 6.12.18 11.2.19 16.5.19 11.7.19 19.9.19 14.11.19 9.1.20	
7	Attend Leaders network	BAME Project Officer	WRES what it is what it does, latest news.	15.11.18	
8	Produce and distribute a WRES 6 monthly update newsletter	E&D Manager	WRES what it is what it does, latest news.	30.11.18 30.4.19 30.11.19 30.4.20	

WRES - Communications Plan

Action		Lead	Key message	Delivery date (s)	Progress
9	CEO Blog promoting WRES	E&D Manager	Endorsement and recognition of the achievements and challenges of the WRES	10.1.19 13.6.19 31.10.19 12.12.19	
10	BAME Project officer Blog promoting WRES	BAME Project Officer	Increase awareness of the role of the BAME project officer	15.11.19 11.4.19 14.11.19 13.2.20	
11	BAME chair Blog promoting WRES	BAME Chair	Increase awareness of the role of the BAME network	25.10.18 9.5.19 19.9.19 12.3.20	
12	Measured Social media promotion of WRES, Trust activity and progress	E&D Manager	Promote positive messages of WRES activity and progress	Weekly, commencing in November 18	
13	Create a suite of WRES information & performance leaflets	E&D Manager	What is WRES, why it matters, current WRES performance and what the Trust is doing to improve performance	31.12.18	
14	Identify and implement a plan to promote WRES at service and team meetings/forums	BAME Project Officer	What is WRES, why it matters, current WRES performance, what the Trust is doing to improve performance and the part everyone has to play	30.4.19	

WRES - Reverse Mentoring Programme

Action required	By whom	By when	Actions	Current position	Desired outcomes
Define why the Trust is creating this	Asst. Director of Workforce & E&D Manager	28.9.18	Identify current WRES issues that would benefit from a reverse mentoring programme		A greater understanding of the benefits for the Trust, individuals and assist in the shaping of the metrics to improve WRES performance
Establish the metrics to measure progress/success	Asst. Director of Workforce & E&D Manager	12.10.18	Identify metrics that will provide the desired outcomes		Create a framework to measure progress
Executive sponsorship	Asst. Director of Workforce & E&D Manager	12.10.18	Establish who on the Trust Board will be the Executive sponsor		
Mentees then Mentors	Asst. Director of Workforce & E&D Manager	1.11.18	Promote the programme at the event on the 1.11.18 and sign up mentees	There is active interest from Trust Board Members and BAME members of the workforce - Diane Belfon (NHFT) programme lead for a Reverse Mentoring programme is leading a discussion and providing SME input	Mentors and mentees in place to run the programme
Commencement of the Reverse Mentoring programme	Asst. Director of Workforce & E&D Manager	2.1.19	Mentors and Mentees agree on frequency and content of meetings		
Review of the programme	Asst. Director of Workforce & E&D Manager	3.7.19	Mid term review conducted		
End of programme review	Asst. Director of Workforce & E&D Manager	3.1.20	Interviews of Mentors and mentees, analysis of feedback from stakeholders (TBC)		
Metrics review	Asst. Director of Workforce & E&D Manager	3.2.20	Evaluate the metrics and feedback from stakeholders (TBC)		
Next steps	Asst. Director of Workforce & E&D Manager	4.3.20	An evaluation and options report to be submitted to the Business Committee		

WRES - Analysis September 2018

Indicator Type	WRES Indicator	Metric Description	2016 Score	2017 Score	2018 Score	Desired score	WRES action
WORKFORCE	2	Relative likelihood of White staff being appointed from shortlisting compared to that of BME staff being appointed from shortlisting across all posts	1.7	1.7	1.69	0	1,5,8
	3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process.	1.57	3.4	3.4	0	3,8
	4	Relative likelihood of White staff accessing non mandatory training and CPD compared to BME staff	1.07	0.7	1.01	0	1,2,3,7,8
STAFF SURVEY	5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	25% (34%)*	25% (27%)	31% (25%)	The same percentage score as White staff	1,3
	6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	24% (22%	15% (16%)	21% (15%)	The same percentage score as White staff	1,3,4,8
	7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.	80% (91%)	78% (94%)	73% (91%)	The same percentage score as White staff	1,2,3,4,5,6,8
	8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team	12% (6%)	9% (4%)	12% (5%)	The same percentage score as White staff	1,3,4,8,
BOARD	9	Percentage of BME Board membership	0	0	0	To reflect the growing BME representation of Leeds, the Trust Board BME representation/score needs to be 19% or 3 Trust Board members.	5,6

* The figure in brackets relates to the percentage of White staff

WRES - Race for Equality

Action required	By whom	By when	Actions	Current position
Planning meeting #3	Asst. Director of Workforce	28.9.18	Agree outcomes required from the event Delegates/invites Comms plan External speakers - script areas for them to cover Workshop details - who, what, how	Dr Habib Naqui, WRES Policy lead, attending (confirmed 20.9.18) Diane Belfon - confirmation of travelling accom needed Elland Road suite booked, PO raised awaiting invoice
Planning meeting #4	Asst. Director of Workforce	25.10.18	Feedback on actions arising from meeting #3	
Final planning meeting #5	Asst. Director of Workforce	30.10.18	Feedback on actions arising from meeting #4	
Event	Asst. Director of Workforce	1.11.18	Initial feedback on content, venue and organising of the event	
Review of the event	Asst. Director of Workforce		Review of the event to be carried out informed by the experience of the individual planning stakeholders and the completed event evaluation forms	
Evaluation	CGO (E&D)	1.2.19	All delegates will be emailed post event evaluation for their completion	
Evaluation	CGO (E&D)	1.5.19	All delegates will be emailed post event evaluation for their completion	
Evaluation	CGO (E&D)	1.8.19	All delegates will be emailed post event evaluation for their completion	

WRES - BAME Talent Management

	Action	By whom	By when	Current position
1	Meeting with ODI lead to understand the components of the leadership development refresh	Asst Director of Workforce	31.12.18	
2	Research best practice to contribute to a Trust BME talent management	BAME project officer	31.12.18	
3	Facilitate engagement of stakeholders (BAME staff network, staffside, staff) to provide input to the shape of a BAME Talent Management section of the leadership development refresh	BAME project officer	28.2.19	
4	As part of the Leader Development refresh, a BAME talent management pipeline will be launched	Asst Director of Workforce	3.6.19	

WRES - Diverse recruitment selection panels

	Action	By whom	By when	Current position
1	E&D Manager, BAME project officer and Chair of BAME staff network group to attend Recruitment and Selection training (Includes Unconscious Bias awareness)	E&D Manager, BAME project officer, Chair BAME staff network	31.12.18	
2	Liaise with the Standing recruitment and selection panel (Neighbourhood teams) organiser to identify 6 opportunities in Q4 17/18 and Q1 18/19 for a member of the team to take full part in the short listing, interview and selection process	E&D Manager, BAME project officer, Chair BAME staff network	30.6.19	
3	Review process, analysis of data and feedback from stakeholders to provide Business Committee with an update on progress and propose next steps	E&D Manager, BAME project officer, Chair BAME staff network	31.7.19	

WRES - Non mandatory training and development

	Action	By whom	By when	Current position
1	Establish the range of training & development opportunities that staff can access and the associated application process.	ODI lead (Stat & Man)	31.3.19	
2	Create a centralised process to be able to report, by protected characteristics, for initial application, decision making, enrolment, completion of course.	ODI lead (Stat & Man)	30.6.19	
3	Provide a baseline report to the Business Committee specifically for BME staff application and when required, to inform analysis of WRES metric 4	ODI lead (Stat & Man)	31.12.19	

WRES - Cultural Competence

	Action required	By whom	Actions	By when	Current position
1	Establish an appropriate definition of Cultural Competence for the Trust	E&D Manager	Seek the view from Staff engagement Staff side engagement NHS Leadership Academy view WRES Experts Programme NHS Employers Diversity & Inclusion partners	31.12.18	
2	Identify appropriate existing Cultural Competence programmes that are available to access	E&D Manager	Provide an Cultural Competence options paper to the SMT for consideration and direction	31.3.19	
3	Review and revise this plan to implement direction provided from SMT in response to the options paper in action 2.	E&D Manager	Provide a paper and action plan, if applicable, to SMT that includes feedback from action 2.	3.4.19	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (58i)

Meeting Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title Emergency Preparedness Annual Report 2017/18	**For approval**	✓
Responsible director Executive Director of Operations **Report author** Resilience Manager	**For assurance**	✓
Previously considered by Business Committee – 26 September 2018	**For information**	

Purpose of the report

This paper is designed to provide the Board with an overview of Emergency Preparedness, Resilience and Response (EPRR) activity over the last year and identifies priorities for 2018/19.

In addition the Trust is required to undertake a self-assessment against the 2018/19 national Emergency Planning, Resilience and Responsiveness (EPRR) core standards and complete the Statement of Compliance identifying the organisation's overall level of compliance. This process is overseen by NHS England to ensure that the NHS is prepared to respond to an emergency and has resilience in relation to continuing to provide safe patient care.

Main issues for consideration

This paper presents the Board with the outcome of the self-assessment of the Trust's position against the EPRR standards (Appendix A). In summary the self-assessment proposes:

- The Trust is substantially compliant (Green) with 51 of 54 core standards and all 8 of the deep dive standards being compliant.
- The 2018/19 standards require the Trust to have an EPRR policy. This policy is included in the papers (Appendix B). This is a new requirement
- The Trust is not fully compliant with 3 of the core standards - the action plan sets out how the Trust will become fully compliant within the next 12 months.
- There are no standards where the Trust is not compliant
- An internal audit on EPRR processes was completed in July 2018. All 7 recommendations from the audit have now been implemented.

The Board is recommended to:

- Note the EPRR activity over the last year and the priorities for 2018/19
- Approve the Trust's new EPRR policy statement.
- Note that the Emergency Planning team has completed a self –assessment against the EPRR core standards
- Note that there are three core standards considered "not fully compliant" and review the Trust's associated action plan
- Approve the recommendation to submit an overall assessment of 'substantially compliant' against the standards (in line with national guidance)

Leeds Community Healthcare NHS Trust

EMERGENCY PREPAREDNESS ANNUAL REPORT

October 2017 - September 2018

1. Overview

The Trust continues to fulfil the requirements placed upon it as detailed in the Civil Contingencies Act 2004 as a provider of NHS-funded healthcare. These requirements ensure that the organisation is operationally resilient to any form of disruption to normal service provision as well as being able to respond to major incidents.

As in previous years, all services both operational and corporate have been required to review and update their Business Continuity Plans as required to ensure that their arrangements for mitigating the effect of and dealing with the impact of disruptive events are fit for purpose.

The Trust has held a number of emergency planning-related exercises throughout the year designed to test the effectiveness of our plans and to provide an opportunity for staff to share knowledge and expertise with each other.

2. EPRR Core Standards Assurance Process

The Trust is required to adhere to the requirements of the NHS England Emergency Preparedness, Resilience and Response **(**EPRR) Assurance Process. The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards in order to provide assurance that both the NHS in England and NHS England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care.

As an organisation we must:

- Undertake a self-assessment against the relevant NHS England Core Standards for EPRR. This comprehensive assessment is attached at Appendix A. The self-assessment includes an action plan to address issues that need to be addressed to reach full compliance.
- A new requirement for NHS EPRR assurance in 2018, is for every Trust to have an overarching EPRR policy statement. The Trust's statement is included in this paper (Appendix B).
- Complete a Statement of Compliance identifying the Trust's overall level of compliance with the standards (see Appendix C)
- Present this to the Trust Board for sign-off prior to submission to NHSE by

2.1 Self-assessment

There were three amber rated standards from the 2017/18 assessment that the Trust needed to address to be fully compliant:

Standard 26 - Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical – now complete

Standard 37 - Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents – now complete.

Standard 49 - Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents – this is largely resolved, but there is still a requirement to train more loggists. This action has carried over in to the 2018/19 EPRR action plan.

The Core Standards self-assessment for 2018/19 was substantially different to the 2017/18 assessment. Whilst the Trust is still substantially compliant there are three standards where the Trust is amber rated:

Standard 5 - The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties. The Trust only has two trained loggists, and therefore additional loggists need to be identified and trained. This will happen before April 2019.

Standard 33 - The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. This is a new requirement for 2018/19, and the Trust does not currently have loggists on call. There are conversations currently taking place with partners to see if a shared rota of loggists can be created. If not, training will be provided for on call managers. Completion date is December 2018.

Standard 40 - The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum. The LHRP meetings are attended by the Operational Service Manager, acting as a deputy for the Director of Operations, as is common with the other organisations on the LHRP. The Trust has 100% attendance at this meeting. Discussions are taking place between all of the organisations to better understand this standard and to put in place arrangements where Accountable Emergency Officer duties can best be fulfilled.

3. Escalation Planning

The Trust continues to work with partner organisations on the OPEL (Operational Pressures Escalation Levels) plan for escalation, both internally to the Trust and externally with our partner organisations. The organisation-wide OPEL plan now includes daily situation reports shared (via the Clinical Commissioning Group) in to one Leeds OPEL plan. Triggers for escalation and mutual support actions have also been identified to ensure that any of the organisations can trigger citywide meetings (Silver Command) to enable the organisation to recover from the period of pressure and de-escalate the situation.

4. Exercises

Emergency planning and business continuity exercises are required as part of our obligations under the CCA and as part of the NHSE Core Standards. The Trust is required to hold a desk-top exercise at least annually and a live exercise at least once every three years.

This year the Trust was not required to hold a live exercise but there has been:

- A desk top exercise focussing on the Chemical, Biological, Radiological and Nuclear (CBRN) plan.

The CBRN scenario mirrored the recent events in Salisbury and required our on-call managers to play out the scenario as though it had happened out of hours at the Merrion Centre in Leeds, where the Trust has a number of services based. Lots of actions were captured during the event which will help the Trust to improve its Major Incident Plan, On Call Manual and Business Continuity plans.

5. Future Priorities

The emergency preparedness and resilience priorities for the forthcoming year are:

- Continued development of the OPEL plan
- Further development and testing of Business Continuity Plans
- Identification and training of additional Loggists to ensure resilience within the Emergency Management Team

Please select type of organisation: **Community Service Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	13	13	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	5	4	1	0
Warning and informing	3	3	0	0
Cooperation	4	3	1	0
Business Continuity	9	9	0	0
CBRN	7	7	0	0
Total	54	51	3	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Community Service Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments (including organisational evidence)
1	Governance	Appointed AEO	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Fully compliant	None	N/A	N/A	Executive Director of Operations
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant	EPRR policy to be produced and approved by Trust Board.	Dominic Mullan	Oct-18	This was a new requirement in 2018/19. LCH had a MIP policy, a BCP policy and plan and these have been incorporated or referenced into the new EPRR policy
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Fully compliant	None	N/A	N/A	Board reports available for inspection
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant	None	N/A	N/A	2017/18 improvement plan, which will be updated in the new EPRR policy - see no 2 Internal audit undertaken in quarter one of 2018
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant	EPRR policy to be produced and approved by Trust Board. identified gap in trained loggists - identify and train additional loggists	Director of Operations	1/10/18 01/03/2019	identified gap in trained loggists - identify and train additional loggists
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant	None	N/A	N/A	All BCPs have an incident log which should be updated with details of exercises/incidents to capture action taken, action required and lessons learned. Debrief reports and action plans produced following exercises.
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Fully compliant	None	N/A	N/A	EPRR risks assessed on a regular basis. No current EPRR risks on the risk register.
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant	None	N/A	N/A	Referenced in new EPRR policy
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Fully compliant	None	N/A	N/A	LCH plays a full part in partner exercises and workshops - i.e. winter planning
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place, and tested regularly.
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place, and tested regularly.
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Annual national guidance, advice and plans are shared with staff when released (no major changes to advice and guidance year on year)
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Cold weather included in BCP's.
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.

17	Duty to maintain plans	Mass Countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, eg mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
18	Duty to maintain plans	Mass Casualty - surge	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Arrangements in place - linked to regional plans.
23	Duty to maintain plans	Excess death planning	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant	None	N/A	N/A	Hard copies of BCPs should be available for all services in each base. Hard copies of MIP in stockdale Links to Pandemic flu policy.
24	Command and control	On call mechanism	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	Fully compliant	None	N/A	N/A	New policy statement includes relevant information.
25	Command and control	Trained on call staff	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement	Fully compliant	None	N/A	N/A	Training in place, and reference in new policy.
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant	None	N/A	N/A	Training in place, and reference in new policy.
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant	None	N/A	N/A	Exercises run in line with guidance, and evaluation, action plans/ feedback can be provided
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff	Fully compliant	None	N/A	N/A	N/A
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Fully compliant	None	N/A	N/A	Three incident control centres in place
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies	Fully compliant				Electronic copies available on hard drive. Hard copies at key locations.
32	Response	Management of business continuity incidents	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans	Fully compliant	None	N/A	N/A	Plans to share all BCPs with on call managers.
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Access to loggists 24 hours a day - Discuss with other organisations whether or not an on call rota for loggists is apropriate for local area. Training will also be made available for other staff/ including on call managers to assume loggist duties.	Emergency planning manager	Dec-18	LCH has access to trained loggists, who have given contact details who MAY be available in the event of an incident
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising	Fully compliant	None	N/A		All previous sit reps have been complied with
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Fully compliant	None	N/A	N/A	West Yorkshire Emergency Media Protocol, LCH crisis communications plan

38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Fully compliant	None	N/A	N/A	West Yorkshire Emergency Media Protocol, LCH crisis communications plan
39	Warning and informing	Media strategy	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Fully compliant	None	N/A	N/A	West Yorkshire Emergency Media Protocol, LCH crisis communications plan
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings	Partially compliant	Discussion within LRHP to identify whether accountable leads can share the role between Trust types, backed up by apropriate deputies.	Director of Operations	Mar-19	Appropriate representation at all meetings
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented	Fully compliant	None	N/A	N/A	Appropriate representation at all meetings
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Fully compliant	None	N/A	N/A	Processes in place, particularly for hospital/ community services support to older people.
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Fully compliant	None	N/A	N/A	Information sharing agreement in place
47	Business Continuity	BC policy statement	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Fully compliant	None	N/A	N/A	In place
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Fully compliant	None	N/A	N/A	In place
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Fully compliant	None	N/A	N/A	In place
50	Business Continuity	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	Fully compliant	None	N/A	N/A	In place
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Fully compliant				need to check supplier arrangements
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers	Fully compliant				monitored, but not against key performance indicators
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	Fully compliant	None	N/A	N/A	Compliant with latest internal audit action plan
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Fully compliant	None	N/A	N/A	N/A
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Fully compliant				we need to check this
56	CBRN	Telephony advice for CBRN exposure	Staff have access to telephone advice for managing patients involved in CBRN exposure incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	Fully compliant	None	N/A	N/A	In the CBRN plan and clothing packs
57	CBRN	HAZMAT / CBRN planning arrangement	There are organisation specific HAZMAT/ CBRN planning arrangements (or dedicated annex).	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Fully compliant	None	N/A	N/A	N/A
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	Fully compliant	None	N/A	N/A	N/A
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	Fully compliant	None	N/A	N/A	CBRN – all front of house premises have previously been issued with a CBRN equipment pack including · Robe/gown to preserve modesty following disrobing · Paper tissue/blue roll to enable dry decontamination · Clinical waste bags or equivalent to hold contaminated waste · Signage to be clearly displayed if incident occurs · Instructions for staff and public
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programme should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Fully compliant	None	N/A	N/A	Latest CBRN desktop exercise

68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Fully compliant	None	N/A	N/A	
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) 24 / 7.	Y		Fully compliant	None	N/A	N/A	Equipment in place

Ref	Domain	Standard	Detail	Community Service Providers	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control										
Domain: Incident Coordination Centres										
1	**Incident Coordination Centres**	**Communication and IT equipment**	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y		Fully compliant				Audit completed - Sept 2018
2	**Incident Coordination Centres**	**Resilience**	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Up to date training records of staff able to resource an ICC	Fully compliant				
3	**Incident Coordination Centres**	**Equipment testing**	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Post test reports Lessons identified EPRR programme	Fully compliant				Audit completed - Sept 2018
4	**Incident Coordination Centres**	**Functions**	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				
Domain: Command structures										
5	**Command structures**	**Resilience**	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				Covered in recent EPRR policy
6	**Command structures**	**Stakeholder interaction**	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	EPRR policy statement and response structure	Fully compliant				Covered in recent EPRR policy
7	**Command structures**	**Decision making processes**	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				JESIP course has been offered to all 2nd on-call mgrs. previously, as well as Strategic Leadership in a Crisis course (which some Directors have attended in the past or declined as they felt they didn't need it due to previous experience). I would question whether we can demonstrate that we are fully compliant with this standard…
8	**Command structures**	**Recovery planning**	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Partially compliant	EPRR policy to be produced and approved by Trust Board. identified gap in trained loggists - identify and train additional loggists	Director of Operations	1/10/18 01/03/2019	identified gap in trained loggists - identify and train additional loggists
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	• Documented processes for accessing and utilising loggists • Training records	Partially compliant	Access to loggists 24 hours a day - Discuss with other organisations whether or not an on call rota for loggists is apropriate for local area. Training will also be made available for other staff/ including on call managers to assume loggist duties.	Emergency planning manager	Dec-18	LCH has access to trained loggists, who have given contact details who MAY be available in the event of an incident
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	• Minutes of meetings	Partially compliant	Discussion within LRHP to identify whether accountable leads can share the role between Trust types, backed up by apropriate deputies.	Director of Operations	Mar-19	Appropriate representation at all meetings

Leeds Community Healthcare NHS Trust

Emergency Planning Resilience and Response Policy (EPRR)

Author	Dominic Mullan Local Security Management Specialist
Corporate Lead	Sam Prince Executive Director of Operations
Document Version	V.1
Date ratified by Business Committee	26 September 2018
Date issued	TBC
Review date	TBC
Policy Number	TBC

Executive summary

Leeds Community Healthcare NHS Trust (THE TRUST) has undertaken a review of its Emergency Preparedness, Resilience and Response Policy (EPRR). The NHS core standards for EPRR (NHS England 2017) requires organisations to have an overarching EPRR policy in place for resilience across the Trust so that EPRR and business continuity issues are mainstreamed in processes, strategies and action plans across the organisation.

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Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to Equity Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in development of this policy

Contents

1. Introduction

EPRR is defined as Emergency Preparedness, Resilience and Response.

Under the Civil Contingencies Act 2004 NHS organisations must show that they can effectively respond to emergencies and business continuity incidents whilst maintaining services to patients. This work is referred to in the health service as emergency preparedness, resilience and response (EPRR)

EPRR remains a key priority for the NHS and the requirements for EPRR is set out in the NHS Commissioning Board planning frame work the NHS standard contract and through this the NHS Commissioning Board Emergency Planning Framework (2013). These responsibilities are detailed in the NHS Commissioning Board Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

The NHS Needs to be able to plan for, and respond to a wide range of incidents that could impact on health or patient care with the aim of maintaining continuous levels in key services when faced with disruption from identified local risks such as severe weather, fuel or supply shortages or industrial action. This is known as business continuity management.

The Trust is committed to working in partnership with staff and partner organisations to make EPRR a core organisational process and to ensure that it becomes an integral part of the Trust philosophy and activities.

As part of this, the Trust undertakes to ensure that adequate provision of resources, including financial, personnel, training and information technology is as far as reasonably practicable made available.

2. Aims and Objectives

This policy describes the systems that the Trust will use to embed EPRR throughout the Trust in order to provide assurance that risks are managed and effective arrangements are in place. The policy is a Trust wide document, and is applicable to employees. This policy links to the Trust's Risk Management policy, in that any EPRR risks and lessons learnt are captured through the Trusts Assurance process.

The policy aims to continually improve the management of EPRR within the organisation and assist with implementation of the NHS core standards for EPRR regulatory requirements.

3. Requirements and Principles of EPRR

Health & Safety

The Health & Safety Executive are the enforcing body for health and safety. Health and Safety legislation requires the Trust to have robust systems in place to identify hazards and associated controls and from this, evaluate the level of risk and to control all health and safety hazards to the lowest level reasonably practicable. Health and safety legislation also requires organisations to plan and respond appropriately to emergency situations within the workplace.

Civil Contingencies Act 2004 (CCA) delivers a single, framework for the provision of civil protection in the UK. The principal objectives of the Act are to ensure

consistency of planning across all government departments and its agencies, whilst setting clear responsibilities for frontline responders at a local level.

The Health and Social Care (2012) Act

The Act embeds the requirement of NHS services to respond effectively to incidents and emergencies. The key elements are:

- The NHS Commissioning Board and each Clinical Commissioning Group must take appropriate steps for securing that it is properly prepared for dealing with a relevant emergency.
- The NHS Commissioning Board must take steps as it considers appropriate for securing that each relevant service provider is properly prepared for dealing with a relevant emergency.
- The NHS Commissioning Board must take such steps as it considers appropriate for facilitating a co-ordinated response to an emergency by the clinical commissioning groups and relevant services providers for which it is a relevant emergency.

4. Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for EPRR within Leeds Community Healthcare NHS Trust and the board demonstrates commitment through endorsement of the EPRR policy.

Executive Director of Operations

The Executive Director of Operations is the accountable emergency officer and provides assurances to the Board that the Trust is meeting its obligations with respect to EPRR including that the Trust:

- Is compliant with EPRR requirements
- Is properly prepared and resourced for dealing with a significant incident or emergency
- Has robust business continuity planning arrangements in place
- Has a robust surge capacity plan that provides an integrated Trust response and that it has been tested
- Provides assurance and information to the NHS commissioning board on arrangements including representation at the Local Health Resilience Partnership (LHRP) and Local Resilience Forum and other sub groups

Local Security Management Specialist and Emergency Preparedness Officer

The Local Security Management Specialist and Emergency Preparedness officer will

- Develop and deliver the Trust's emergency preparedness and resilience function, improve standards of such preparedness across the Trust and provide leadership on specialist emergency preparedness and resilience issues

- Ensure that EPRR responsibilities are met and provide assurance to the Trust board that it complies with relevant legislation and guidance as summarised by NHS England core standards for EPRR
- Complete regular inspections on proposed emergency planning materials, rooms and buildings, making sure all equipment and materials are up to date, access to the assigned buildings
- Support the Executive Director with information and updates on emergency planning issues
- Co-ordinate emergency preparedness and training exercises for the Trust
- Carry out annual reviews of service Business Continuity Plans.
- Ensure representation at Local Health Resilience Partnerships (LHRP)
- Work with communications staff to ensure an appropriate communications and media response by the NHS to significant events and emergencies

THE TRUST Head of Communications

- Develop, disseminate and maintain arrangements for handling the media.
- Develop and deliver appropriate training for the Trust staff who are likely to be involved with handling the media, before, during or after and emergency response.
- Represent THE TRUST at multi-agency working groups focussing on the duty to warn and inform the public and handling the media
- To support staff by providing information and communicating with internal staff
- Attend in desk top and live planned EPRR events

THE TRUST Trust Staff

Trust staff are responsible for:

- Supporting the preparation and implementation of emergency and business continuity plans.
- Ensure that they are familiar with the arrangements detailed in the Trust's major incident plan
- Undertake business continuity training as required
- Certain staff will also be responsible for a loggist role with the Trust. This role will be determined by service leads

Heads of Service

- Service business continuity plans are developed, maintained and updated on an annual basis, or following a significant event or emergency
- Service leads must ensure all up to date business continuity plans are forwarded to the Local Security Management Specialist and Emergency Preparedness Officer
- The business continuity plan is fit for purpose and tested
- Ensuring all relevant staff are conversant with business continuity plans and are appropriately trained in line with their responsibilities

On Call Managers

- Ensure when on call they maintain a resilient single point of contact within the Trust, capable of receiving notification at all times of an emergency or business continuity incident
- Act in line with arrangements set out within this policy and the Trusts major incident plan.

5. EPRR Arrangements

Emergency and business continuity plans are prepared as part of a risk assessment including hazard mapping and co-ordinated multi-agency response required for expected impacts of an event. Risks identified during the planning process, exercise programme or following any incident debriefs will be placed on the risk register either by the service or the risk manager, and will be included in the Trusts annual EPRR work plan.

Business Continuity Plan (BCP)

Under the CCA (2004) the Trust has a duty to develop and maintain arrangements to ensure continuity of service whilst responding to an emergency, be it internal or external.

The Trust recognises ISO 22301 and PAS 2015 (Publicly Available Specification) as the definitive guidance for business continuity management. THE TRUST will develop, disseminate and maintain business continuity plans and work to embed a culture of business continuity management within the Trust.

All THE TRUST services must review their BCP's, update as necessary and forward to the Local Security Management Specialist and Emergency Preparedness Officer

Major Incident Plan (MIP)

The Major Incident Plan outlines how as a Trust we plan for, respond to recover in the event of a major incident, meet our responsibilities as an operational responder and comply with relevant guidance and legislation.

THE TRUST response to a major incident is co-ordinated by a member of the Trust's senior management team. This person:

- Has authority to over-rule all normal management arrangements
- Can direct any member of staff to perform any duty made necessary by the major incident
- Can direct any resources to be used in connection with the major incident
- Can cancel or prioritise its services
- Can authorise expenditure in connection with the major incident

Hard copies and laminated action cards are also located in the major incident rooms located around the city.

Organisational Plans

In addition to the Major Incident Plan there are a number of organisational plans which have been developed in line with national plans, these plans support the Major Incident plan and include:

- Cold weather plan
- Heat wave plan
- Escalation and surge plan
- Fuel plan
- CBRN (Chemical, Biological, Radiological and Nuclear incidents) plan
- Pan flu plan
- Community outbreak plan

Major incident room

The Trust has a responsibility to provide a suitable environment for managing an incident or an emergency. This is known as the Major Incident Room.

The functions of the Major Incident Room are to:

- Act as a focal point for everybody involved in the response to the incident
- Gain intelligence and ensure intelligence is made available.
- Bringing staff together who are responding to the incident.
- Offering all the facilities that may be required.
- Providing a clear focus for the response
- To provide information to the Trust and other agencies in response to the incident

The Trust major Incident can be located in the most up to date version of the Trust on call managers manual.

Command and Control Arrangements/On Call Arrangements

The Trust operates a 24-7-365 on call management rota to manage and support business continuity. The on call manager also provides advice in relation to out of hours incidents, effectively acting in a delegated first line capacity representing the Chief Executive in case of critical inclidents.

The Trust has a 1st and 2nd on call rota, the 2nd on call is Trust Director or senior manager.

The on call out of hours number is 0845 265 7599. This number will allow anybody requiring an on call response to speak to whoever is fulfilling the 1st on call duties at that time.

Training is provided to all on call managers around the procedures to follow if a critical incident is called anywhere in the city.

6. Communication Arrangements

The overall aim for communications in any EPRR incident will be to provide effective accurate and timely communications to the public, staff and other agencies. The Major Incident Plan, EPRR plans and the On Call Managers standard operating procedures identify arrangements and methods for establishing and maintaining communication channels to all involved.

7. Training and Exercising

The Trust will test EPRR arrangements in line with NHS England Emergency Preparedness, Resilience and Response (NHSE EPRR) Framework (2015) and Civil Contingencies Act (2004) by:

- Conducting a desk top exercise to be completed once a year with senior managers and relevant staff.
- Live exercises to be completed every 3 years with senior managers and relevant staff.
- Refresher and awareness training for individuals undertaking information handling roles
- Strategic Leadership in an Incident training
- Familiarisation of Major Room awareness sessions

8. Process for Monitoring Effective Implementation

Monitoring compliance of this policy and associated plans will go through an annual internal audit and self-assessment against the EPRR core standards undertaken to assess the effectiveness of the arrangements.

The Local Security Management Specialist and Emergency Preparedness officer will complete the annual self-assessment core standards and provide assurance for the Executive Director of Operations and the Trust board.

The Local Security Management Specialist and Emergency Preparedness Officer will produce 2 reports on an annual basis. One report for the Health & Safety Group and one report for the Trust Board. The reports will focus on issues relating to EPRR, desk top and live exercises and compliance with core standards

9 Ratification and approval process

This policy has been approved by LCH Clinical & Corporate Policies Group, and ratified by the Quality Committee, on behalf of the Board.

10 Dissemination and Implementation

Security information presented at the Health and Safety for Managers Training session and is also presented in the City wide staff induction. The LSMS will also carry out site security audits and inspections, attend staff meetings to discuss and answer questions on request.

11 Review arrangements

This EPRR Policy will be reviewed by the Local Security Management Specialist and Emergency Preparedness Officer after 3 years or after any significant change in structure.

12 References

Civil Contingencies Act 2004

Emergency Preparedness Framework (NHS England 2015)

Health and Social Care Act 2012

The NHS Planning Guidance- Everyone Counts Planning for Patients 2014

NHS Standard Contract

Incident Management Reporting Policy

The Health and Safety at Work Act 1974

The Management of Health and Safety and Work Regulations 1999

Policy Consultation Process

Title of Document	EPRR Policy
Author	Dominic Mullan
New	
Lists of persons involved in developing the policy	Dominic Mullan Peter Ainsworth
List of persons involved in the consultation process	Sam Prince Peter Ainsworth John Glynn Richard Slough Martin Harris

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

Leeds Community Healthcare NHS Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Leeds Community Healthcare NHS Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of **Substantial** (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

05/10/2018

Date signed

05/10/2018	05/10/2018	_____
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (59)

Meeting Trust Board 24 September 2018	**Category of paper**	
Report title Infection Prevention Control Annual Report 2017/2018	**For approval**	✓
Responsible director Executive Director of Nursing **Report author:** Executive Director of Nursing	**For assurance**	
Previously considered by Infection Prevention and Control Group (IPCG) 21 August 2018	**For information**	

Purpose of the report

The purpose of the report is to inform the Trust Board of progress which is being made to reduce Health Care Acquired Infections (HCAI) and the many elements of work completed by the IPC Team during the financial year of 2017/2018. The Trust Board are asked to agree the action plan for sustained reduction and improvements in infection control practices for 2018/19.

Main issues for consideration

- Remained within organisational target for meticillin resistant Staphylococcus aureus (MRSA) bacteraemia and C difficile (CDI) infections.
- Further developed links with the local Clinical Commissioning Groups (CCGs) and other stakeholders to enhance the processes around infection surveillance and case management strategies within the HCAI Group.
- Identified as the second best performing community trust in England and Wales for the provision of influenza vaccine to frontline healthcare staff.
- Exceeding the Department of Health target for staff influenza vaccination and emerging as the best performing community trust with over 75% frontline staff being immunised.
- Improved engagement with key stakeholders, including Leeds Teaching Hospital Trust, Public Health England (PHE) and the Local Authority
- Further integrated the processes of Systm One® and Leeds Care Records to improve interagency communication and management of alert organism infections/conditions
- Working with GPs and Care Home teams to review and where necessary improve IPC compliance
- Ongoing development of a group of IPC Champions from different business units and the facilitation of targeted training held quarterly throughout the year.
- Enhancement of engagement opportunities with the General Public and LCH membership to enable completion of Patient Led Assessments of the Care Environment (PLACE) Inspections.
-

Recommendations

The Trust Board is recommended to:

1. Note work undertaken to date
2. Approve the programme for 2018/19
3. Advise on any areas for development

Leeds Community Healthcare NHS Trust

Infection Prevention and Control

"Shaping the Future of Local Healthcare"

Annual Report 2017-2018 and IPC Programme for 2018/19

Leeds Community Healthcare NHS Trust

Executive Summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HCAI) within Leeds Community Healthcare NHS Trust (LCH).

The aim of this report is to provide information and assurance to the Board that the Infection Prevention and Control Team (IPCT) and all staff within the Trust are committed to reducing HCAI and that LCH is compliant with current legislation, best practice and evidenced based care.

The report covers the period 1st April 2017 to March 31st 2018 and provides information on:

- IPC activities undertaken within the organisation.
- Description of the (IPC) arrangements.
- HCAI statistics.
- Forthcoming IPC programme 2018/19.

Key Achievements

- Achieving 76.8% uptake in the staff Flu campaign and awarded second community Trust in England. The IPC Team were shortlisted for a number of awards at the recent NHS Employers Flu Fighter Conference, and Joanne Reynard was awarded 'Flu champion' which was a marvellous achievement.
- LCH has organisationally remained within commissioned targets for CDI and MRSA bacteraemia. No cases of MRSA bacteraemia had been assigned to LCH within the report period. Within the report period there was one case of CDI assigned to an LCH in-patient area. This case was identified in June 2017 and related to a patient admitted to the Community Inpatient Care Unit (J31). A comprehensive multiagency PIR was completed on the case, with conclusion that antibiotics were prescribed as per LHP whilst on CICU. The patient has been hospitalised for a considerable amount of time and received a large number of broad spectrum antibiotics.
- Development of surveillance system to monitor "alert organism" infections and new acquisition MRSA colonisation to create an early warning system identifying periods of increased incidence (PII) within geographical areas of city.
- Ongoing development of a group of IPC Champions from different business units and the facilitation of targeted training held quarterly throughout the year.
- Enhancement of engagement opportunities with the General Public and LCH membership to enable completion of Patient Led Assessments of the Care Environment (PLACE) Inspections.

Key Risks

- Major infection/outbreak – this is a risk for any service. This risk has been assessed within the Trust and removed from its Corporate Risk Register/Assurance Framework as the risk is felt to be managed with the service provided. There were a number of minor outbreaks of infection this year.

- Ensuring that the environment is maintained in good physical repair and condition is a constant challenge. The PLACE (Patient led assessments of the care environment) inspections, cleanliness validation visits and infection control audits support unit managers and Senior Nurse Managers to progress Estates and refurbishment work required. Maintenance of the environment remains a risk. Recently a central fund has been agreed to support clinical teams who cannot replace condemned furniture on existing ward environment budgets.

- Ensuring robust documentation for legionella control has been an issue. Although systems are in place for flushing of water outlets, audit has revealed some gaps in documentation which are being addressed. Non-compliance could present a risk for the Trust as failing to meet national guidance and could subject the Trust to prosecution if a case of Trust acquired legionella infection should occur.

- Ensuring that the correct systems and processes are in place to reduce where possible the risk of needle stick injuries to staff throughout LCH. To work with neighbourhoods and teams identifying causation behind injuries, and where appropriate deliver training on needle safety devices and potentially evaluate equipment in use.

Key Plans for 2018/2019

- Co-ordinate the seasonal staff influenza campaign to meet the national target of vaccinating 75% of frontline staff and ensuring that staff are fully briefed on the prevention, detection and management of Influenza. There is also a Commissioning for Quality and Innovation (CQUIN) payment attached to this target for 2018/19 with full payment for 75% uptake this year, a 5% increase on 2017/2018.

- Collaborate with the Leeds Healthcare economy on the implementation of a work plan to reduce the number of Gram-negative E.coli bacteraemia and aim

to reduce by 10% in accordance with Department of Health and NHS Improvement programme.

- Continue to promote knowledge and compliance with hand hygiene practice and other standard infection control precautions through education and audit activity.

- Continue to offer support and guidance to Infection Prevention and Control champions across LCH, providing study days and support.

- Work collaboratively across the Leeds Healthcare Economy to support staff to identify correct detection, reporting and management of sepsis.

- Risk assessment and planned action in relation to environmental or cleanliness issues.

- Continued education on the standards relating to antimicrobial use and re-audit to monitor compliance with national antimicrobial stewardship guidance.

- Continued support and guidance provided to font line staff in the use of sharp safety devices and the prevention of needle related incidents. This requires continued engagement with all business units particularly adults and specialists.

Leeds Community Healthcare NHS Trust

Contents Page:

1. Background

This document provides the annual report on IPC activity within Leeds Community Healthcare NHS Trust. The primary focus throughout this year has been to raise the profile of infection prevention practice, both within LCH teams and also across the wider community health economy. Central to this strategy has been a subtle changing of perceptions about the importance of infection control and the use of an increasing wealth of evidence relating to the rise of antimicrobial resistance and patient vulnerability to change “hearts and minds” and increase compliance with safe practice.

Infection prevention and control is central to all aspects of health care, from concept and planning to implementation. Therefore, those involved in health or social care must be aware of the role and importance of this. The specialist infection prevention and control team (IPCT) is a key resource, providing knowledge and expertise to encourage and enable staff working across the organisation to embrace infection prevention and control. Effective infection prevention and control requires the following elements:

- Surveillance
- Audit
- Education
- Policy development
- Specialist advice
- Commitment from all members of the healthcare community

At the time of the report the Infection Prevention and Control service consisted of the LCH Infection Prevention and Control Team (IPCT), the Communicable Diseases Control Team (CDC) and IPC commissioned service provision to care homes with nursing and GP Surgeries.

This annual report captures some of the developments and achievements made during the last year, with progress being mapped against the 2017/18 work plan (see appendix 1). Performance management information as well the IPC programme for 2018/19, which sets out objectives to meet the needs of the organisation to ensure patient and staff safety (appendix 2) is also included.

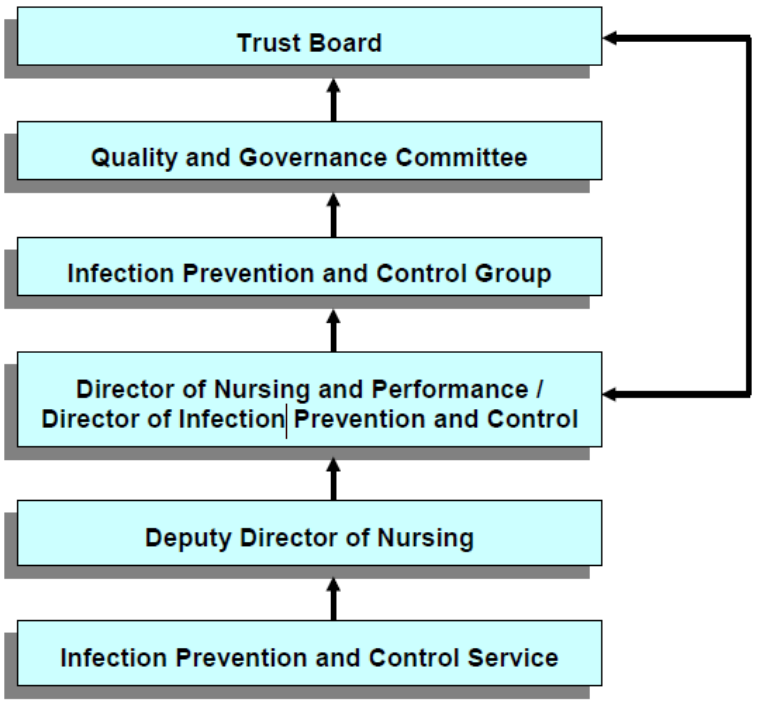
2. Provenance

The information contained within this report has been sourced from the Trust’s IPCT and other Infection Control Committee members and is reflective of actions undertaken throughout 2017/18 as part of the work of the Committee outlined in the 2017/18 annual programme

3. Key points for the board to note

- Reporting requirements for the annual report are pre-set by the Department of Health.
- The Trust has registered with the Care Quality Commission as having appropriate arrangements in place for the prevention and control of healthcare associated infections.
- Significant input from the IPCT to support this year's influenza campaign with improved uptake of vaccine in staff groups.

4. Infection Prevention and Control reporting arrangements



5. Care Quality Commission Review

All elements of the infection prevention and control annual programme are designed to ensure that LCH fully complies with the Code of Practice on the prevention and control of infections and related guidance (Department of Health 2015). This requirement forms part of the CQC regulation 12 (safe care and treatment) and regulation 15 (premises and equipment).

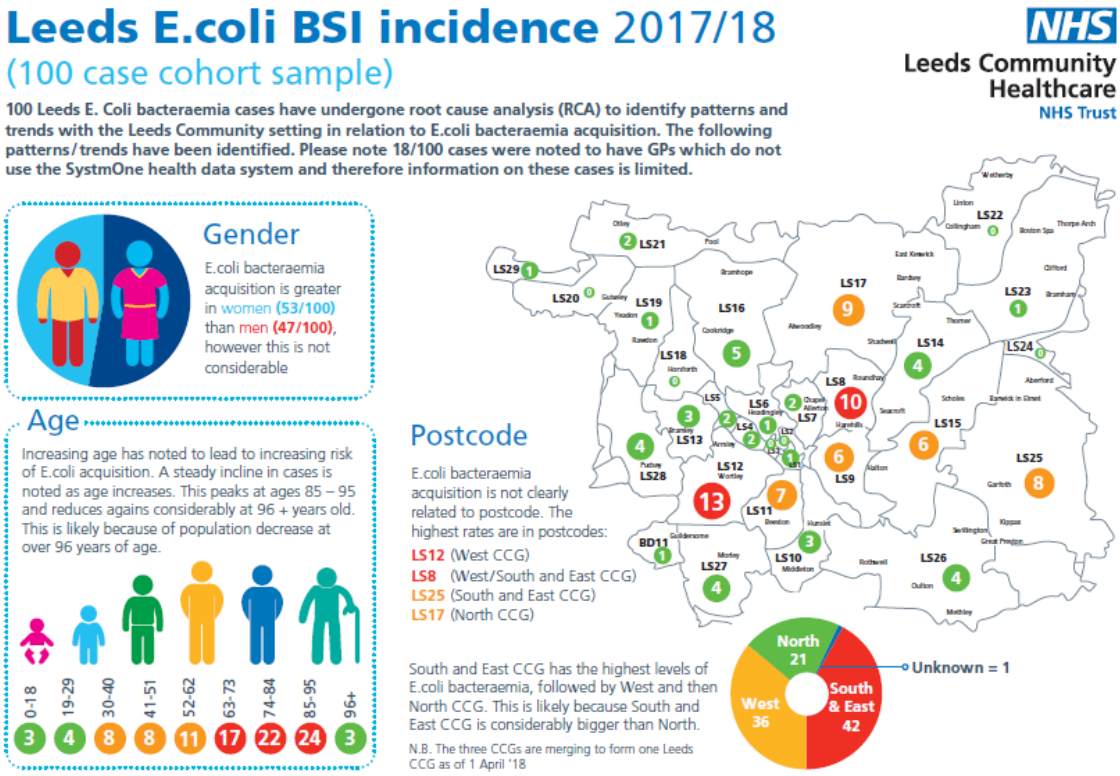
6. Healthcare Associated Infections (HCAIs) Statistics

6.1. Surveillance of Alert Organisms

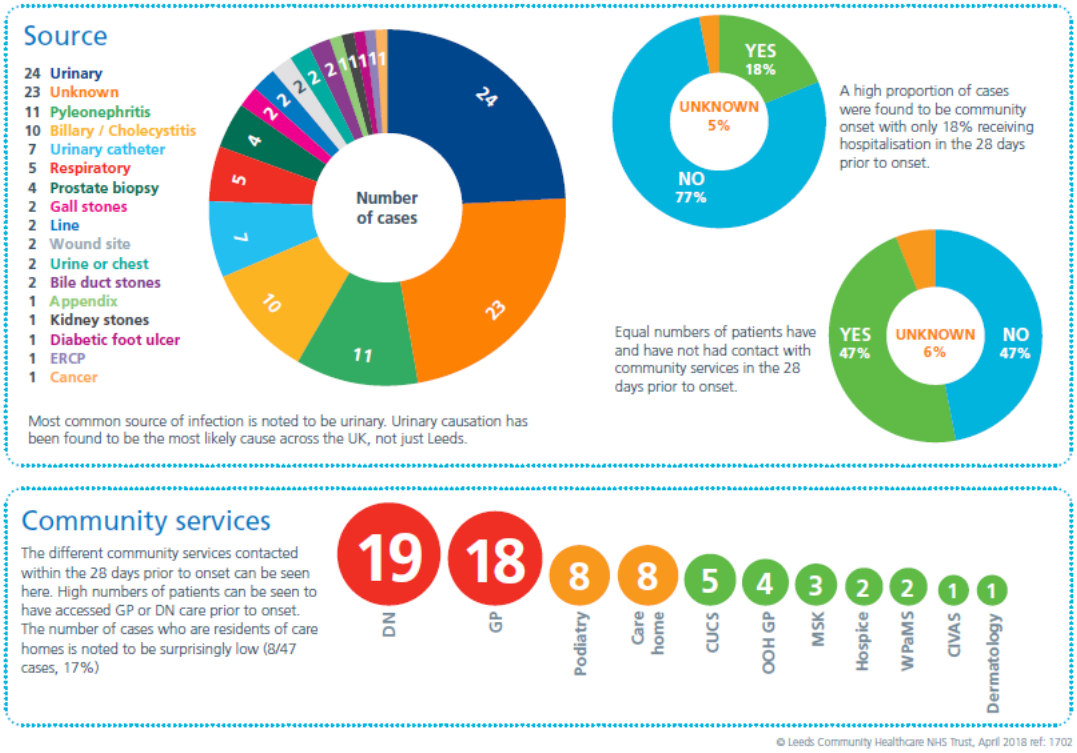
Although there are no specific government mandatory targets for individual community care organisations for the incidence of Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (CDI), locally agreed targets were developed for LCH. These targets included no more than 2 cases of MRSA bacteraemia and 3 cases of CDI being directly attributed to LCH where a multiagency review identifies lapses in care that have directly contributed to the infection episode.

6.2. Gram negative bacteraemia programme of work

During Q4 of 2017/18, work began to reduce E. coli bacteraemia burden in Leeds by 10% yearly leading to a 50% reduction in 2020 as set out by the Department of Health.



Following discussion in HCAI improvement group and with Pauline Bradshaw, RCA's were conducted on 100 E. coli bacteraemia patients who were attributed to community care. The results are summarised in the infographic below. Further work on E. coli bacteraemia is due to start April 2018 (Q1) which will include adding information to HCAI DCS, commencement of E. coli Collaborative Working Group, release of patient and staff posters on E. coli plus a patient leaflet specific to urinary tract infections. Going forward the IPC Team plan to conduct PDSA project cycles, to aid bacteraemia reduction.



6.3. Meticillin Resistant Staphylococcus aureus (MRSA)

During the report period there have been no cases of MRSA bacteraemia directly assigned to LCH. The last case attributed to LCH was reported in 2014 and so the organisation has consistently demonstrated effective MRSA bacteraemia prevention strategies.

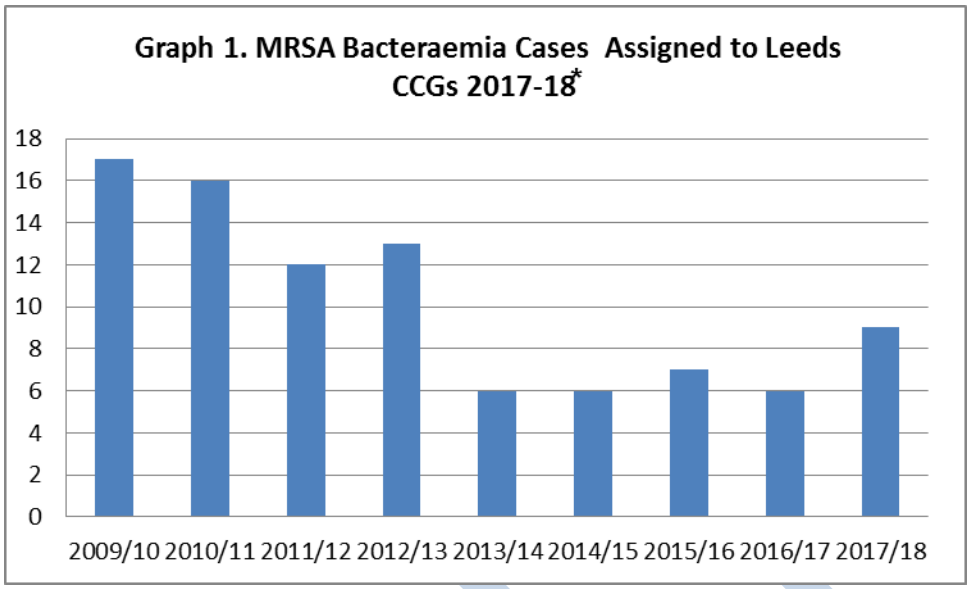


Figure 1 MRSA Bacteraemia cases identified within 48 hours of admission to Secondary Care

During the report period a total of 9 cases of MRSA bacteraemia have been reviewed by the Leeds IPC Team. Following a comprehensive Post Infection Review 2 cases were finally assigned to Leeds CCGs. As stated previously no case had been assigned to LCH.
The IPCT have also worked collaboratively with Leeds Teaching Hospital Trust to review a further 3 cases having a provisional Secondary Care assignment.
Within the community cohort 2 bacteraemia cases were related to patients who were noted to be involved in elicit IV drug usage.
Two bacteraemia cases with initial assignment to Leeds CCG's were also noted to be residents of care homes.

6.4. Learning from Post Infection Reviews

All reported cases of MRSA bacteraemia within the wider community health economy are subject to a full Post Infection Review (PIR), with the contributing factors and root causes of the infection identified. Significant work has been done to improve interagency collaboration with reviews where cases have received care from both Primary and Secondary Care providers.
As stated earlier, no cases of MRSA bacteraemia have been assigned to LCH during the report period. Some elements of learning have, however been identified and integrated into care delivery within LCH. These include:

- Improvements in communication between GP's and LCH services, along with more extensive documentation on SystemOne from both GP and LCH services in relation to treatment rationale and patient needs.

- Further highlight importance of mouth care in the care home setting and implement training
- Improvements in care home documentation of patient risk assessments, care plans and over all note taking.

Within the wider community health economy there have been a variety of predisposing risk factors identified in MRSA bacteraemia acquisition. These have primarily related to soft tissue damage due to Intravenous drug usage or ulcer infection, parotitis and catheter manipulation. Deficiencies in the communication of patient's infection status between healthcare providers have also featured as an issue.

6.5. Clostridium difficile Infection (CDI)

Within the report period there was one case of CDI assigned to an LCH in-patient area. This case was identified in June 2017 and related to a patient admitted to the Community Inpatient Care Unit (J31). A comprehensive multiagency PIR was completed on the case, with conclusion that antibiotics were prescribed as per LHP whilst on CICU. The patient has been hospitalised for a considerable amount of time and received a large number of broad spectrum antibiotics. There were no other known patients on CICU around the time that were CDI positive and patient was in a side room for the duration of her stay due to wound infection and used own commode.

The review did not identify any lapses in care that directly contributed to the infection episode, therefore the infection was considered unavoidable. This learning has been addressed by the care team and appropriate actions taken to prevent future occurrences.

Within the wider community healthcare economy the common themes and risk factors relating to CDI included:

- Patients having had recent secondary care in-patient treatment
- The use of antibiotic treatments
- Elderly patients with multiple pathologies
- Patients receiving Proton Pump Inhibitor treatments.

Multi agency work has been ongoing throughout the report period to address the incidence CDI infection within the Leeds area and a city wide action plan is in place. This work has focussed on:

- The active review of antibiotic prescribing related to each case with follow up remedial action being taken when practice has deviated from guidance
- Ongoing distribution of a CDI patient information leaflet and alert card
- Bringing together key stakeholders to form a collaborative forum which enables cross boundary reviews of cases where secondary/primary care interface issues are identified.

Throughout the report period the team have struggled with issues relating to the quality of CDI data provided from GP's. Investigation is ongoing and work to rectify this issue aims to be completed in 2018-19.

7. Outbreaks of Communicable Infection

7.1. **Pertussis September 2017** During this period the IPCT worked collaboratively with Leeds Teaching Hospitals Women's Services and Community Midwifery to identify a number of women regarding an outbreak of pertussis. We risk assessed six contacts during this period and provided advice and support to the GP's.

7.2. **Hepatitis A Outbreak July 2017** There was a Hepatitis A outbreak in July 2017, the IPCT responded to this outbreak working collaboratively alongside LCC Public health and PHE in coordinating a vaccination programme for individuals and contacts affected. There was one isolated sporadic case; however this required a full vaccination programme for the contacts of the isolated individuals and risk assessment of the establishment.

7.3. **Measles Outbreak December 2017** There was an outbreak of measles in Leeds from November 2017 to January 2018 with a total of ***36 confirmed*** cases. Control measures to reduce the risk of spread of measles included targeted school vaccination sessions, recall of patients for MMR vaccination at GP practices in Leeds with low vaccine uptake and high numbers of new migrants, community vaccination sessions and a wide ranging communication strategy. IPC worked collaboratively across the city, assisting with vaccine delivery and engaging with members of the public in the areas required and liaising with colleagues through the Outbreak meetings on a weekly basis.

7.4. **Invasive Group A Streptococcal disease (iGAS)** Two cases of iGAS were notified to the Health Protection Team from a nursing home in May

and June 2017, with onset dates 33 days apart. The first case had an onset date of approximately 8th May 2017 and GAS was isolated from an infected hip joint. The second case had an onset date of 15th June and GAS was found on blood cultures. Both cases were elderly with co – morbidities and died from causes other than iGAS infection. IPC supported the nursing home and attended collaborative meetings with PHE, an environment audit was completed, which triggered the need for IPC Training to be delivered alongside other concerns raised.

8. Management of Panton Valentine Leukociding (PVL) Cases

PVL is a toxic substance produced by some Staphylococcus aureus strains which has been implicated in severe infection and invasive disease. Throughout the year the IPCT have responded to 18 cases identified within the community economy to provide advice and information to patients and healthcare workers on appropriate management strategies. This represents a significant decrease in numbers in comparison to the 37 cases reported in the previous year.

9. Seasonal Staff Influenza Campaign 2017/2018

The team achieved the target of 76.9% in the 2016 -17 Flu season and the priority was to achieve this once again in 2017 -18. The trust had a CQUIN target of 70% which was reached by the end of November 17 and they ended the season as the second highest uptake for a community trust when benchmarked nationally with 76.8%.

We had great Trust support in 2016-17 and wanted to maintain the momentum from senior leadership and communicate to all levels of the organisation; all the while dispelling myths and keeping staff engagement high, through out.

Data was previously paper based and with ever changing metric requirements the team were aware our process needed to change. The vision to develop an electronic consent form was taken from good national practice, timings were tight but the team had a working tool the first week of the flu campaign. Staff members commented after a couple of weeks that it made the documentation easier, campaign paper light and data management far more accessible. It also helped in making the process of adding new starters and removing leavers and staff on long term sick a lot simpler and aided the monthly change of the denominator in line with the CQUIN guidance.

We are aware this is not the finished tool and learning will improve and assist in further development to a paper free tool by the next flu season.

Figure 2 Infection Prevention and Control team following BBC Radio Leeds Interview, December 2017

In the last two years there has been increased awareness of the flu campaign due to the financial incentive of the CQUIN and this was a key driver for the Trust along with the general health and well-being message to protect staff, patients and those around you.

Within the trust, senior management were kept informed weekly by email and fed details into the community newsletter with stats and myths This showed the organisation that the top level was supportive of the campaign which helped boost organisation wide participation. The communications team were also updated so they could update the flu page on the trust intranet. All of this, was enhanced by the ambition to achieve the target by Christmas to run the incentive based flu prize draw. Visibility of senior leadership having immunisations was on the trust home page and Twitter, showing videos and getting them to share messages.

All Staff members were encouraged to have flu jabs and we identified that a small number of staff were needle phobic. It was highlighted that if they had to wait they often would not have the vaccine, so we communicated that these staff could contact us direct and we arranged a visit, pre-sending forms and reducing anxiety of waiting. This was deemed a personal service and resulted in needle phobic staff getting their vaccinations.

The team leads on vaccination to increase uptake in council staff in Leeds. Working closely with Leeds City council there was an increase in vaccination, with 261 more

staff getting vaccinated from 2016-17 to 2017-18. This was done by holding planned sessions in agreed venues, some specific to social care, others in healthcare. Staff who were unable to have immunisations due to previous sickness or returning from maternity leave were offered a specific appointment and this was part of the #dialajab initiative launched in December. #Dialajab was part of our mop up strategy, Though labour intensive, when clinics started slowing down as most teams were vaccinated LCH infection prevention team opted to make flu jabs more accessible and we set up #dialajab. This was so health and social care staff who had missed the planned sessions could call the team and arrange a mutually convenient time and place to vaccinate, this was often done the same day. This was advertised through posters in neighbourhoods and on Twitter, this worked especially well with needle phobic patients.

Increased collaboration is planned for the next season, with more communication and visibility with potentially a joint health and social care launch.

Our Flu lead Joanne Reynard was awarded the 2018 NHS Employers National Flu champion.

Figure 3 Joanne Reynard awarded with 'NHS Employers Flu Champion of the Year, 2018' with Nicola Meredith from PHE Wales and Danny Mortimer CEO NHS Employers April 2018

NHS Employers: Top Three Community Trusts:		
Trust	**1 Sept 2017 – 28 Feb 2018 (%)**	**1 Sept 2016 – 28 Feb 2017 (%)**
Shropshire Community Health NHS Trust	80.2	72.4
Leeds Community Healthcare NHS Trust	76.8	76.9
Norfolk Community Healthcare NHS Trust	76.3	52

10. Learning for Patient Safety

10.1. Systems

The IPCT continue to work with managers and clinical staff to support learning for patient safety. Systems are in place to ensure incidents are recognised, recorded, analysed and learning shared across services.

10.2. Incidents

Incidents are categorised into four areas;

- Environment
- Exposure to infection
- Sharps
- Other infection control incidents.

10.3. Sharps

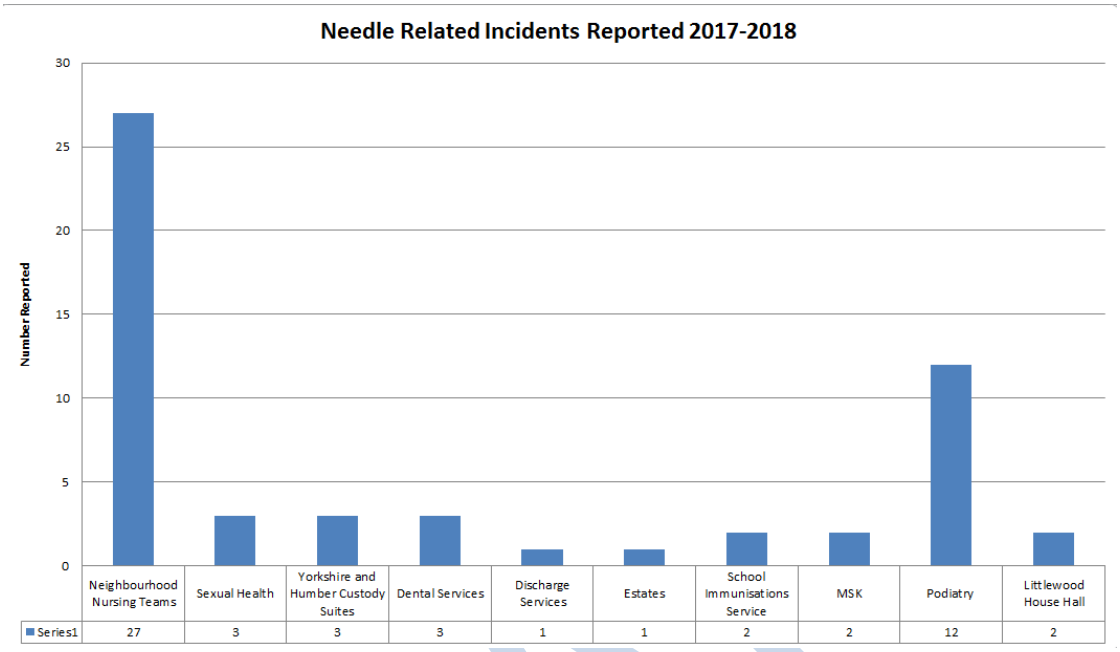
Wherever a medical sharp device is used there will always be risk of sharps injury associated with these devices. The IPCT strive to reduce this risk as far as possible by following LCH risk management strategies and ensuring that all teams are provided with adequate education, safer sharps equipment, adhere to standard infection control precautions and follow relevant LCH policy.

There was a total of **56** Infection Control related incidents reported from April 2017 to March 2018. These were reported from a range of services citywide including neighbourhoods, custody suites, sexual health and podiatry services.

- **38** related to Treatment/procedure
- **30** of which resulted in a sharps injury with minimal harm.

This highlights that sharps related incidents remain the greatest reported infection control related incident.

10.4. Breakdown of reported sharps incidents with harm;



The majority of sharps injuries reported were related to non-safety insulin pen needles and non-safety Blood Glucose Lancets (81%, 22 out of the 27 incidents reported within the neighbourhoods).

Each injury that is reported is followed by an individual specialist review and any learning is disseminated locally and wider if appropriate.

The significant themes that emerge from the review of the injury data indicate that a number of the injury episodes are related to the use of non-safety insulin pen needles.

A comprehensive work stream has been established to address this burden and includes:

- Multiagency working with CCGs to review the availability of safety equipment. The Leeds CCGs have developed a “commissioning statement” which indicated that they will not prescribe safety needles or syringes for administration of insulin by LCH staff. An organisational decision has been made by LCH to provide an appropriate safety device to all staff engaged in the use of insulin delivery pens during patient care. Further work is required with the CCGs and informal carers administering injections
- The production and distribution of posters and leaflets to staff, outlining safe practice requirements

- Joint working with the Diabetes Team to increase awareness of safety system usage within care teams
- Enhanced awareness raising at IPC Mandatory Training sessions
- Effective post injury review and investigation with the dissemination of learning throughout the organisation
- Audit of equipment use within neighbourhood Teams

If you receive a sharps injury

1. **Encourage bleeding** immediately
2. **Wash** the puncture site with soap and water. Cover with a waterproof dressing,
3. **Report** it to your line manager promptly so a Risk Assessment can be undertaken. Complete a Datix report form if applicable.
4. **Contact** Occupational Health immediately for further advice. If out of hours contact/attend A&E.

Contact us

Infection Prevention & Control Team
Chapeltown Health Centre
Spencer Place
Leeds LS74BB
Monday to Friday, 9am to 5pm
Tel: 0113 8434511

LCH Occupational Health
Block 11, Fieldhead Hospital
Ouchthorpe Lane
Wakefield, WF1 3SP
Monday to Friday, 9am to 5pm
Tel: 01924 316031

infectioncontrolleeds@nhs.net

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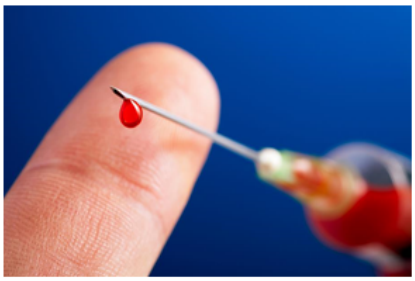
NHS
Leeds Community Healthcare
NHS Trust

Sharps Safety

for Healthcare staff and Carers who assist or administer injectable medication



What are sharps?

Sharps are needles, blades (such as scalpels) and lancets that could cause an injury by cutting or pricking the skin

What is a sharps injury?

When a sharps accidentally penetrates the skin, known as a ***percutaneous injury.*** If the sharp is contaminated with blood or body fluid, there is the potential for transmission of infection

What's the Risk?

If you have a sharps injury from a **contaminated sharp**, there is the potential risk of exposure to the major Blood Borne Viruses (BBV's) such as

- HIV (Risk of transmission is 1 in 300)
- Hepatitis C (Risk of transmission is 1 in 30)
- Hepatitis B (Risk of transmission is 1 in 3)

Anyone working in Healthcare can be at risk. You may be exposed when sharps are not stored or disposed of correctly.

How to reduce the Risk?

- Always use a **Sharp Safety Device**
- **Be prepared!** Organise your work area and ensure the sharps bin is within reach and not overfilled.
- **Be aware!** Your more likely to receive a sharps injury if you are distracted or rushed.
- **Dispose of Sharps with care.** Activate safety device after use and immediately dispose in a sharps bin.

NEVER RESHEATH OR RECAP THE USED NEEDLE

What is a Sharp Safety Device?

A sharp that incorporates a safety feature which either activates automatically following injection or requires manual activation by the user. These include retractable needles, safety shields and blunt needles. They may also be called ***Safer Needles*** or ***Safety Devices***

You should receive training on the safety device before using but they all should have common features:

- The safety mechanism must be an integral part of the device and not compromise patient care
- Easy to activate and give a visual or audible indicator when activated
- Single handed activation and not reversible after activation.,

The European Directive (2010) states that all Healthcare workers should be provided with a sharp safety device

When should I use a safety device?

If a patient is unable to self administer or requires some assistance but is not able to dispose of the used sharp completely independently, then a safety device should be used .

If the patient is ***completely independent*** and prefers to use non-safety sharps, then they can do so to ***self administer***.

Be Prepared

If you visit patients in their own home you should carry your own supply of safety devices and a sharps bin with you incase the patient does not have them in their home.

10.5. Environmental Matters

During the report period there have been a variety of incidents reported in this category. As seen during the previous year, a high proportion of these reports related to environmental conditions within patients own home setting and included infestations, cleaning issues and health promoting to patients about potential risks such as Sepsis.

Other incidents have related to the identification of poor water quality at an LCH managed health centre and deficits in the condition of the environments of facilities used but not managed by LCH. Actions have been put in place to resolve all identified issues.

Hannah House: Following the identification of infection prevention compliance issues at Hannah House, (Children's Respite Centre) a comprehensive environmental and practice improvement programme was implemented. Work was done to improve the general condition of the care environment and specific input was provided to ensure the care team was fully compliant with the requirements of the Health and Social Care Act.

Central to the improvement plan was a re-evaluation of cleaning standards and resources, with a full reassessment of the cleaning schedule enabling a more targeted and effective cleaning process being implemented.
The care team have worked tirelessly to improve practice standards and with the implementation of a Link Worker driven audit process, a robust programme of quality assurance has been established.

10.6. Exposure to infection

No particular themes or trends have been identified and actions have been implemented following each investigation. Typical examples of incidents within this category are exposure of staff to body fluids from burst abscesses, bleeding following injection etc.

All incidents reported via the DATIX system will continue to be monitored on a daily basis. Quarterly reports and action plans will be fed into the Infection Prevention and Control Group (IPCG).

11. Decontamination

LCH has a robust decontamination process for the management of reusable surgical equipment used in dentistry, podiatry and offender health. The organisation continues to utilise a central reprocessing system from and external provider with "state of the art" facilities. The Infection Prevention Team continues to monitor decontamination standards with regular meetings and "Duty of Care" visits to the facility. During the reporting period the decontamination site moved premises from Chorley to Ashton-Under-Lyne, and a pore-contract move visit was made for assurances purposes.

Within the report period there have been no reported untoward incidents relating to the provision of sterile medical devices from this source.

12. Estates/ Facilities

The IPCT have continued to foster integrated working arrangements with the Estates/Facilities teams to reduce the risk of infection in LCH care environments.

The Facilities team are actively linked into the audit activity to enable effective monitoring and response to environmental issues identified during the audit process
A more integrated approach with IPC and Estates has been made, which has ensured that IPC requirements are included at the outset of all refurbishment work.

The IPCT has contributed to the development of environmental policies and also provided advice in the event of water quality issues or other problems relating to the healthcare environment. A Legionella positive sample was found within Morley

health centre which was effectively dealt with by cohesive team working between the estates and IPC teams.
Working collaboratively with the Estates Project Team, the IPCT contributes by ensuring the proposed sites are fit for purpose ergo safe delivery of services continues when teams move to new sites.

13. Clinical Governance

13.1. Governance Structure

Governance is assured through the Infection Prevention and Control Group (IPCG) and its reporting mechanisms via the organisational governance structure. Throughout the year further work has been done to ensure a robust communication pathway is available via the Patient Safety and Experience Group and Quality Committee. The monthly Director of Nursing Briefing also reviews infection prevention and control issues/status.

13.2. IPC Policies

The IPCT are responsible for a suite of policies and have continued to develop and review clinical policy documents and best practice clinical guidelines to support front-line staff. A number of “key note” policies have been updated throughout the year and the team continue to “horizon scan” to ensure that practice in concurrent with current evidence and best practice.

The IPC policies and guidelines are directly related to patient, staff and visitor safety and to the consistency of quality of care a patient receives. They ensure compliance with the standards outlined by the Health and Social Care Act (2008), National Health Service Litigation Authority (NHSLA) and Health and Safety at Work Act. A number of “key note” policies have been updated during the report period.

13.3. Audit

Audit is a requirement of the **Health and Social Care Act 2008, Code of practice for registered providers on the prevention and control of health care associated infections and related guidance**. The code states that registered providers must audit compliance to key policies and procedures for infection prevention.

13.4. Process

Due to a lack of suitable products being available the IPCT has yet to acquire an effective tablet-based tool that will allow paper free auditing and reporting, however work is ongoing with this goal. On the completion of audits, feedback is provided to the relevant team leader(s) via the action plan.

Areas or systems of good practice are highlighted as well as areas / issues of concern that required addressing. Time specific, ameliorative recommendations are included for the highlighted areas of concern. Recommended actions are agreed with the staff identified as being responsible and the progress of any improvements is monitored by subsequent follow up visits.

Simultaneously, the action plan is registered on the organisational data base and sent to relevant departments, for example facilities which include external cleaning agencies.

13.5. Audit Results

To fulfil part of the auditing requirements the IPC team perform annual audits of dedicated areas and premise used by LCH staff. Data gathered from the LCH auditing activity is used to improve LCH environments, services and staff performance. These improvements will reduce the risk of transmission of healthcare associated infections to patients, staff and visitors.

Areas audited for 2017/18 are as below:

- All LCH health centres
- Clinics performed by LCH clinical teams
- The assisted living centre
- Leeds Integrated Sexual Health
- Community Neurological Rehabilitation Centre
- Hannah House
- Little Woodhouse Hall
- Chapel Allerton Hospital Rheumatology MSK Spinal assessment clinic
- St Georges Centre for Musculoskeletal (MSK) and Children's Out patients
- The Custody Suites for East, North, South and West Yorkshire
- 3 Special inclusion learning centre (SILC) schools
- Community Intermediate Care Unit (now closed)
- South Leeds Independent Centre (now closed)

During the report period a total of 47 environmental audits have been completed by the Infection Prevention Team. This represents 100% of the areas identified in the LCH audit programme for the year.

- A number of recurrent themes also become apparent which include: Across the premises were varying standards of cleaning which resulted in the accumulation of dust on high surfaces and dirt and debris to floors. Ongoing liaison with the Locality Support Officers (who audits cleaning standards of the premises and

liaises with the cleaning company of LCH premises) is done by the IPC team to improve and maintain cleaning standards.

- Hannah house had poor standards of cleaning. Since then Hannah House has undergone refurbishment and the cleaning standards have improved.

- One SILK school had suboptimal standards of the health care rooms. Since this was identified by the audit, plans for refurbishment have been made.

- Some concerns around staff compliance to bare below the elbow.

- Staff knowledge and compliance.

Current audit findings are incorporated into the mandatory IPC training sessions to improve staff appreciation of IPC risks as well as their role in prevention of incidents resulting from practice that deviates from policy and safe practice.

13.6. Dental Water Lines (DWL) Audit

A programme of systematic testing of dental waterlines has continued with 6 monthly reports on water quality results being submitted to the IPCG. On the identification of elevated bacterial levels within lines, specific remedial action is implemented to assure patient safety.

The surveillance and monitoring process identified high bacterial counts within the equipment at Yeadon Dental Suite. Rapid intervention and modification of the disinfection regime prevented any risk to patient safety and enabled resolution of the problem.

13.7. Hand Hygiene Compliance Audits

The process provides an element of assurance that clinical staff members have an appropriate level of competence in relation to hand hygiene and the basic principles of IPC. A process of weekly hand hygiene compliance monitoring has been established at the Community Rehabilitation Unit (CNRC) and Little Woodhouse Hall. Work is ongoing to establish a formalised process for Hannah House. Within the wider community economy peer assessment observations have been ongoing within care delivery teams. Compliance information generated as a result of The Essential Steps observational process is submitted by teams to the Quality Challenge + programme.

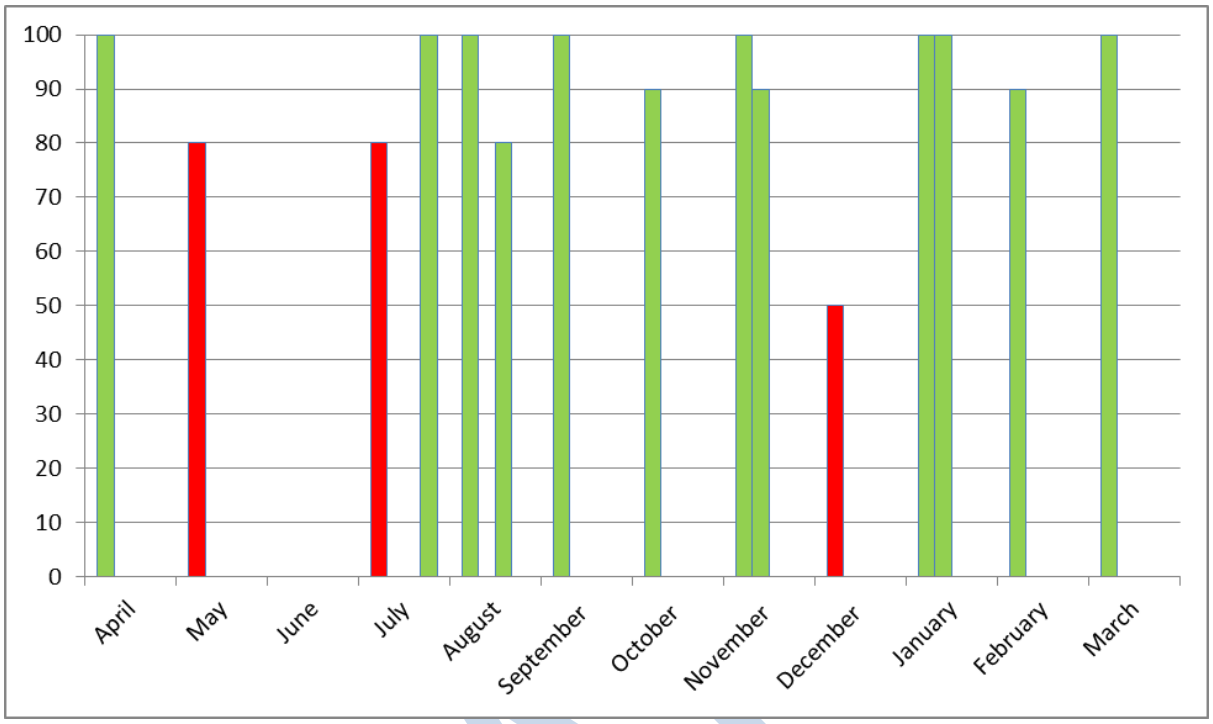


Figure 4: Hand Hygiene Compliance CNRC 2017/2018

14. Quality

14.1. Quality Challenge plus

In order to provide robust quality assurance pathways, IPC features on the organisational Quality Challenge + Framework. This involves all care providing teams giving assurance that they are compliant with important infection prevention criteria such as; having appropriate hand hygiene materials available at all times. That IPC features on job descriptions, is reviewed during appraisal and performance review and that staff have peer led assessments of individual hand hygiene compliance. As stated previously data collection and review has been difficult and measures to improve the process will be integrated into the activity during the 2017-18 year.

15. User Engagement

15.1. Patient Public Involvement (Safe Clean Care and PLACE projects)

The Infection Prevention Team (IPCT) continues to closely work with a group of Public Members to appraise the standards of infection prevention practice within health centres and in-patient areas. The IPCT reflects the organisational philosophy of putting the patient at the centre of the care delivery process. In order to develop sustainable links with patients and the general public the IPCT have rited a group of

Public members to help with IPC and environmental standards monitoring. A core group of six individuals have now been actively involved for the last three years with their individual experiences/ views used validate assessments of the quality of the environments in a number of LCH health centres. The team also are closely involved in the mandatory Patient Led Assessment of the Care Environment (PLACE) inspections which were completed on CNRC and at Little Woodhouse Hall.

Patient Led Assessment of the Care Environment (PLACE) Inspection Results 2017-18

The PLACE programme is undertaken annually within LCH and follows the assessment framework published by the Department of Health. During April and May 2017 a group of Patient Members and other stakeholders visited CICU (J31), Little Woodhouse Hall, South Leeds Independence Centre and The Community Neurological Rehabilitation Unit (St Mary's Hospital).

The purpose of PLACE is to provide a non-technical view of the quality of non-clinical services provided to in-patients and other hospital users across all qualifying hospitals. It is based on a visual assessment, not relying on the application of any technical or scientific tools. It is therefore a fundamental component of the process that assessors will need to exercise a degree of judgement, particularly when required to agree the score to allocate for a particular aspect of the assessment.

An Action Plan which sets out how the organisation expects to improve their services before the next assessment is also required and has been undertaken per site.

The results for the "Privacy, Dignity and Wellbeing" assessment criterion demonstrated an organisational compliance which was more than 11% above the national average. All comparable areas recorded significantly improved scores when compared to the previous year's results on this criterion.

The standards of cleanliness in all areas other than South Leeds Independence centre (SLIC) , were noted to be above the national average. Unacceptable dust accumulations and staining to some wash hand basin outlets at SLIC impacted on the local score and also reduced the overall organisational score to just below the national average.

The assessment of the condition, appearance and maintenance of the care environment identified issues at Community Intermediate Care Unit (CICU St James J31) and SLIC. This was balanced by above average results from Little Woodhouse Hall and Community Neurological Rehabilitation Unit (CNRU). The deficits identified at CICU and SLIC have been identified in organisational action plans that have been submitted to the respective Land Lords for the premises. These two areas will not

feature in the 2018 programme as they will no longer be operationally under the management of LCH.

The overall results from this year's PLACE inspection demonstrate a significant improvement in the way in which the patient environment is managed to both physically and psychologically enhance the patient experience. This improvement is testament to the hard work and dedication of the unit managers and their teams.

15.2 Information Technology

The IPCT continues to review its activity in relation to available Information Technology systems.

The Flu campaign continued to see the team using Social Media in a more advanced nature, linking professionally using Twitter and Facebook. The team also used electronic consent forms to allow ease of completion and reduce admin time when collating patient information for flu database.

15.3 Patient and Public Information

A dedicated infection prevention and control information resource page for patients and public is maintained on the Leeds Community Healthcare NHS Trust website. This site provides easily accessible IPC resources and tools suitable for use by the general public or healthcare professionals. Staff can also access these resources via the IPC pages on the LCH intranet system ELSIE.

15.4 Collaborative Working

The IPCT have continued to work hard to improve engagement and collaborative working with other agencies/ stakeholders in the Leeds health economy. Throughout the year, the LCH Team have actively contributed to the city wide promotion of infection prevention, working on such initiatives as pandemic Influenza planning, antibiotic resistance and winter planning.

Throughout the year the IPCT have worked with LTHT on cases of MRSA and C difficile infection where joint involvement has been noted. This joint review process has enabled a more integrated approach to identifying causes and solutions to infection related issues.

The IPCT have actively engaged with the Local Authority Social Care provider Teams and deliver bespoke IPC training to the care providers. Work has been done within a number of schools and children's centres the team provided a number of IPC awareness sessions.

The IPC team have worked collectively with the hospice economy including Wheatfield's and Martin House Hospice, to provide bespoke IPC training and over the phone advice.

Home Life collaborative working with the IPC team providing advice and bespoke given to care workers with hearing deficits

Villa Care IPC bespoke training delivered as part of a NHS collaborative agreement for social care delivered with the Leeds Healthcare Economy.

15.5 Student Learning Opportunities

For several years, the IPCT has been providing placements for 1-3rd year nursing as well as Allied Health Professional Students. The IPCT works closely with the practice learning facilitators to ensure that placements are stimulating and meaningful. A wide range of exposure to IPC is provided, including visits to the acute and mental health trusts, offender health and related teams within LCH.

Students are provided with a current, comprehensive workbook, microbiology work sheets and case studies to complete prior to placement commencement. These are updated as the placement and their insight into IPC priorities and education progresses. Students are allocated a primary and secondary mentor with whom to work as well as support from the wider IPCT members.

Verbal, written and student portal feedback is consistently excellent. Student feedback is woven into workbook and placement honing.

16.0 IPC Training

16.1. Programme

The IPC mandatory training programme has undergone further modification through the year.

16.2. Attendance

The proportion of staff that have attended IPC training as set out in the statutory and mandatory training grid had remained at around 87% (source ESR) throughout the report period. This figure is below the 90% organisational threshold and so the IPCT have implemented a host of local measures to increase uptake. These have included:

- Providing bespoke training within staff bases, including sessions out of hours for night and twilight staff

- Reviewing individual team/neighbourhood performance and providing targeted sessions to areas of low compliance
- Reviewing data quality issues with the Workforce Information Team
- Increasing the availability of generic training sessions

The issue remains on the organisational Risk Register and the issue is identified on the IPC programme for 2018-19, with an expectation that the training target will be achieved by March 2019.

17.0 Communicable Disease Control (CDC)

17.1. The CDC Team

The CDC Team consists of 1.2 WTE nurses and is based with Leeds City Councils (LCC) Environmental Health Food and Health Team. Their purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds. They investigate confirmed and suspected food poisonings and also manage outbreaks of viral gastroenteritis within any establishment including care homes, child care settings, schools, day centres, etc. They work closely with partner agencies including Leeds City Council and Public Health England (PHE) and have continued to work with PHE and West Yorkshire local authorities to review and standardise key principles of managing Gastro intestinal illnesses across West Yorkshire.

Outbreak management details (Wider Leeds Community Health Economy) 1/4/17 to 31/3/18.	**Total outbreaks 104**

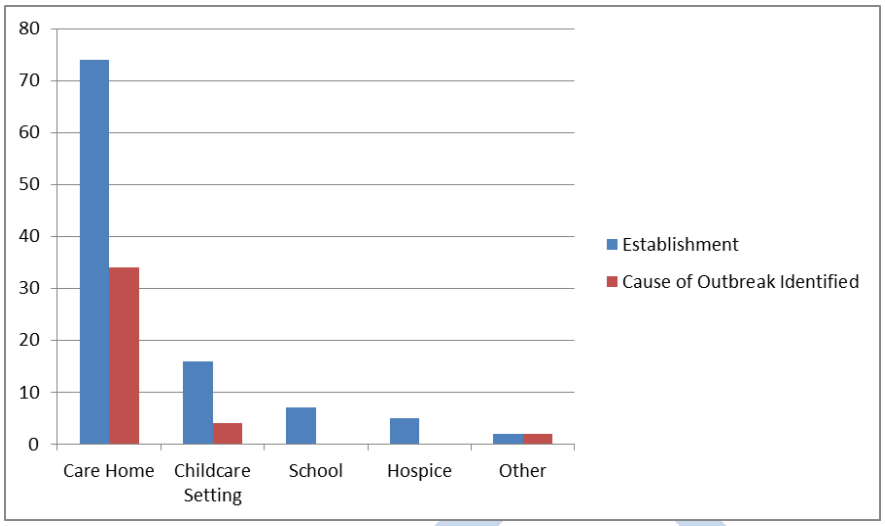


Figure 5: Overview of Outbreak Settings 2017-18

The chart provides an overview of the types of facilities that have reported outbreaks of gastro intestinal illness during the report period. Each of the identified outbreaks have been visited, advised and managed by the CDC nursing team. The graph shows that a variety of settings have reported incidents, ranging from Care Homes, Schools, Child Care facilities, and other establishments including food premises. The majority of causative organisms identified have been identified as viral in nature with Norovirus being identified as the main cause of many outbreaks.

Enteric Illness

Reported cases 1/4/16 to 31/3/17

Suspected food poisoning - **258** individual reports of illness after eating from establishments in Leeds which were all responded to and advised accordingly.

Organisms identified through notification of infectious disease reporting 1/4/17 to 31/3/18

ORGANISM	NUMBER OF CASES
Campylobacter	933
Cholera	3
Cryptosporidia	71
Cyclospora	7
E.Coli 0157	16
Entamoeba Histolytica	11
Giardia	136
Listeria	7
Salmonella	113
Shigella (including sonnei, boydii, flexneri and disenteriae)	28
Typhoid/Paratyphoid	8
Yersinia	4
TOTAL POSITIVES	**1337**

17.2 Ectoparasitic Management

The IPCT provide a specialist service for the management of head lice (Headstart) infestations within the community. The service offers advice and support in cases of persistent head lice infestation. The main sources of referrals come through school staff, with additional referrals via school nurses, health visitors and social workers.

During the 2017/2018 period the service has seen a further reduction in referrals with a total of 27 cases referred this year. These were assessed and appropriately managed by the team with 24 referrals being accepted. Three referrals were declined as inappropriate – feedback and advice was offered in these cases.

In addition to this many concerns were dealt with through telephone discussion where advice was given on possible reasons for treatment failure, followed up with provision of our head lice resource suite (head lice flowchart, check list, referral form, advice leaflet for health professionals, booklet, posters and flyers) sent via e-mail. This was often effective in aiding schools, health professionals and social workers to support parents in managing their child/children's head lice.

Access to free Hedrin via the Pharmacy First Minor Ailments Scheme has been a positive step in reducing referrals by removing the financial barrier to obtaining treatment, while also directing parents for first-line advice to their local pharmacist rather than attending their GP Practice. There has however been occasional feedback from parents that they have been declined provision of free Hedrin due to some pharmacies saying they do not participate in the scheme. These reports have been fed back to the CCG Pharmacy Lead for investigation.

The service continues to encounter some complex and challenging cases where children have presented with severe head lice infestation in addition to other issues, which have occasionally led to safeguarding concerns. These families are often hard to engage and repeatedly fail to check their children's hair and/or apply a pharmacy-approved head lice product in accordance with the instructions. These cases can be hard to resolve. It can be very difficult to get all family members together and frequently adult members of the family are reluctant to have their hair checked.

Often difficulties with head lice management have arisen due to family breakdown, parental illness or disability. Support and advice has been provided in these circumstances to help the parent acquire the necessary knowledge and skills to take on the responsibility of managing their child/children's head lice.

Headstart visits continue to take place predominantly in the school environment wherever possible. This facilitates better engagement with parents/guardians and closer collaborative working with the school staff, particularly the learning mentors/child protection leads, who are the main source of referrals into the service. Moreover, seeing referred cases in the school environment has eliminated the problem of unattended appointments and minimised the potential risks associated with lone working. Visits are conducted in the home only in special cases when we are specifically requested to do so (as in the example of the migrant family given above), or when this is the only remaining option available.

18 CCG Commissioned Services

Much progress has been made to engage advise and provide quality assurance for the commissioned services within the Leeds healthcare economy. Specific work streams have been implemented to improve IPC compliance in these areas.

18.1. **Care Homes**

The IPC nurse visits Care homes with nursing (CHWN) to perform periodic IPC audit visits. Currently there are 39 CHWN in the Leeds locality. The purpose of auditing is to appraise the activities of IPC in CHWN against national standards. From this non-compliant areas are identified and advice and an action plan is given to support care homes work towards compliancy.

Each CHWN should receive a primary audit visit minimally every 3 years. Care home visits are followed up again in 3 months to review progress and further advice is given as needed. The audits are scored in line with the Department of Health

scoring system which provides a clear indication of compliance for each audit criterion and of the overall audit score:

Compliance score	Compliance rating	Risk rating
85% or above	Compliant	Minimal Risk
76-84%	Partial Compliance	Medium Risk
75% or less	Minimal Compliance	High Risk

Results for the year 17/18

For the year 2017-18:

- 20 care homes received a primary audit
- 30 care homes received follow a follow up visit(s)

Out of 20 care homes that had primary audits completed

- 13 had a compliant overall score
- 7 had a partial compliance overall score

Out of the 30 care homes that had a follow up review

- 29 care homes were either already compliant or had improved to Compliant status on follow up.
- 1 care remained partially compliant and a review visit with the new manager will be performed this month

Additional Support

IPC support to the care home economy has is provided in the form of:

- Telephone/email/face to face advice
- Visits and meetings at care home premises
- 4 monthly IPC champions training
- Biannual IPC newsletter
- Speaking at care home forums and events
- A dedicated care home IPC information web page which includes guidelines and promotional material.
- Sharing IPC new updates via the web page, email and meetings
- Developing supportive material as necessary .i.e. best practice posters and fact sheets
- Invitations to LCH events such the LCH IPC conference (and 21 free places were allocated to CHWN staff)
- IPC visits to areas where outbreaks of communicable disease or untoward infection episodes have been identified.
- Inclusion in shared learning cascades of HCAI's untoward incidents

Additional visits to care homes with nursing

In addition to the support discussed above the audit nurse also visited 3 care homes (with the nurse who was performing the post infection reviews) that had a resident who developed an MRSA bacteraemia. Furthermore the audit nurse visited a CHWN who had an Invasive Group A streptococcus (IGAS) Outbreak.

Residential care home support for year 2017/18

Residential care homes have access to and are included in the list of additional support above. In addition to this support to the residential care homes has included:

- A care home review visit of the operational areas (following initial request for visit by the manger). (Due to poor progress of the operational areas in the care home the audit nurse has liaised with local authority who will continue to monitor the care home)
- A visit to provide support following a potential Clostridium difficile outbreak. Following the visit a full IPC audit was arranged and was completed January 2018.
- A visit to provide support following a resident developing an MRSA bacteraemia. A follow up visit was performed to review progress with the advice given
- A newly built care home was visited (after request from the deputy manager) to give IPC advice on the new environment.
- One Recovery Hub was visited due to several infection outbreaks occurring in the home after soon after opening. The audit nurse has agreed to perform a full IPC audit (after the care home has finished refurbishment works).

Link to health and social care agencies and commissioning teams

Further to the all auditing activity and support provided above, the IPC nurse acts as a link for care homes to the wider health and social care agencies, services and commissioning teams. Consequently this provides a pathway for escalations of concerns and sharing of good practice.

18.2 GP Commissioned Audit Programme

During the financial year of 2017/2018 a total number of 47 GP practices in Leeds received a face-to-face audit by the LCH Infection Prevention and Control Team, commissioned on behalf of the NHS Leeds CCG.

Areas of non-compliance and concern –

- Organisational controls – training, assurance mechanisms
- Overarching risk assessment

- Annual statement – recommendation for practices to highlight and demonstrate their zero tolerance to HCAI's as outlined in the Health and Social Care Act 2008.
- Legionella management and control systems in place: practices that are independently ran out of their own premises often have difficulty in ensuring full compliance with this element inline with the L8 Guidance around Legionella.
- Sanitary assembles – many are compliant throughout general practice. Those that are not are recommended to have an action plan in place outlining a period of refurbishment.
- Needle safety issues and getting hold of the devices and completion of appropriate risk assessments: risk assessment template provided as part of feedback.
- Cleaning in some practices with dust with high areas.
- Assurance mechanisms around aseptic technique and minor surgery.
- Hand hygiene compliance amongst members of staff in line with policy and procedure.

19 Infection Control Champion Programme

The IPCT continues to provide support and training to Infection Control Champions. They act under the supervision of the IPCT as a resource and role model for colleagues. They are a key contact for the IPCT, cascading new information and facilitating change as required. The IPCT provide quarterly training for all champions covering a range of different topics.

20 Personal Development of IPCT

As part of a development opportunity two band 7 nurses have had a period of time as acting 8a, this is to increase skillset and succession plan for the future when a senior member of the team retires in October 2018.

A band 6 in the team has been successful in being appointed as a secondment opportunity filling the role as a band 7 to complete a commissioned piece of work on the Gram negative E.coli programme initially for 12 months.

A Band 5 (already in an existing secondment role to cover maternity leave) in the team has been successful at being appointed as a band 6 secondment to backfill the above post.

National study days or conferences are attended as appropriate for professional development, and all members of the IPCT are members of the Infection Prevention Society (IPS). The Senior IPC Nurse is the chair of the Yorkshire Branch of the IPS. There is regular communication with other members of the Infection Prevention Society IV Forum and Research and Development Forum for networking and sharing of ideas and expertise, and we have linked with

21 Conclusion

Throughout the year, The IPCT have continued to raise the profile of Infection Prevention and Control and to ensure that safe IPC practice is a fundamental element of all care delivery activities. The team have worked hard to foster relationships with internal and external partners, developing collaborative working arrangements to form the foundation of a strong partnership with a multi-faceted approach to the prevention and management of communicable disease.

To ensure continued quality improvements and to support the organisations zero tolerance to HCAIs, further work has been indentified throughout this report which will form the basis of the IPC programme and priorities for 2018-19 as set out in the 2017-18 Infection Prevention and Control Programme (Appendix 3).

23 Recommendations to the Board

The Board of Directors is asked to note the contents of this report and approve its publication.

Approved by:

Compiled by: Liz Grogan Senior IPC Nurse Specialist

With reports compiled by:
Joanne Reynard Acting IPC Lead Nurse Specialist
Dave Hall Senior IPC Nurse Specialist
Louise Popple IPC Nurse Specialist
Jeanette Wood IPC Nurse Specialist
Trish Keeney IPC Nurse
Dawn Scholes IPC Nurse
Janice Collier CDC Nurse

Appendix 1

Infection Prevention and Control Policy and Guideline Plan 2016 – 2018									
No	**Policy identification Number**	**Author**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
1	Overarching Policy PL305	D Hall		July 17			Sep 2020		
2	Management of body fluid exposure incidents (including needle stick injuries) Included in IPC Manual PL322	L Grogan		Oct 17				April 2021	
3	Local Decontamination of Re-useable Equipment PL331	D Hall			Mar 2018			April 2021	
4	Diagnostic and Screening including safe sampling PL332	Louise Popple			Mar 2018			May 2021	
5	Healthcare Waste PL341 Included in IPC Manual	D Hall			June 2018				
6	Scabies Policy PL344	L Grogan				June 2019			
7	MRB PL351	Jo Reynard			June 2018				
8	ANTT PL338	L Grogan			June 2018				
9	Specific Infections PL345	D Dobson				June 2019			
10	Outbreak Policy PL261	D Dobson	01/10/ 15		Oct 2018				
11	MRSA Policy PL343	L Grogan			June 2018				
12	Standard Precautions (including HH, PPE and spillages) PL227	Louise Popple		31/10/ 17			Oct 2020		
13	Clostridium Difficile PL288	D Hall	25/06/ 16			June 2019			
14	Isolation Policy PL306	Liz		June				Jan	

		Grogan		17				2021	
15	*New* CPE Policy	D Hepworth	30/03/16			March 2019			
16	TSE Policy PL319	L Popple			July CCPG 18				
17	Linen and Laundry PL314	J Wood		Nov 2017			Nov 2020		
18	Deceased Patient PL330	D Hall				Mar 2019			
19	Food Safety PL299	D Hall		15/03/17			Mar 2020		
20	Respiratory Virus Policy PL294	D Hep	Aug 2016				Jan 2020		

Guidelines				
1	Guideline for the Management of Head lice in the Community	D Scholes	01/09/17	Due
2	Animals in a Community Health Setting GL022	L Grogan	03/05/16	Due April 2019
3	Toys in the Community GL037	D Hall	Feb 2017	Due Mar 2020

Appendix 2

Infection Prevention and Control Programme 2017-18

In addition to existing IPC activities this programme describes activities that meet the needs of the organisation to ensure patient safety

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Policies								
Update existing LCH policies due for expiry 2017-18 • Overarching IPC Policy • Isolation Policy • Standard Precautions Policy	LG	March 18						
Training								
Ensure compliance levels for IPC Mandatory training reaches 90% target	DH	Interim results to IPCG Quarterly						
Develop organisational algorithm for management of Sepsis in Children and young people	DH	March 18						
Facilitate a one day IPC conference	LG	November 17						
Collaborative working to support AMR Agenda in GP economy	LG	September 17						*Facilitated Target working as part of Leeds Economy Approach*
Develop and implement IPC Training for GP and Practice based Teams	Team	Nov 17						
Review and refresh IPC mandatory training programme	LG	Dec 17						
IPC Performance and Quality Assurance								
Work collaboratively with CCG partners to develop surveillance and investigation process of Gram negative bacteraemia episodes in line with DH Mandatory requirements	LG/ JR	October 17						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Standardise IPC assessment and assurance framework in Custody Suite areas	JR	Nov 17						
Assist clinical teams through the completion of IPC elements of Quality Challenge Plus and integrate into IPC Assurance Framework	DS	Sept 17						*IPC standards integrated into framework*
Undertake structured audit activity within GP practices as part of commissioned service	LG and Team	April17						*IPC Audit process under way*
Undertake and Coordinate PLACE reviews of : • Little Woodhouse Hall • CICU J31 • South Leeds Independence Centre	DH	June 18						*Awaiting PLACE review process 2018*
Produce an Annual Report and release it publically	DH	June 2018						
Modify and refresh LCH Internal Audit Tool	JW/ LG	Jan 18						
Review IPC Overarching Assurance Framework	DH	August 17						
Review and undertake audits of antimicrobial usage as directed by Medicines Management Team	LG/CN	Jan 18						
User Engagement								
Coordinate staff influenza vaccine campaign 2016-17 achieving CQUINN target of 75% frontline uptake	TBC	Feb 18						
Foster engagement with cohort of membership with PLACE induction training session	DH	Dec 17						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Undertake Hand Hygiene awareness Campaign within LCH	TEAM	Nov 17						
Further develop FFP3 Mask Fit Testing programme for LCH in response to potential Pan Flu risks	DH	Jan 18						
Service Improvement								
Facilitate IPC Team Building Event	DH	Dec 17						
Work with CCG partners to review and improve the wider community CDI review process	LC/DH LTHT/LYPFT	Nov 17						
Work with facilities and Estates to support team/service relocation activities	DH	Dec 17						
Work with CCG partners and other stakeholders to review the MRSA decolonisation protocols	DH LC	Feb 18						

Appendix 3

Infection Prevention and Control Programme 2018-19
In addition to existing IPC activities this programme describes activities that meet the needs of the organisation to ensure patient safety.

This year's annual programme is mapped to the Health and Social Care Act 2008, Code of Practice for Health and Social Care on the Prevention and Control of Infections and related guidance (2015). Compliance with the Code of Practice is enforceable by the Care Quality Commission and a declaration of compliance with the Code by the Trust, is a statutory requirement for registration under the Health & Social Care Act 2008. The Code comprises of ten compliance criteria against which the Trust will be assessed by the CQC. In addition Infection Prevention and Control cleanliness standards are monitored under regulation 12 and 15 of the Care Quality Commission Regulations.

There are also relevant NICE standards that are referenced in the plan. The NICE quality standard QS113 on Healthcare Associated Infections (2016) and QS61, the overarching quality standard which reflects other NICE guidance are also referenced. In addition the programme reflects recommendations from other relevant NICE standards such as NICE PH36 (2011) Healthcare associated infections: prevention and control and NICE PH43 (2012) Testing for Hepatitis B and C in drug services and NICE NG60 (2016) HIV testing: increasing uptake among people who may have undiagnosed HIV (Joint NICE and Public Health England guideline).

In addition NHS Improvement (2017) has published its ambition to halve healthcare associated Gram-negative bloodstream infection (BSI) rates across the NHS by 2021, which will involve all parts of the healthcare community working together on improved surveillance of E.coli*, Klebsiella* and *Pseudomonas* blood stream infections and prevention of these infections.

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Policies								
Update existing LCH policies due for expiry 2018-19 • Healthcare Waste • Aseptic Technique • Outbreak Policy • MRSA Policy	LG/LP	March 19						
Training								
Ensure compliance levels for IPC Mandatory training reaches 90% target	JR	Interim results to IPCG Quarterly						
Facilitate a one day IPC conference	LG	May 19						
Collaborative working to support AMR Agenda in GP economy	LG	ongoing						
Develop and implement IPC	Team	December						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Training for GP and Practice based Teams		18						
Develop champion based training for GP practice staff.	LG	December 18						
Review and refresh IPC mandatory training programme look too develop innovative ways to reduce travel	LG							
Perform IPC training for social care staff at Enterprise House, discuss evaluations and maintain the contract	Team / JR							
IPC Performance and Quality Assurance								
Work collaboratively with CCG partners to facilitate surveillance and investigation process of Gram negative bacteraemia episodes in line with DH Mandatory requirements. Report monthly and input on DCS.	LP							
Standardise IPC assessment and assurance framework in Custody Suite areas and initiate self-assessment tool.	JR	Sept 18						
Assist clinical teams through the completion of IPC elements of Quality Challenge Plus and integrate into IPC Assurance Framework	DH	March 19						
Undertake structured audit activity within GP practices as part of commissioned service	LG and Team	March 19						
Undertake and Coordinate PLACE reviews of : • Little Woodhouse Hall • Hannah House • CNRC	DH	May 19						
Produce an Annual Report and release it publically	Lead	June 2019						
Modify and refresh LCH Internal Audit Tool	JW/ LG	August 18						
Review and refresh Risk assessment process	DH	August 18						
Identify ongoing concerns and audit 50 cases that were telephoned from LTHFT to CDC for accuracy. Explore what can be done to	CDC Nurse	September 18						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
mitigate the risk as an IT solution is not forth coming.								
The partnership agreement is in development by LCC and will be shared to LCH by July 18. This will need senior review by the board and DIPC.	DIPC	March 19						
IC net will cease to be used by April 19. LTHT are transferring to PPM plus. IPC team need to understand the impact this will have on their processes and ensure their needs are addressed as part of the development led by LTHT.	Lead	March 19						
To review with EH and LCH the role of EH and CDC nurse role	Lead							
To review and continue ongoing contracting arrangements for the Care Home staff IPC training.	Lead/JW							
User Engagement								
Coordinate staff influenza vaccine campaign 2018-19 achieving CQUINN target of 75% frontline uptake	JW	March 19						
Foster engagement with cohort of membership with PLACE induction training session, to look to engage at developing connections with Health Watch with the PLACE process.	DH	March 19						
Undertake Hand Hygiene, Sepsis and AMR awareness Campaigns within LCH	Team	March 19						
Further develop FFP3 Mask Fit Testing programme for LCH in response to potential Pandemic Flu risks. To ensure database is effectively in place to record LCH staff in line with HSE guidance.	DH	Dec 18						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Work with LCH colleagues to develop a sepsis forum and look at develop engagement at all levels within the organisation	LG	March 19						
Service Improvement								
Facilitate IPC Team Building Event	Team	March 19						
Work with CCG partners to review IP performance and improve the wider community CDI review process	LC/DH LTHT/LYPFT	Nov 17						
Work with CCG partners and other stakeholders to review the MRSA decolonisation protocols	LG	September 18						

PEYS = Predicted end of year target
Joanne Reynard and IPC Team
IPC Team
20th June 18

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (60)

Meeting: Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title: Safeguarding – Annual Report 2017-18	**For approval**	✓
Responsible director: Executive Director of Nursing **Report author:** Head of Safeguarding (lead author)	**For assurance**	
Previously considered by: • Quality Committee • Safeguarding Committee • Patient Safety Experience and Governance Group	**For information**	

PURPOSE OF THE REPORT

Review of the key achievements and challenges addressed by the Safeguarding Team on behalf of LCH throughout 2017-18.

MAIN ISSUES FOR CONSIDERATION

The report reflects close partnership working with our front line services and across the multi-agency partnership, particularly with our colleagues in commissioning, Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Leeds.

Safeguarding is a complex and dynamic environment and this is reflected in the sub-sections of the report, with contributions from each of the key areas the Safeguarding team is accountable for. Significant achievements in 2017-18 and ambitions for 2018-19 are identified at the head of each section.

Most notable for the future are:

- Commissioning intentions in relation the paediatric Sexual Assault Referral Centre (SARC) and the impact this will have on Community Paediatric services
- The embedding of the new strategic partnership with the replacement of the LSCB with the LSCP and impending publication of guidance on Child Death Overview Panels strategic arrangements
- The continuing internal review of safeguarding levels of training and competence to bring ESR in line with Intercollegiate Guidance

RECOMMENDATIONS

The Board is recommended to: Approve the report.

Safeguarding
Annual Report 2017-18

Authors:
Safeguarding Adults – Lynne Chambers
Prevent – Sharon Thomas
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia – Kulvant Sandhu
Safeguarding Children – Tracy Taylor and Wendy Brown
Specialist Child Protection Medical Services – Dr Alison Share
Sudden Unexpected Death in Infancy and Childhood (SUDIC) – Shelagh Davenport
Children Looked After and Care Leavers – Deborah Reilly

Contents Page:

Introduction and Executive Summary

Leeds Community Healthcare NHS Trust (LCH) places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2018, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this suite of reports is to provide the Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2017 – 2018 and outline those areas requiring further development.

Team Structure

The Safeguarding Team based at Armley Moor Health Centre provides both corporate and operational functions and sits within the Quality and Professional Development directorate providing safeguarding advice, guidance, support, supervision and training for all LCH employees.

The team consists of Named and Designated Professionals, Lead Professionals, Safeguarding Advisors and Specialist Practitioners with responsibility for:

- Safeguarding Adults
- Mental Capacity, Deprivation of Liberty Safeguards and Dementia
- Prevent
- Safeguarding Children
- Specialist Child Protection Medical Services
- Sudden Unexpected Death in Infancy and Childhood
- Children Looked After and Care Leavers

Functions

Staff can contact the safeguarding team Monday to Friday for specific advice in relation to new and ongoing cases where a safeguarding concern is under consideration. The team also undertakes Health Needs Assessments (HNAs) and health interventions for Children Looked After (CLA) and Care Leavers for Leeds children and those children placed in Leeds from other areas across the country.

Partnership Working

The Team works closely with the designated and named professionals within community paediatrics, the Clinical Commissioning Groups (CCGs) and across other health care providers as well as colleagues in Social Care to ensure our work force have the skills and support they need to safeguard all those in our care.

Governance Arrangements

The Safeguarding Team sit within the Quality and Professional Development unit under the Executive Director of Nursing (the board member with responsibility for safeguarding). The Safeguarding Committee, a subcommittee of the Quality Committee meets bi-monthly to both drive and oversee the safeguarding agenda

The Safeguarding Nurses meet with operational service lead practitioners on a bi-monthly basis (safeguarding operational groups) to develop and implement objectives identified in the safeguarding work plan. We have two safeguarding operational groups:

- Safeguarding Adults Champions, and the
- Safeguarding Children Operational Group

Safeguarding reports go on a quarterly basis to the Quality Committee via the LCH Safeguarding Committee. In addition outcomes from these groups are shared with Leeds Clinical Commissioning Group (CCG) through the Children's and Adults Advisory groups and with Leeds Safeguarding Children Partnership (LSCP) and Leeds Safeguarding Adults Board (LSAB) through the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is regularly reviewed and updated through the Safeguarding Committee.

The Safeguarding Team is continually learning, improving and disseminating best practice. Through our contributions to LSCP practice audits, the continuous cycle of preparation for Ofsted Joint Targeted Area Inspection (JTAI), as well as through collaboration with agencies in the Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Leeds, we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the best possible care.

Key achievements in 2017 – 18 are set out at the head of each report

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Safeguarding Adults

Key achievements 2017-18:

- **Strong partnership working established with Safer Leeds delivering Domestic Violence and Abuse awareness raising and training**
- **LCH workforce is equipped with the necessary skills and knowledge to ensure safeguarding arrangements are effective**
- **Investigative documentation has been streamlined to be more effective and create less duplication for staff, adults at risk and their families**
- **Relationship established with West Yorkshire Police Public Protection Unit leading to better risk assessment and safety planning for staff and patients**

Key ambition 2018-19:

- **Develop and implement a training plan to expand the use of Routine Enquiry across LCH services**
- **Raise awareness of self-neglect, develop a self-neglect training package and deliver to all staff**
- **Embed the use of SystmOne safeguarding templates**

Leeds Community Healthcare aims to work together with other multi-agency professionals to prevent and stop all forms of abuse or neglect happening wherever possible and to keep vulnerable adults safe whilst also meeting statutory obligations and our duty of care.

Leeds Community Healthcare Safeguarding Adults team focus on creating an environment where abuse is not tolerated; we work with staff to ensure our patients can live free from abuse within their own homes. To do this we follow 6 recognised safeguarding principles set out in the Care Act (2014):

Empowerment: people being supported and encouraged to make their own decisions and give informed consent
Prevention: it is better to take action before harm occurs
Proportionality: the least intrusive response appropriate to the risk presented
Protection: support and representation for those in greatest need
Partnership: local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse
Accountability: and transparency in safeguarding practice

Making Safeguarding Personal (MSP) is essential in ensuring that any support offered or provided is tailored around the needs identified by the adult, ensuring their wishes are central to any process, and that they stay in control, as much as possible, of any decision made affecting them. Personalised support is empowering and crucial for everyone but some people will need more support than others to make choices and manage risks, therefore risks should be made clear by using effective communication skills and good mental capacity assessments to ensure understanding. MSP is embedded into LCH adult safeguarding training and reinforced with the additions to our serious incident/root cause analysis documentation.
MSP is an approach to safeguarding work which aims to move away from safeguarding being process driven and instead, to place the person at risk at the centre of the process and work with them to achieve the outcomes they want.

LCH has a robust mandatory eLearning package which is accessible to all staff members. Further face to face training packages available this year include routine enquiry into domestic violence and self – neglect. Additional support is available on the intranet, one minute guides, flow charts, Standard Operating Procedures and voice over PowerPoint presentations. Staff are also supported during coroner's court hearings, police statements, safeguarding supervision, 1-1 meetings and telephone support.

LCH is introducing safeguarding templates for use within our electronic patient records (EPR) which mirrors the process for safeguarding children within our organisation therefore increasing consistency throughout the patient journey; this includes working with services not using SystmOne to understand the extent to which this approach can be replicated in other EPR systems

The Safeguarding Team continues to work with safeguarding adult champions; they attend bi-monthly meetings where we are able to share learning across the adult business and specialist units and discuss and address safeguarding themes. Over the next year the champions will become more involved in plans to further engage frontline staff in the safeguarding process.

The safeguarding team aim to work with partners to address a number of training requirements. Self-neglect in the context of safeguarding will be one such area in order to ensure that the workforce is competent in addressing and supporting adults who self-neglect. The team will explore and inform the wider workforce of the legal frameworks that can be accessed, the links to safeguarding adults, and will draw upon the learning from Safeguarding Adult Reviews locally and nationally.

Over the past year the safeguarding team have participated in several Domestic Homicide Reviews (DHR) and one thematic Safeguarding Adult Reviews (SAR). A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances surrounding the death of a person over the age of 16. The Safeguarding Adult Review (SAR) process intends to establish whether there are any lessons to be learnt from the circumstances of a particular case, to look at the way agencies worked together to safeguard the adult at risk. Both processes allow for analysis of the findings from investigations carried out by individual agencies involved in the case, in order to make recommendations for improving future practice where this is necessary. Recent

As a new staff member to the trust, I have found the safeguarding team an invaluable resource to support me within my role to ensure I am able to support the team with relevant clinical concerns. Since starting in post in March, the team have supported me in the identification of two formal safeguarding concerns and has been integral in how we investigate and learn from the incidents we found. The safeguarding team has also supported me with domestic violence training. They are available for informal support as well as formal support and are very accessible for this. Everyone I speak to within the Neighbourhood Team are aware where the team are and how to contact them if required.

Clinical Pathway Lead

We recently had discussions regarding concerns raised in a care home specifically around pressure area care. Following a discussion with LCH safeguarding team and due to integrated working we were able to sit down together as a team in a timely manner to talk about further concerns raised from a root cause analysis that day. We were able together to create the referral, place it on the system and have our strategy discussion there and then and plan immediate actions required.

Safeguarding and Risk Manager LCC

reviews highlighted the need for more knowledge and training around routine enquiry and self-neglect and the safeguarding team has responded by working with partners to develop bespoke training packages to address this.

Case Study:
LCH was also able to use the learning from these reviews to address issues with a patient who had full mental capacity but was self-neglecting by declining services when he had a significant pressure sore and was at high risk of developing septicaemia. An urgent multi-agency professionals meeting was called and held on the same day. Information regarding this serious situation was shared with relevant professionals and an urgent plan put in place with the goal of ensuring the patient fully understood the inherent risks in declining hospital care. One attendee at the meeting was the plastic surgeon who drew upon his good relationship with the patient and was to be able to expedite an admission which the patient accepted. This outcome allowed the patient the best possible chance of recovery.

Learning from reviews is disseminated to front line clinical staff by electronic communication to be read and deliberated at team meetings, discussion at champions meetings and face to face discussion during safeguarding briefings. In addition to this, learning was shared with the senior management team at our safeguarding committee meeting in December last year.

The next year will be dedicated to continuing to support staff and the SMT, and raise staff knowledge and awareness of adult safeguarding and whilst focusing on all aspects we will be specifically working on self-neglect and routine enquiry training.

Prevent

Key achievements 2017-18: • **Compliance with NHS England target for Prevent training coverage** • **Development of an e-learning package with health partners**
Key ambition 2018-19: • **Develop and implement a training plan to maintain high levels uptake** • **Identify and develop the skills of colleagues within the Safeguarding Team to ensure continuity of service delivery**

Prevent is a strand of the Government's counter terrorism strategy known as CONTEST. The Prevent strategy aims to address radicalisation and safeguard those who hold radical views from being drawn into criminal activity. Prevent addresses all forms of extremism but prioritises these according to the terrorist threat they pose to our national security. Prevent is delivered in multi-agency partnership by a wide range of statutory and third sector organisations.

Safeguarding vulnerable people who may be at risk of being drawn into criminal extremism is an essential part of the Prevent Strategy. Nationally there is a requirement for Prevent local action plans to be in place, reflecting the support available to vulnerable individuals; the necessity for a robust training package to ensure LCH staff are appropriately aware of and supported to fulfil their Prevent duties stems from this national mandate.

Healthcare practitioners have a key role to play in the multi-agency planning and delivery of services to those at risk; ensuring access to a wide range of support from mainstream services, on through to specialist mentoring or faith guidance and wider diversionary activities.

Since Nov 2017 LCH staff have worked hard with the Safeguarding Team to achieve compliance with the NHS England training target of 85% by march 2018.

A joined up approach, motivation and commitment to drive standards forward have resulted in LCH not only achieving this target but exceeding it by a considerable margin.

Dec 2017-76.2%

Jan 2018-82.7%

Feb 2018-87.9%

March 2018-97.6%

These figures highlight the effectiveness of the current e-learning package which was developed using a grant from NHS England. The e-learning package is locally relevant and has been a useful means of gaining engagement from staff around this sensitive subject.

Staff feedback has been positive; comments describe the package as: *"clear and interesting"* and *"concise and easy to use"*.

The Safeguarding Team continue to offer bespoke face to face training to teams if this is more conducive for them, however, the training package has been a great success in raising awareness.

It is noteworthy that LCH exceeded this challenging target at a time of significant pressure across the healthcare system; this is a testimony to staff resilience and commitment.

In order to maintain compliance, measures are in place to monitor when staff have completed the training and when they are due for renewal (3 yearly).

NHS England has adopted the action planning template used by LCH as an exemplar for providers across the region to support them their efforts to replicate our success.

With continued support and commitment across LCH we will maintain our compliance level and be a flagship to other healthcare providers across the region.

2018-19 will also see the strengthening of Prevent support available to practitioners and partner agencies through the development of knowledge and skills within the Safeguarding Team in keeping with the Prevent local action plan which requires each partner agency to identify, as a minimum, a lead practitioner and deputy to ensure continuity of service delivery.

Mental Capacity Assessment (MCA), DoLS and Dementia

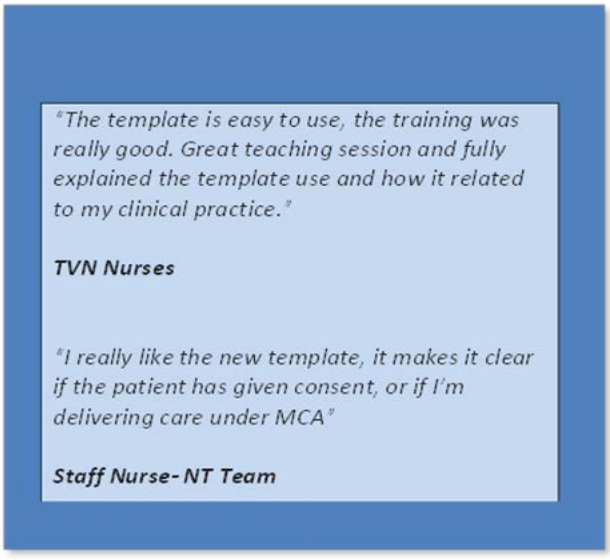
Key achievements 2017-18: • Rollout of new SystmOne Valid Consent to Care and Treatment template (NHS England would like it shared) • Development of Dementia training package now being delivered to staff as part of statutory and mandatory training • Development of guidelines to help manage clinically related challenging behaviours
Key ambition 2018-19: • Increasing uptake of Dementia statutory and mandatory training across the trust • Development of consent/MCA and young people guidance • Ensuring we are capturing and adhering to patient's wishes in the form of Advanced Decisions, Lasting Powers of Attorney and integrating the new Respect document

The purpose of Mental Capacity Act 2005 (MCA 2005) is "to empower people to make decisions for themselves whenever possible, and protect people who lack capacity by providing a flexible framework that places individuals at the very heart of the decision making process".

LCH has a statutory requirement to ensure staff comply with the MCA 2005 when working with those who lack capacity, the role of the MCA lead is to help embed this into everyday clinical practice. Working in the field of mental capacity highlights the importance of understanding and ability to apply the law on consent to care and treatment, as the starting point for ensuring staff act lawfully when providing care and treatment. A person must have the capacity to be able to consent to their care and treatment. This principle reflects the rights of our patients to determine what happens to their own bodies, and is a fundamental part of good practice (Department of Health, 2009, *Guide to consent for examination or treatment*, 2nd edition). The MCA 2005 outlines the actions that must be taken when providing care and treatment to a person who lacks the capacity to give valid consent.

New Initiatives

In January 2018 the Valid Consent to Care and Treatment template was introduced on SystmOne to enable practitioners to document when they have obtained valid consent, capacity assessments, and how the care and treatment they are providing is in their patient's best interests.



This new template has improved the documentation of consent and capacity assessments which enables LCH to evidence how we are implementing the above legislations. Feedback from clinicians is that this template not only streamlines the recording of consent and capacity assessments, it is also encouraging more person-centred care, placing our patients at the heart of decisions about their care and treatment, and truly respecting their fundamental human rights.

Face to face training has been provided by the Specialist Safeguarding Adults/MCA Nurse across the trust to all teams within the Adult Business Unit and bespoke sessions for those teams within the Specialist Business Unit who use SystmOne, to support practitioners to use the new template to document consent and capacity assessments. NHS England have expressed interest in the new developed template and would like LCH to share this with local partner NHS agencies and to have it presented at their next regional forum in the Autumn.

Audits

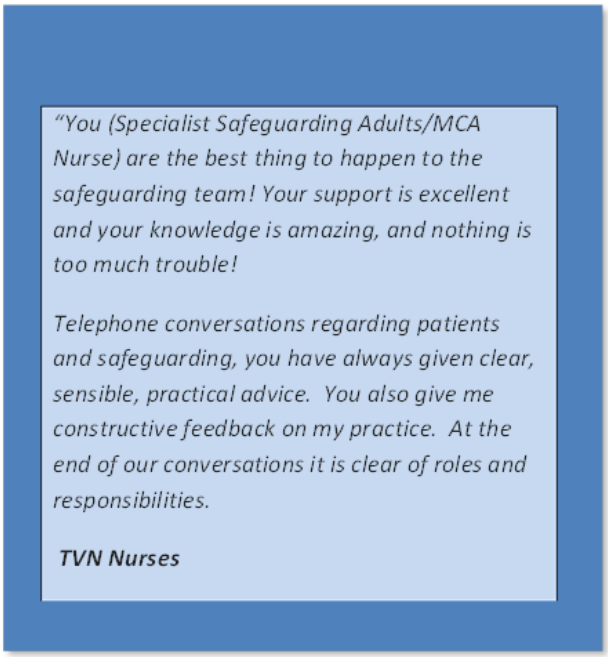
Annual audits continue to be conducted to measure MCA 2005 compliance across the trust. With the introduction of the Valid Consent to Care and Treatment template, this will be incorporated into LCH's annual documentation audit to capture compliance around consent. Work has been undertaken with the trust's data analysts to be able to capture the use of this new template, as well as data on how many patients within LCH that lack capacity that we are providing care to, to help plan future initiatives for improving care delivery and patient experience.

MCA Champions

LCH continues to have a well-established MCA champions forum which meets bi-monthly. This group is made up of clinicians within the various teams across the trust, with enhanced knowledge and practice of the MCA 2005 and able to support their teams locally with implementation of the legislation. The Specialist Safeguarding Adults/MCA Nurse has taken over the facilitation of this forum since November 2017 and continues to provide that vital MCA clinical supervision as well as relevant case law update and learning shared from relevant Serious Adult Reviews (SARs) where mental capacity has been a feature.

Specialist Support

Specialist Support continues to be provided across the trust to various teams within the Adult, Specialist and Children's business units. The specialist support and legal knowledge of the MCA 2005 has helped to ensure clinical decisions and care delivered comply with the MCA 2005, is lawful practice, person-centred, and respecting of the patient's human rights as much as possible. More advice and support has been sought from teams within the Children's business unit who are working with young people over the age of 16 who lack capacity, bringing them into the scope of the MCA 2005 legislation. The support given has been in the form of telephone advice, 1:1 and group supervision, case discussion and analysis, team bespoke training, practical support of accompanying clinicians on patient visits, and facilitating best interests meetings with multi-agency input.



Multi-agency work

Since the retirement of the Named Nurse for MCA, DoLS and Dementia, the Specialist Safeguarding Adults/MCA Nurse has taken a lead on MCA and Dementia until the position is more substantively filled. This has included the strategic role of being a member of the Mental Capacity Act- Local Implementation Network (MCA-LIN) which is

a sub-group of the Leeds Adult Safeguarding Board (LSAB). One initiative which the Specialist Safeguarding Adults/MCA Nurse is part of, is the organisation of learning conferences for front line practitioners on aspects of the MCA 2005 such as best practice for capacity assessments and Advance Decisions, to help improve knowledge, skills and confidence on the application of the MCA 2005, the first conference is due to be held in Autumn 2018.

Other multi-agency collaboration continues across with LTHT, LYPFT, CCG and LCC especially for patients with complex presenting needs and who are known to the other partner agencies to ensure effective communication, information sharing, and multi-agency approach is taken when making best interests decisions for those who lack capacity. The Specialist Safeguarding Adults/MCA Nurse is also working with safeguarding colleagues to plan a local self-neglect conference, to ensure the MCA 2005, patient's human rights, and capacity assessments are incorporated when working with high risk, self-neglecting patients. This conference is also due to be held in autumn 2018.

A legislative review of the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) is underway; the Law Commission published its final report and draft Bill in March 2017 outlining recommendations to bring in the Liberty Protection Safeguards which will also apply to those aged 16 years and older, and shifting responsibility for authorising some deprivations to the relevant NHS bodies. When the Government passes this bill and new legislation comes into effect, it is anticipated some targeted support and guidance for staff within the trust will be required to advise on how to implement any necessary changes to current practice, to comply with the new legislation.

"Course was fantastic for my learning, relevant and important, I wish this was made available years ago!"

"Very useful watching actual real life cases of those living with dementia"

"I have learnt so much from this day and feel more positive about working with those living with dementia who may have challenging behaviours"

"I have a much better understanding of the difficulties those with dementia go through on a daily basis. I have a better understanding of how to manage some behaviours of my patients with dementia which I used to struggle with"

"Reminds me to listen and respect the individual needs and treat the person not the dementia. Has helped learn how to diffuse some conflicts to prevent aggression in some situations"

"Good re-cap on how to provide person-centred care to those living with dementia. Excellent film clips that have helped me reflect and be more mindful before I visit patients. What I have learnt today will help me communicate more effectively with both patients and carers"

Attendees of Dementia Level 2 Training

Dementia

For staff working primarily with adults, dementia training has now become part of the LCH's statutory and mandatory training from April 2018. The requirement is for staff in patient facing roles to complete this training once every 3 years. There are two levels, level 1 for those in patient facing roles where they may have contact with people living with dementia and level 2 which is for those clinicians who have regular contact with people living with dementia. An appropriate level 1 package has been sought and is now available for staff to access and undertake this learning. This involves watching a short video and some reflective learning.

We have developed the level 2 training package which is 1 day face-to-face with the content being aligned to the Department of Health- Dementia Core Skills Education and Training Framework. Since the rollout we have received very positive feedback from staff who have attended, not only enhancing their skills and knowledge within their professional practice, but many who have personal experience of

caring for a loved one living with dementia, have also valued the training.

Also featured in the level 2 dementia training are newly developed LCH guidelines titled ‘Managing Clinically Related Challenging Behaviours’ after it was identified the number of verbal and physical incidents on staff being on average 60%, were by those categorised as a ‘confused patient’ identifying the need to provide staff with the knowledge and skills to not only manage but reduce these incidents of challenging behaviours, and be able to provide effective care safely.

Since retirement of the Named Nurse for MCA, DoLS and Dementia in February 2018, the Specialist Safeguarding Adults/MCA Nurse has taken a lead for Dementia within the trust and continues to have strategic input across the key city and regional forums such as the city’s Dementia Board, specialist Dementia & End of Life (EoL) group, and the Yorkshire and Humber Clinical Networks forum for Dementia, to ensure best practice and evidence-based initiatives are implemented within LCH to improve care delivery within the community setting for those living with dementia, to enable them to live well and remain within their own home environment for as long as possible.

Future Ambitions

After the roll out of the Valid Consent template and initial focus for adult patients, other teams have requested support and training when working with young people and children, to ensure they are complying with relevant available legislations on consent, and when appropriate using the MCA 2005 for those aged 16 years and over who lack capacity to give consent. A training packing has been developed in partnership with the Specialist Safeguarding Adults/MCA Nurse and the Named Nurses for Safeguarding Children, and delivered to staff in the young person’s secure settings which was well received. It is hoped this partnership work can continue to support those services seeing young people, to enhance their knowledge of the relevant legislations for consent and young people, and how to appropriately apply them and make decisions when delivering care and treatment to children and young people.

Other areas of work next year will focus on is the consistent recording of patients’ wishes and rights in the form of advance care plans, Lasting Power of Attorney for health and welfare, as well as ensuring the new Respect document which will be piloted and rolled out city-wide, is successfully incorporated and taken into consideration when LCH staff are delivering care and treatment to their patients.

Safeguarding Children

Key achievements: 2017-18
• Exploration of tripartite meetings to ensure high quality standards of Child Safeguarding supervision. • In conjunction with Front Line Services and the Workforce Team, ensure staff are aware the level of safeguarding training and competence they are required to achieve, maintain and evidence in line with Intercollegiate Guidance (2014)
Key ambition 2018-19:
• Identification of a service for pilot implementation of tripartite supervision. • Implementation of any changes highlighted within the updated "Working together guidance" • In line with "Wood Review" recommendations support the implementation of any changes to the structure and performance of the Leeds Safeguarding Children Partnership (LSCP) and its impact on LCH services.

The LCH Safeguarding Children Team is a highly respected partner in practice in Leeds and committed to ensuring children, families and LCH staff receive high standards of care and support at times of significant vulnerability.

Responsiveness to and organisational leadership on emerging safeguarding issues, whether identified through Serious Case Reviews (SCRs), DHRs, case work or national guidance is at the heart Safeguarding Children team practice. Over the past year the team has been engaged in leading, developing and supporting practice across LCH and within the multi-agency partnership; examples over the past year include:

- **Leeds Sexual Health**

The Safeguarding Team has worked closely with Leeds Sexual Health Service to develop and support the implementation of a safeguarding template similar to that used in SystmOne to ensure appropriate sharing of safeguarding information and awareness of risk throughout the service. This ensures vulnerabilities of children and young people are shared and appropriate support plans established.

- **Early Help Arrangements**

The Safeguarding Team have formed part of a multi-agency group to review and update the arrangements for Early Help across the city. This has resulted in the development of a new Early Help package for staff across agencies including the development of formal qualification in relation to early help.

Early Help combines staff across agencies supported by the Safeguarding Children team in the development of processes and procedures to encourage collaborative working which meets the core organisation objectives, such as training and supervision, to ensure compliance for staff as per intercollegiate document.

- **Multi-agency working**

The Safeguarding Children Team has continued their commitment to multi agency working and supporting our partner agencies including LSCP. This has comprised of contribution to and leading multi-agency audits. Safeguarding Named Nurses represent LCH at all LSCP sub-groups; contributing to pan-Leeds and West Yorkshire Consortium Policy and Procedures review and development, e.g. updating Children Travelling abroad, Bruising protocol, reviewing of FGM process and developing a new flow chart to support practitioners in fulfilling their safeguarding duties. The Safeguarding Children team also chair several Task and Finish groups on behalf of LSCP and have recently

contributed to the planning and implementation of training and development across the city.

- **Vulnerabilities and Risk**

The Safeguarding Children Team is continuing to review and develop mechanisms for recording and managing risk across LCH services in line with multi-agency risk management processes. This is to ensure appropriate information sharing and the planning of personalised care based on individual needs. The Team is working with multi-agency partners to facilitate sharing information across all information systems e.g. LSHS, Systmone, Carenotes and Leeds Care Record.

- **Front Door Safeguarding Hub**

Our commitment to support the FDSH continues to ensure the 0-19 service is fully engaged in the development of safeguarding practice with our partners in West Yorkshire Police and the Children's Social Work Service, offering health support, advice and guidance to colleagues and frontline practitioners at the earliest opportunity. The LCH Safeguarding team provide guidance and support and supervision for practitioners fulfilling this role.

- **Care Quality Commission**

The Safeguarding Children Named Nurses, along with the rest of the Safeguarding team contribute to implementing the recommendations and changes from the most recent CQC inspection; specifically with regard to ensuring all staff understand their training and competence requirements in relation to "Safeguarding children and young people: roles and competences for health care staff" (2014). This important and complex piece of work has carried over in our Work Plan for 2018-19.

- **In-patient Units**

We have supported our in-patient units to address identified areas of learning, practice development and escalation of safeguarding concerns with partner agencies where needed. We have worked closely with the front line teams and their managers to improve knowledge and awareness of multi-agency processes and procedures.

- **Training**

The Safeguarding Children team, along with colleagues in the Children's Business Unit, continue to offer support to the LSCP training and development programme. LCH currently provides a number of safeguarding trainers who facilitate sessions for multi-agency professional groups. The Safeguarding Children team facilitate "Lunch and Learn" sessions on key and emerging topics to provide up to date evidenced based information to LCH practitioners across all services and job roles.

- **Supervision**

The Safeguarding Children team have developed and audit plan for Safeguarding supervision standards and an electronic safeguarding supervision template within SystmOne; work will continue with services not using SystmOne to explore how to replicate the supervision template within other Electronic Patient Record systems.

- **Electronic Patient Record**

The Safeguarding children team have previously developed five safeguarding e-templates which have been embedded for use throughout LCH children services which utilise SystmOne. As a team we continue to consider how best to embed safeguarding templates across recording systems with the Children's Business unit who are not reliant on Systmone. We continue to support the development and implementation of these templates across the Adult and Specialist business units to ensure a consistent approach to safeguarding practice across the organisation.

- **Serious Case Review and Domestic Homicide Review**

The safeguarding Children team continue to conduct investigations ranging from scoping incidents to Agency Report writing. As part of this process we offer support to all staff

affected by these cases. We identify and support the implementation of learning within our agency and within the multi-agency arena via learning events. The Safeguarding team (Adults and Children) are developing processes to support collaborative working in response to SCR/SAR and DHR's where the victims and perpetrators cross age groups.

The Safeguarding team are contributing to the implementation of the "Appreciative Inquiry" approach being introduced across the city as a new way of reviewing cases of significance; ensuring learning is identified in a positive, restorative and constructive way.

Enquires and Support

The Safeguarding children team continue to provide guidance and support to practitioners throughout the trust from Children's and Adult's business unit in relation to Children and families where safeguarding concerns exist, we have:

- provided telephone support,
- face to face case reviews
- assistance with legal statements
- support with attendance at court
- escalated concerns in keeping with city-wide Concerns Resolution Process; and
- contributed to the "Re-think Formulation" process and Restorative practice.

Audits

Audits have taken place during 2017-18 to support best practice by front line practitioners regarding management of cases and multi-agency processes. These audits relate to:

- quality and compliance with provision of multi-agency reports – LCH has continued to be highly responsive to the need for timely, high quality reports,
- quality of contacts with front door services – where it is evident that that challenges remain with ensuring we are able to easily identify LCH practice within the broader "health" arena; and
- attendance rates at Initial Child Protection Conferences and Review Child Protection Conferences which continue in line with commissioning requirements – this places substantial demand on Health Visiting and School Nursing services, but audit results confirm attendance has remained a priority for 0-19 service practitioners.

Development and review of quality standards, policies and procedures, horizon scanning and analytical reviews of practice in response to significant incidents offer the framework in which the Safeguarding Children team ensure front line practitioners are equipped to deliver high standards of safeguarding practice and maintain the strong reputation of LCH as a credible and reliable partner in practice.

Specialist Child Protection Medical Services (SCPMS)

Key achievements 2017 – 18:

- Successful move of Community Paediatric services from SJUH to St George's Centre
- Better engagement in Strategy meetings and Case conference for children suspected of abuse or neglect.
- Continued improvement in the working relationship with SARC including communication and handover of patients.
- Five senior doctors have completed the FMERSA training.
- Involvement with the Risk and Vulnerability Subgroup for LSCP for children with Female Genital Mutilation.
- Photo-documentation training from LTHT and provision of a SOP for the use of the cameras.

Key ambitions 2018 – 19:

- To continue to provide non-forensic CSA services for Leeds children with careful negotiation with Commissioners and Mountain Healthcare LTD.(MHL)
- To develop clinical pathways for children with STIs including ano-genital warts and other medical genital conditions with MHL.
- Engagement in regional peer review.
- To be part of the new MASOG meetings that will be set up to look at the operational workings for community paediatrics, police and social care.
- Continue to learn from our patient's experiences giving particular attention to the voice of the child by improving collection of feedback directly from children in a child friendly way.
- To develop a robust pathway for the diagnosis, investigations and treatment of Ano-genital warts and STI.
- 3 clinicians to attend national training for Named and Designated doctors recognised by the RCPCH.
- Improve links with the Safeguarding team and LCH Safeguarding named nurses.
- To upgrade the cameras to modern fully working models.

Who are we?	What are we proud of?
10 community paediatricians, 2 band 5 nurses, 1 play therapist, 2.8 admin staff and 1 clinical services manager Part of ICAN (integrated children with additional needs) services; commissioned by CCG	Providing a daily *consultant led* clinic to see children (0-18)referred for all forms of child abuse *Trained and skilled administrative staff* to take referrals from 0900-1700 on weekdays *Compassionate, highly skilled nursing staff* to chaperone and support families & staff in clinic Clinical work underpinned by *peer review and supervision* to challenge practice & offer support *Dedicated team*, who show great strength and resilience to rise to the many changes this year Continue to provide *medical training* in child protection *Information sharing* and working together to safeguard children *Monthly governance programme* for continued professional development and links with the Regional peer review programme.

What did we do in 2017-18?

- Saw 354 children between April 2017 – March 2018
- 51% (181) of children were seen for physical abuse, 28% (100) of children required sexual abuse examination & 20% (71)of children were siblings of index children .
- Of the sibling assessments 81% were seen for physical abuse and 18% seen for sexual abuse.

- We have not been able to collect feedback from children and families on our service. We are unable to use standard Friends and Family Test and use a specially designed feedback form. No responses have been returned.

- We have designed and printed leaflets for children and young people to explain the nature of our service. These have been well received by parents, Social Care and other agencies.

- We aim to provide child protection medical reports to social care in 4 working days. We need to improve in this area as on an average only 58% of the reports are returned in a timely manner. This is an improvement since the previous year and 60% were sent within 7 days. Much of this is related to staffing issues and many doctors are not based at SGC. We have addressed some issues by switching to EPR.

  We held 49 peer review/colposcopy meetings in the last year and have started to attend 2 regional peer review sessions.

Sudden Unexpected Death in Infancy and Childhood (SUDIC)

(Abridged from the report produced for the Local Safeguarding Children Partnership)

Key achievements 2017-18:

- SUDIC process completed for 21 children (12 - 2017-18 deaths, 9 - 2016-17 deaths)
- Access to psychological support for the SUDIC Professional Lead
- Peer review of SUDIC Reports

Key ambition 2018-19:

- To ensure access to supervision for all team members (administrative and clinical)
- To demonstrate increased timeliness in processes within LCH SUDIC Team
- In conjunction with SUDIC Strategic Reference Group partners organise a West Yorkshire wide SUDIC conference
- Light bite sessions by Prof Lead

Leeds Community Healthcare NHS Trust (LCH) employs the team which is responsible for the implementation and co-ordination of the SUDIC process in Leeds, following confirmation of the child's death. This report aims to provide a detailed account of the activity, in relation to the SUDIC statutory guidance (Working Together 2015, Chapter 5), of the Leeds Community Healthcare NHS Trust (LCH) SUDIC Rapid Response Team for the period April 2017 - March 2018. The Leeds SUDIC Rapid Response is facilitated by a multi-agency partnership under the aegis of Leeds Local Safeguarding Children Panel (LSCP).

The LCH SUDIC team comprises; 0.5 WTE SUDIC Consultant (currently covered by 2 clinicians), 1.0 WTE SUDIC Secretarial Support and 0.5 WTE SUDIC Professional Lead (Nursing). The team are also supported by the Named Nurses for Safeguarding Children when required. The team provides reports on the circumstances of the child's death to HM Coroner and the Leeds LSCP Child Death Overview Panel (CDOP). SUDIC activity is reported into the LCH Children's Mortality Governance Group and LCH Performance Monitoring who further report to the NHS Leeds Clinical Commissioner (CCG).

SUDIC Activity

All Leeds SUDIC deaths since April 2016 have been notified on the LCH Incident Management System - Datix®. These are also reported into LCH Children's Mortality Governance Group and further reported to LCH Mortality Review Group where they are reviewed from an organisational perspective in order to identify opportunities for learning.

During the period April 2017 to the end of March 2018 there were 25 childhood deaths which met the SUDIC criteria. This is 8 more deaths than for the same period 2017-2018. The SUDIC process has been finalised for 12 of these children and 4 of these have also been reviewed by the CDOP.

During 2017-18 the SUDIC process was also finalised in the 9 cases outstanding from 2016-17. 7 of these children's deaths have been reviewed by CDOP at the time of this report.

SUDIC Home Visits
Home Visits were made for 13 of the 25 cases.

Visits were carried out by the LCH SUDIC Team to the 5 cases where unsafe sleeping was identified as a factor. These were carried out in close partnership with relevant multi-agency partners where appropriate. In the 5 instances where unsafe sleeping had been identified; in 3 instances visits were performed within 24 hours of the child's death, within 48 hours in 1 and within 72 hours in the remaining instance. When a child dies at the weekend the time frame for the visit is usually beyond 24 hours as the service operates Monday to Friday.

For the remaining 8 Home Visits, 2 were carried out within 24 hours, 2 within 48 hours and the remaining 4 visits took place over 72 hours after the child's death.

For the 12 cases where home visits did not take place by the LCH SUDIC Team the reason was that it was not appropriate in relation to the mode of the child's death and that partners in the SUDIC process were actively investigating at the time. This includes the National Enquiry into the 2017 Manchester Bombing.

Initial Meetings
This meeting aims to; 'seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learned about how best to safeguard and promote children's welfare in the future' (WT 2015).

Initial multi-agency meetings were held in a sit down format for 14 of the 25 cases occurring 2017-18. In the 11 cases where meetings were not held, it was considered that sufficient information had been gathered by telephone liaison and access to the child's records to enable a 28 Day Report to be produced for HM Coroner and to assess for ongoing support to the family.

28 Day Report to HM Coroner
Reports to HM Coroner have been provided for 20 of the deceased children. A letter was sent regarding the child who died in the bombing explaining the reason for no report. A further 4 reports are in progress at the time of this report.

15 reports provided to the coroner 2017-18 exceeded the 28 day deadline due to either a lack of information (n=5) or the availability of the SUDIC Consultant (n=10).

Final Case Discussion Meetings

During 2017-18 Final Case Discussion Meetings were held for the 9 cases which were outstanding at the time of the 2016-17 report. A further 9 Final Case Discussion Meetings have been held during 2017-18 for children who died in this period.

Review of the 7 children's deaths (2016-17) by the CDOP panel made recommendations in 4 instances and accepted the findings and recommendations of an LTHT investigation in 1 other. (CDOP Annual Report 2017-18)

CDOP review has been completed for 4 SUDICs occurring during 2017-18. In 3 of the cases no specific recommendations were made. In 1 case the recommendation was that

relevant health professionals provide all parents with information in relation to the law, and co-sleeping with children under the age of 3 years, whilst under the influence of alcohol or drugs.

Training & Awareness Raising Activity
The multi-agency National Training at Warwick University, (Management of Unexpected Child Deaths), was undertaken by the new SUDIC Consultant in June and alongside the recently appointed Named Nurse for Safeguarding in October 2017.
This year 2 SUDIC Awareness Sessions have been facilitated with 40 clinical participants in LCH. In addition an RCPCH CPD accredited multi-agency Child Death Study Session was organised and facilitated by the SUDIC Team in February 2018 which evaluated very well.

Governance
The Leeds Child Death Overview Panel (CDOP) for older children met 7 times in the year 2017-18. The SUDIC Rapid Response Team attended all the meetings, 5 were attended by both the SUDIC Consultant and SUDIC Professional Lead. Of the 2 remaining meetings; 1 was attended by the SUDIC Consultant and 1 by the SUDIC Professional Lead. This was during a period of 0.25WTE Consultant cover.

The LCH SUDIC Rapid Response Team takes responsibility for providing reports on SUDIC cases to CDOP and ensuring that the recommendations from CDOP are fed back to the LCH Children's Mortality Governance Review Group for dissemination to relevant services.

Further details can be found in the CDOP Annual Report 2017-18 available on the LSCP website.

LCH Children's Mortality Governance Review Group met 6 times during 2017-18. The SUDIC team were represented at 4 of these. All SUDIC deaths are reported into the group along with the deaths of children actively receiving care from LCH services. The latter are reviewed by the group with the aim of ensuring that a critical appraisal of the healthcare input is carried out and where necessary further action is taken to ensure that lessons are learned. Information from the Children's Mortality Review Group is reported to the LCH Mortality Review Group who provides assurance to the LCH Trust Board.

The SUDIC Strategic Reference Group (SSRG)
This is a sub group of the LSCP which meets quarterly and is made up of representatives from the SUDIC Rapid Response agencies and is a sub-group of the Leeds LSCP. The group met three times in year 2017-18 and each was attended by the LCH SUDIC team (1 scheduled meeting was cancelled due to severe weather).

The SSRG is now chaired by one of the Children's Commissioner for the Leeds CCG. The administration of this meeting is the responsibility of the LCH SUDIC Administrator in partnership with the Chair. The multi-agency SUDIC Action Plan is monitored at the meetings.

Conclusion
Child Death Review processes have been under review nationally since 2016 (Wood Report March 2016, SUDIC Multi-agency Guidelines November 2016). The LCH SUDIC

Team is working with partner agencies in the local implementation of the recommendations of the Wood Report (2016).

The SUDIC process is organic in its day-to-day practical implementation therefore although the review of each child's death may not meet the deadlines laid down in the guidance, the compilation of the facts around the death of every child remains our paramount objective. SUDIC team members are constantly reviewing their practice and challenging themselves as well as being challenged by partners via CDOP and the SUDIC Strategic Reference Group. This is welcomed by the team who strive to continually improve the service to families at such a very sad time in their lives.

Children Looked After (CLA) and Care Leavers

Key achievements 2017-18:

- Refreshed the Thematic Analysis of the health needs of Children Looked After and Care Leavers
- Improved mapping of health needs across EHC and Looked After HNA plans

Key ambitions 2018-19:

- Maintain high standards of service delivery for 0-16 year olds while working alongside Social Care colleagues developing the Care Leaver Offer and restructuring children's residential care in Leeds
- Contribute to the expansion and revitalising of the Multi-agency Looked After Partnership (MALAP) and Corporate Parenting Board
- Work with colleagues in commissioning and within LCH to develop new approaches to the delivery of Initial Health Needs Assessments
- Work with colleagues in Social Care to ensure timely notification of children being received into Local Authority care
- Exploration of technological solutions to improving efficiency, productivity and engagement of young people in the HNA process

Our client group includes children placed with their parents under a Care Order; placed for adoption or fostering (voluntarily or under a Care Order); Unaccompanied Asylum Seeking Children (UASC), and those living in Residential Children's Homes in Leeds, including secure settings.

To meet the needs of CLA we collaborate with universal and specialist services within LCH, particularly Health Visitors, School Nurses and Community Paediatricians; with partners across the health economy; commissioners; and with the Children's Social Work Service and the Multi-Agency Looked After Partnership (MALAP).

The delivery of Children Looked After health services is crucially dependent on the commitment of practitioners across LCH children's and specialist services, all of whom recognise and respond to the specific health needs and vulnerabilities of our young people while also acknowledging and celebrating their incredible strength and resilience in coping with significantly challenging life events.

The cohort of Leeds Children Looked After has increased through 2017-18, in keeping with the national upward trend in Children Looked After numbers; only a small subset of the increasing cohort is accounted for by Unaccompanied Asylum Seeking Children most are Leeds children becoming Looked After in Leeds.

In keeping with previous years, the number entering care averaged at approximately 30 per month; greater numbers are remaining in care which is leading to the overall increase in the cohort.

The age profile, particularly of Unaccompanied Asylum Seeking Children (UASC) has led to a higher proportion of those new into care falling under the remit of the CLA Specialist team. This increase presents a challenge which has been ably met by the Children Looked After Specialist Nursing Team due to their flexibility, resilience, team work and with some compromise on the level of attendance at e.g. care reviews and Foster Panels.

After initial health needs assessment (IHNA) undertaken within the Community Paediatric Service, the addressing of ongoing health needs and assessment review has largely fallen to Health Visitors, School Nurses and the CLA Specialist Nursing Team, with some reviews also being undertaken alongside Paediatric Neuro Development, Neonatal Abstinence Syndrome or Adoption clinic reviews to avoid duplication of effort and ensure CLA are reviewed by the most appropriate health professional to assess and meet their needs including young people resident in secure settings.

Despite the agile approach taken by the Community Paediatric Service to ensuring Children entering care receive an initial assessment within 20 working days, **we fell short of the 95% quality indicator**, with 140 of 160 (87.5%) receiving their IHNA within the statutory timeframe. The current service delivery model, sickness absence and vacancies within the Community Paediatric service all contributed to this outcome. With the commissioning team and I-CAN colleagues, throughout 2018-19 we will explore new models of service delivery to address this matter with improved performance on this quality indicator acting as barometer of progress.

Efforts to reduce the number of CLA excluded from the IHNA quality indicator due to late notification from CSWS met with limited success in 2017-18.

Late notifications, i.e. those received more than 10 working days after the child came into Local Authority care, continued to be the most common reason for breaching the quality indicator. Planned changes in the reporting mechanism will lead to inclusion of late notifications in IHNA data; this will result in more children appearing in the numbers not seen within 20 working days with a view to working with partner agencies to drive improvement.

Reporting in this way will bring greater transparency and focus on performance both within LCH and Social Care.

The Special Educational Need and Disability SEND Ofsted/CQC Inspection which took place in December 2016 resulted in a recommendation that we look at ways of ensuring children with additional or complex needs are readily identifiable within the CLA population.

A flag has been added to SystmOne enabling immediate identification of CLA with an EHC plan in place.

The thematic analysis of CLA health needs to be undertaken in 2017-18 confirmed that there was information held in the HNA which was not always reflected in the EHC plan and vice versa. To address this, the two assessment tools used have been mapped against one another so that CLA and I-CAN practitioners can more readily pull out pertinent information from one another's assessments. A CLA Specialist Nurse has been identified to join the LCH SEND steering group to ensure continuous dialogue and development of practice to ensure CLA receive a high standard of care from LCH staff without the need for repletion or duplication of assessments.

Nationally the fragmentation of reciprocal arrangements for delivery of HNAs to CLA placed out of area has continued to be problematic. This continues to be mitigated for Leeds CLA by our specialist nurses travelling up an 80 mile radius to see our children placed out of area. Challenge remains with regard to those outside the 80 mile radius, requiring case by case negotiation and problem solving. In 2018-19 we will explore

technological solutions to address this and improve overall efficiency e.g. use of Skype for clinical appointments which may offer us the opportunity to engage with our client group in a manner more acceptable to them than the traditional approach while also increasing productivity and efficiency.

Safeguarding Annual Report Conclusion

2017-18 has been another busy and productive year for the Safeguarding Team in all areas of our practice; key themes emerging from this report point to the priorities for the team being:

- the setting and maintaining of quality standards;
- responding to CQC recommendations e.g. improving clarity for staff with regard to safeguarding training and competences and clearer identification of CLA with special educational needs or disabilities; and
- the essential development and maintenance of internal and multi-agency relationships and networks to ensure high quality service delivery with safeguarding of vulnerable children and adults at the core of all we do.

2018-19 will see the Safeguarding Team:

- continue to respond to the training and support needs of LCH staff;
- embed learning from the Independent Inquiry into Child Sexual Abuse (IICSA) SCRs and DHRs;
- succession plan and restructure the team to ensure we are responsive to the needs of the organisation and to the changing landscape of heath service delivery; and
- ensure LCH practice in Children Looked After and Safeguarding is of a high standard and responsive to the needs of the people of Leeds.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (61)

Meeting: Trust Board 5 October 2018	**Category of paper** *(please tick)*	
Report title: Significant risks and Board Assurance Framework (BAF) report	**For approval**	
Responsible director: Chief Executive **Report author:** Risk Manager	**For assurance**	√
Previously considered by: SMT 19 September 2018	**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 four risks scored as 'extreme' risks.

One risk has a revised (higher) score

- Risk 798 caseload management of children's dietetics

The risks on the risk register (both clinical and non-clinical risks) have been interrogated for this report. The strongest theme continues to be about capacity: sickness absence, vacancies, retention of staff in a competitive market, and not meeting demand for service (referral rates). An emerging theme is about staff safety concerns.

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 the agreed revised risk scores are shown on the BAF summary (appendix 2).

Recommendations

Trust 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 note the current assurance levels provided in the revised BAF summary

SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Introduction

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

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

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

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

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

2.0 Background

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

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

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

3.0 Summary of current risks scoring 15 or above

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

Table 1 Extreme risks (scoring over 15)

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

3.2 Full details of these four extreme risks are given in **appendix 1** (extreme risks).

4.0 New or escalated risks scoring 15+

4.1 Since the last report to the Board in August 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 August 2018 report, there have been no closed risks previously recorded at 15 or above.

6.0 Summary of risks scoring 12 (high)

6.1 High risks (scoring 12)

6.1.2 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by SMT 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). Risk 798 has recently been added to this list as an escalated risk from a score of 9 to a 12, no risks have been closed, and four risks have been de-escalated below 12 since August 2018.

Table 2 High risks (scoring 12)

ID	Description	Rating (initial)	Rating (current)	Rating (Target)
798	Caseload management of children's dietetics	16	12	2
874	Sickness levels - Neighbourhood Teams including Neighbourhood Night Nursing Service.	12	12	6
913	Increasing numbers of referrals for complex communication assessments in ICAN service risks breaching waiting time target.	15	12	3
944	Myplan self-harm risk assessment tool within CAMHS is not being utilised systematically by clinicians	16	12	3

7.0 Summary of all risks currently scoring 8 or above

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

7.2 At present, the Trust's risk register comprises of 30 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 34 risks on the previous report.

7.3 **Risks scoring 8 or above**

7.3.1 The chart below shows the number of risks by area of the business, logged on the Trust's risk management database (Datix) as at 6 September 2018.

Table 4 risks by area of the business

Directorate	Risks scored 8-12 High	Risks scored 15+ Extreme	Totals by directorate
Adult Services	6	1	7
Children's Services	10	1	11
Specialist Services	3	0	3
Operational Support Services	1	0	1
Corporate & HQ functions	6	2	8
Totals by risk severity	**26**	**4**	**30**

8.0 Current risks scoring 8 or above by theme

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

8.2 Themes within the current risk register are as follows:

- Six risks relate to the retention of existing staff
- Six risks relate to LCH processes (new ways of working, administration, IT systems, e-rostering)
- Four risks concern staff sickness levels
- Four risks are about concerns for staff safety (lone working, violence, aggression, inadequate equipment storage)
- Two risks concern staff capacity due to increased numbers of referrals, complex referrals
- Two risks concern potential cyber-attacks on LCH systems
- Two risks relate to changes in legislation and new requirements

8.3 These themes links to the following BAF strategic risks:

- BAF Risk 2.1 achieving principal internal projects
- BAF Risk 2.2 delivery of contracted activity requirement
- BAF Risk 2.3 Improving productivity, efficiency and value for money

- BAF Risk 3.1 suitable and sufficient staff capacity and capability
- BAF Risk 3.2 the scale of sickness absence
- BAF Risk 3.3 engaging and involving staff

8.4 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. During July and August 2018 SMT, Quality Committee and Business Committee have reviewed their assigned BAF strategic risks, as part of ongoing BAF review processes.

9.0 Risk profile - all risks

9.1 There are 15 open clinical risks on the Trust's risk register and 44 open non-clinical risks. The total number of risks on the risk register is currently 59. This is a decrease compared to the 65 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	0	3	1	4	0	8
3 - Moderate	2	14	18	3	0	37
2 - Minor	0	3	9	0	0	12
1 - Negligible	0	0	1	0	0	1
Total	2	21	29	7	0	59

10.0 Board Assurance Framework Summary

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

10.2 Definitions:

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

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

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

10.5 The BAF summary **(appendix 2)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board, in line with the risk assurance levels described in **appendix 3** (BAF risk assurance levels).

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

Positive movement (indicating an improved situation)

- BAF risk 1.1 (effective systems and process for assessing quality) has received reasonable assurance for progress with the clinical audit programme and for the good progress towards achieving compliance with NICE guidance.

- BAF risk 1.3 (maintain and continue to improve service quality) received reasonable assurance from the action developed after Little Woodhouse Halls Mental Health Act review and from the progress made with the Trusts QIP plan.

- BAF risk 3.1 (suitable and sufficient staff capacity and capability).The workforce quarterly report, which included a refresh of priorities provided reasonable assurance.

- BAF risk 3.2 (address the scale of sickness absence). The workforce quarterly report, which included a refresh of priorities provided reasonable assurance.

Negative movement (indicating a worsening situation)

- BAF risk 3.3 (engage with and involve staff) the WRES indicators report provided only limited assurance because of year on year deterioration.

11.0 Risk management activity

11.1 A bespoke training session scheduled for the Children's Business Unit service managers was completed in May 2018, which was well received. There has also been an increase in the number of service managers, clinical leads and operational leads attending the risk management training course organised as part of the HR programme for managers/leaders in September 2018. Both courses covered the topics of risk terminology, risk assessments, the risk appetite statement, the role of the risk register (Datix®), and the need to include risk as an agenda item at team meetings. These topics address the weaknesses identified through the January 2018 Risk Management Health Check survey. Further discussions are planned with senior managers to discuss roles, responsibilities and the integration of risk management within each business unit.

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

11.3 Readership of Risky Business fell for the Summer 2018 Edition as it was published at the same time as the NHS' 70th Birthday celebration events were taking place, and there was a lot of traffic on the Elsie site, resulting in the publication disappearing quicker than normal from the homepage.

Articles in the recently published summer 2018 edition included:

- Risk assessing workplace violence
- Clarity around RIDDOR (reporting of injuries, diseases and dangerous occurrences regulations) reporting
- Risks of administering out of date medicines
- IG message about not adding patient names to travel claims

11.4 The Risk Review Group met on 12 July 2018. The members continue to review all new risks (graded 8 and above) that have been added to the risk register, escalated and deescalated risks and risks that have recently been closed to assure data quality, to act as a moderator for risk grading, to ensure appropriate ownership of the risk and to ensure that effective management of the risk is being recorded

The Risk Review Group terms of reference were reviewed and agreed with minor changes. These will be submitted to SMT for approval.

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

13.3 The actions formulated to address the risk management comments and recommendations made by the CQC in their 2017 inspection report continue to be monitored.

14.0 Reporting schedule

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

Risk register reporting schedule

		Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Meeting type	RRG		FULL		FULL		FULL		FULL		FULL		FULL
	SMT	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY
	QC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	BC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	Board		FULL		SUMMARY		FULL		SUMMARY		FULL		SUMMARY

FULL	= in depth report
Summary	= snapshot report
	= information flow

BAF reporting schedule

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

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

15.0 Recommendations

15.1 Trust 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 note the current assurance levels provided in the revised BAF summary

Significant risks (15+)

Appendix 1

ID	Risk Owner	Director	Opened	Description	Controls in place	Adequacy of controls	Latest update	Risk level (initial)	Rating (initial)	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Review date
Lead Directorate: Finance and Resources														
Portfolio: Corporate & HQ functions														
939	Machin, Bryan	Machin, Bryan	03/05/2018	Title: New CAMHS Tier 4 building costs. The Trust has been allocated £13m of public sector capital to deliver a new CAMHS Unit for 22 beds on the St Mary's Hospital site. There is a risk that the cost of the Unit cannot be contained within the £13m risking delivery of the Unit in the required timescale and requiring the Trust to identify other sources of funding that could compromise other plans.	Project Board. Business case to Board in June 2018. LCH/LYPFT plan to fund up to £2m from existing capital resources if needed.	Adequate	The appointed P22 contractor is currently working to determine the guaranteed Maximum Price. LCH and LYPFT continue to work in partnership to secure the best possible building within the resources that can be made available (Updated 06/09/2018)	Extreme	16	Extreme	16	High	8	05/10/2018
Lead Directorate: Operations														
Portfolio: Adult Services														
872	Rowlands, Megan	Prince, Sam	23/11/2016	Title: Difficulties recruiting to and retaining staff within neighbourhood teams. There is a high turnover of staff within neighbourhood teams. There is a risk of not having enough staff capacity to meet the demands on the service, a risk of missed visits / delayed appointments impacting on patient safety, a risk of having a less experienced and reduced workforce causing additional pressures on remaining staff, which will impact on staff wellbeing, a risk of a reduced offer impacting on activity levels and finances, and on ability to release staff for skills and competency training. There is a particular risk and impact where there are issues with recruitment and retention of senior clinical staff who provide leadership as well as direct clinical care. There is a risk that negative perceptions and reputation compound the ability to recruit and retain staff.	Management reports in each service area. Oversight at weekly Ops meeting, monthly Performance Panels and weekly at SMT Establishment Control process Service specification plans in place Daily management consideration of workload. Support with prioritisation. Movement of staff between teams to offer more balanced capacity. Proactive recruitment plan in place Rolling recruitment and focused recruitment events Key clinical skills training matrix and enhanced training support in place Sourcing short term support via CLASS. longer term partnership arrangements with subcontracted suppliers in place to increase registered nursing capacity	Limited	Some Neighbourhood Teams disproportionately affected. Significant turnover in clinical leadership roles citywide however new team in place and induction underway. Sourcing short term support via CLASS continues. Subcontract in place to October 2018. Rolling recruitment and focused recruitment events for community staff nurses - successful in recruiting additional staff. improved fill rate for community staff nurses due to new starters progressing with induction and preceptorship - time delay to be fully confident and competent to deliver full range of duties. Lack of capacity continues to impact on service delivery. further skill implemented including self management advisors and therapy leads. Further skill mix option being considered including nursing associates. Ongoing action required to reduce risk rating. Resourcing review meeting with Directors of Workforce and Nursing planned 6/9/18 to review further actions to be taken in advance of winter. (Updated 23/08/2018)	Extreme	20	Extreme	16	Low	3	30/09/2018

Portfolio: Children's Services														
940	Prince, Sam	Prince, Sam	03/05/2018	Title: Risk of delays to new CAMHS Tier 4 Service Model The CAMHS Tier 4 service is currently designed to provide 8 beds at little Woodhouse hall. the service needs to plan to provide a service to 18 general and 4 PICU beds from the opening of the new building in summer 2020. The risk is that an affordable service model has not been designed and recruited to in time.	Project Board	Limited		Extreme	16	Extreme	16	Medium	4	28/09/2018

Lead Directorate: Workforce													
Portfolio: Corporate & HQ functions													
224	Hobson, Ann	Allen and Smith, Jenny and Laura	01/01/2012	Title: Prevalence of staff sickness: Due to current high levels of staff sickness absence across the Trust, there is a risk of greater reliance on agency cover and a risk of remaining staff being under pressure to manage an additional workload. The impacts are the financial cost of agency cover and an effect on staff morale and wellbeing	Regular monthly reporting by individual team to managers.Monthly discussion of absence by teams at business unit performance meetings.Monthly discussion of absence by Business unit at operational performance meetings, SMT, Business Committee and Board.Health and wellbeing team in place to support managers. Greater scrutiny within business units re compliance with return to work interviews. New Managing Attendance Policy.	Limited	The Trust has been invited by NHS improvement (NHSi), to be part of their Health and Wellbeing Programme. We will receive support, guidance and expertise on this area, culminating in the production of a plan to focus our attention on 2 or 3 areas that will yield the greatest improvement. A Task and Finish Group is being set up headed up by the Assistant Director of Workforce, using the Quality Improvement (QI) methodology, with the first session to take place during August 2018. edit (updated 02/07/2018)	Extreme	16	Extreme	16	Medium	6	27/09/2018

Board Assurance Framework (summary) 2018-19

Appendix 2

Details of strategic risks (description, ownership, scores)									Level of Assurance					
Risk		Risk ownership		Risk score					Current Level of Assurance (denoted by ◆).					
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement		No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	MP	QC	3	4	12	Was 16 ↓				◆		Quality Committee noted that services are making good progress towards achieving compliance with NICE guidance, which provided reasonable assurance. The update on the clinical audit programme provided the Quality Committee with 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.	MP	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	MP	QC	2	3	6					◆		Quality Committee reviewed the Performance Brief Safe domain, which provided reasonable assurance. The action plan from Little Woodhouse Halls Mental Health Act review and the progress made with the Trusts QIP plan both provided reasonable assurance.	→
	RISK 1.4 If the Trust does not achieve external and internal quality priorities and targets then this may cause damage to reputation and loss of income.	MP	QC	3	2	6					◆			
Provide sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects 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	Was 12 ↓				◆			
	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	3	3	9	Was 12 ↓				◆			
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	BM	BC	3	3	9	Was 12 ↓				◆			
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12					◆		Business Committee gave the Business Development Strategy substantial assurance. Progress made with the new foot protection service provided reasonable assurance	
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8					◆		Business Committee agreed the operational plan 2018/19 provided reasonable assurance that the Trust's priorities were on track	

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		The workforce quarterly report, which included a refresh of priorities provided reasonable assurance to Business Committee of renewed efforts to manage priority issues	
	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	4	16		The workforce quarterly report, which included a refresh of priorities provided reasonable assurance to Business Committee of renewed efforts to manage priority issues	
	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		Business Committee reviewed the WRES indicators report and was disappointed by the year on year deterioration, which provided only limited assurance.	
	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.	MP	QC	3	3	9	Was 6		
	RISK 4.4 If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered.	TS	BC	3	3	9			
	Risk 4.5 If the Trust does not ensure there are robust agreements and clear governance arrangements when working with complex partnership arrangements, then the impact for the Trust will be on quality of patient care, loss of income and damage to reputation and relationships	BM	BC	3	3	9			

Appendix 3

Glossary- BAF risk assurance levels

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

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (62)

Trust Board public workplan 2018-19
Version 10 03 September 2018

Topic	Frequency	Lead officer	3 August 2018	7 September 2018 Extraordinary	5 October 2018	4 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
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 annual report	2 x year	CE	X			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		
Professional strategy	annual	EDN				X			
OD strategy	2 x year	DW	X Deferred from May		X				X
Research and development strategy	annual	EMD	X						
Other strategic service developments	as required	EDO							
Reports									
Equality and diversity report	annual	EDN				X			
Safeguarding annual report	annual	EDN			X				
Infection prevention control annual report	annual	EDN			X				
Emergency preparedness annual report	annual	EDO			X				
Governance									
Medical Director's report: doctors' revalidation	annual	EMD	X						
Nurse revalidation	annual	EDN	X						
Well-led framework (in CE's report)	2x year	CS	X CEs report			X			
Annual report	annual	EDFR							X
Annual accounts	annual	EDFR							X
Letter of representation	annual	EDFR							X
Audit opinion	annual	EDFR							X
Audit Committee annual report	annual	CS							X
Standing orders/standing financial instructions review	annual	CS							X
Annual governance statement	annual	CS						X	
Going concern statement (part of corporate governance update)	annual	EDFR						X	
NHS provider licence compliance	annual	CS							X
Committee terms of reference review	annual	CS							X
Board and sub-committee effectiveness	annual	CS							X
Register of sealings	annual	CS							X
Declarations of interest/fit and proper persons test (part of corporate governance update)	annual	CS						X	
Significant risks and risk assurance report	every meeting	CS	X		X	X	X	X	X
Corporate governance update	as required	CS							
Decisions for ratification	as required	CS							
Board workplan	every meeting	CS	X		X	X	X	X	X
Minutes (for noting)									
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board(for noting)	every meeting	CS	X		X	X	X	X	X
Additional items									
West Yorkshire 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: Memorandum of Understanding	as required	CE			X (MOU APPROVAL)				
Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common: Memorandum of Understanding	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

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (63ai)

Quality Committee
Monday 25 June 2018
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Vanessa Hunt	Interim Professional Lead for Allied Health Professionals
	Debbie Myers	Interim Deputy Director of Nursing
	Julie Mountain	Clinical Head of Service for Adult Services
	Angela Gregson	Interim Clinical Lead for Specialist Services
	Suzanne Slater	Clinical Governance Manager
	Stephanie Lawrence	General Manager and Clinical Lead for Children's Services (Item 22)
	Debbie Gill	The Head of Service for Healthy Child Pathway (Item 22)
	Melanie Epstein	Medical Lead for Children's Services (Item 22)
	Benita Powrie	Head of Service for ICAN (Item 22)
	Janet Addison	Head of Service for Speech and Language Therapy and Project Manager for Children's Strategy (Item 22)
	Helen Rowland	Interim Senior Quality Lead for Children's Services (Item 22)
	Sara Clarke	Service Manager for the Child and Adolescent Mental Health Service (Item 22)
Observing	Cara McGuire	Risk Manager
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Diane Allison	Interim Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (21a)	**Welcome and Apologies** The Committee Chair welcomed members and discussed the format of the meeting, which would take a developmental format. These focussed workshop meetings would take place four times throughout the year, with the remaining six as full business meetings. The members introduced themselves. Apologies were noted from Diane Allison, Caroline McNamara and Elaine Goodwin.	

2018-19 (21b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (21c)	**Minutes of meeting held on 21 May 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2018-19 (21d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>2017-18 (80b i) Committee's review of agenda composition</u> The timescale was amended to July 2018. <u>2017-18 (80b ii) Committee's review of agenda composition</u> The Chair confirmed that the Non-executive Director visits and links with Quality Challenge+ would be discussed at the Board meeting in June 2018. The timescale was amended to July 2018. <u>2018-19 (15c) Director of Nursing report</u> This action was completed. <u>2018-19 (18a) Quality Committee future work plan</u> The Executive Director of Nursing stated that a provisional list of topics had been tabled and welcomed any further suggestions. The action was completed. <u>Prompt: safety alert process (May meeting)</u> The Chair requested that the prompt be added to the action log. The Executive Director of Nursing confirmed that the update would be included in the Director of Nursing report for July 2018.	
Business unit focus: Children's Services		
2018-19 (22)	The General Manager and Clinical Lead for Children's Services provided an overview of the Children's Business Unit. There was a brief question and answer exercise to ascertain the Committee's knowledge of the services. <u>Children's Strategy 2018-2021</u> The Head of Service; Speech and Language Therapy and Project Manager for Children's Strategy updated the Committee on the Children's Services Strategy 2018-2021. It was noted that the strategy was launched in May 2018. Copies of the strategy were available for members to take away. <u>Challenges for the Children's Business Unit</u> The General Manager and Clinical Lead for Children's Services introduced the item and highlighted that the following would be discussed: • Update on Hannah House including action plan • Child and Adolescent Mental Health Services (CAMHS) community – new ways of working and staff members' perspective on this and the plans to reduce waiting times • 0-19 tender process • Outcomes – how these are being used in Speech and Language Therapy	

	(SLT) and the Integrated Children's Additional Needs (ICAN) service *Update on Hannah House including action plan* The General Manager and Clinical Lead for Children's Services gave an update on the issues at Hannah House and actions taken. It was acknowledged that a lot of good work had been completed, but there were still challenges ahead. The Trust Chair questioned why Hannah House had such challenges in terms of managing the service. The General Manager and Clinical Lead for Children's Services stated that the inconsistency in leadership had been the main issue and therefore staff engagement had proven difficult. It was noted that the new Team Manager in place had successfully completed her prescribing exam, but would require more support and development; however the team were confident that the correct actions were in place to deliver improvement, including moving a senior manager to Hannah House to give the support required for a period of time. The Chair asked for further updates with regards to the support being offered to the leadership team. **Action: Update on support given to the leadership team at Hannah House to be given at a future Committee meeting.** A Non-Executive Director (TD) asked about care planning and training. The General Manager and Clinical Lead for Children's Services stated that the move to electronic patient records (EPR) had caused some issues but a process was in place to ensure that there would be no further oversights. The Chair asked about integrated care and waiting lists. The General Manager and Clinical Lead for Children's Services confirmed that the issue had not yet been addressed in the action plan as they were awaiting the commissioner's decision on eligibility to be shared. The Chief Executive confirmed that Hannah House was on the agenda for the senior team meeting each month. It was agreed that the action plan would be discussed at a future Committee meeting. *CAMHS community – new ways of working and staff members' perspective on this and the plans to reduce waiting times* The Service Manager for CAMHS gave an overview of the levels of entry into the service and the work involved in agreeing the new ways of working to benefit the process. The Committee's attention was drawn to the following: • How the changes were received internally / staff morale / turnover • Increase in did not attend (DNA) and cancellation rates • Maintenance model for internal waits The Chief Executive asked why the DNA rate had increased. The Service Manager for CAMHS confirmed that it was being investigated, but it would appear that the sooner the appointment offer was made, the higher the rate seemed to be. It was noted that self-referral would be introduced in October 2018 and it was hoped that this would assist in reducing DNA rates. It was also noted that digital support would be offered to patients. The Executive Director of Nursing welcomed the progress and stated that nationally, the Trust was ahead in terms of good practice. It was suggested that the good practice could be shared.	**General Manager and Clinical Lead for Children's Services**

	In response to a question from a Non-Executive Director (TD), the Service Manager for CAMHS stated that future direction for the service would see pathway development by working alongside schools. The Chair acknowledged the operational progress and stated that he would welcome an update on pathways. *0-19 tender process update* The Head of Service for Healthy Child Pathway gave an overview on the 0-19 tender process and staff engagement. It was acknowledged that a lot of support had been received from corporate colleagues. A Non-Executive Director (TD) asked for an outline of the key changes and risks/challenges that would be faced going forward. The Head of Service for Healthy Child Pathway stated that unique selling points were expected within the remodelling of the 0-19 service. It was noted that a one team approach was being taken. In response to a question from the Trust Chair, The Head of Service for Healthy Child Pathway confirmed that the pathway development would provide far greater flexibility and access. *Outcomes* The Head of Service for ICAN gave a presentation on how outcomes were being used in SLT and ICAN and the challenges of implementing goal setting and outcome measures. The Chair asked about working with and learning from other groups. The Head of Service for ICAN confirmed that they had links with lots of other groups however; further work was needed to find more groups to share learning with. The Head of Service for Healthy Child Pathway stated that the head lead commissioner was looking at models of care and a pilot was being rolled out from the Imperial Model from London to Pudsey. The Chief Executive commented that there were very strong lessons to be learnt from citywide change within Children's Services. *Quality Challenge +* The General Manager and Clinical Lead for Children's Services gave a brief presentation on Quality Challenge + and the self-assessment results for 2017-18. *Engagement* The General Manager and Clinical Lead for Children's Services updated the Committee on work currently being undertaken in relation to engagement within Children's Services. A takeover of services by young people is planned for one day in November 2018 and it was suggested that Quality Committee would take part. The Chair thanked the attendees for their excellent presentations and asked the group to reflect on their experience at the Committee and provide feedback. **Action: General Manager and Clinical Lead for Children's Services to request feedback from the attendees' experience of the Quality Committee focussed workshop.**	**General Manager and Clinical Lead for Children's Services**

Quality Assurance focus: Mortality Review		
2018-19 (23)	Mortality surveillance in LCH – the history The Head of Medicines Management introduced the item and gave a brief history of the mortality review process from 2010 to present, explaining some of the challenges and complexities around the recording of deaths in Leeds. National Guidance on learning from deaths The Head of Medicines Management outlined the Trust's requirements following the publication of the National Quality Board Guidance on Learning from Deaths document. It was reported that the main challenge in reviewing mortality was around capturing accurate data. The Committee was pleased to note that the requirements of the policy were in place. The Committee noted that the system for Level 1, Level 2 and Learning Disabilities Mortality Reviews (LeDeR) were running and working effectively. It was noted that the Trust had developed a Level 1 reviewing process and details of the criteria for a level two review were provided. Case studies including interactive session The Committee discussed a case study involving a death within the Adult Business Unit. The Committee noted that the deaths reviewed were largely related to deaths in adulthood. There was a Child Death Overview Panel (CDOP) in place for investigating child deaths. The Chair commented that it was assuring to know that a process for reporting and reviewing deaths was in place. He asked about the next steps and how the organisation could support the process to be even more robust. The Head of Medicines Management stated that the data going forward would be a starting point. It was suggested that it would be beneficial to pair with colleagues from Leeds Teaching Hospitals Trust (LTHT) to learn from each other's processes. The Committee noted the recent publicity around events at Gosport War Memorial Hospital and had a discussion about difficulties in identifying potential issues such as those. It was noted that any guidance emerging from these events would be of interest to the Committee. It was also noted that the Mortality Surveillance Group were aware to be alert to these issues. The Chair thanked the Head of Medicines Management for the presentation.	
Performance brief and domain reports		
2018-19 (24)	**Performance brief and domain reports** The Committee reviewed the document and the Executive Director of Nursing highlighted the following for the Committee to note under the safe, caring, effective and responsive domains: Safe The Executive Director of Nursing stated that performance remained on track. It was noted that one patient had self-discharged within 24 hours so there was no opportunity for a VTE screen to take place and so the overall percentage was down. Caring The data showed a small increase in the percentage of respondents who would recommend care in the community. Effective	

	It was noted that as the measures in the domain were reported quarterly, the next report would be published at the end of June 2018. <u>Responsive</u> The Executive Director of Nursing stated that the Business Committee scrutinised this domain and it would continue to be observed from a quality perspective by this Committee. <u>Statutory breaches</u> The Executive Director of Operations referred to the number of patients waiting more than 18 weeks for treatment in a consultant-led service, and stated that the Trust's performance was excellent by comparison. In response to a query from the Trust Chair, the Executive Director of Nursing stated that early detection and action had resulted in a decrease in the number of higher category of pressure ulcers.	
Quality governance and safety		
2018-19 (25a)	**Director of Nursing quality and safety report key issues** <u>Clinical Governance exception report</u> The Executive Director of Nursing presented the report, and highlighted that work was underway to ensure that data would be portrayed accurately. A Non-Executive Director (TD) asked about sharps injuries. The Executive Director of Nursing explained that GPs were not currently required to provide safety pens or needles for diabetic patients. Although the Trust does provide these, there were occasions where the patients' safety pens or needles were used and this would be where most of the injuries occurred. <u>Director of Nursing report</u> *CQC inspection update* The Executive Director of Nursing updated the Committee on the CQC inspections in month and highlighted the short notice system wide inspection of Children's Safeguarding and Looked After Children's Services (LAC) including visits to the Sexual Health Service and CAMHS. It was noted that there had been an unannounced CQC Mental Health Act (MHA) inspection at Little Woodhouse Hall (LWH). The draft report had been received for factual accuracy and it was agreed that the full report would be shared at a future Committee meeting. The Executive Director of Nursing thanked the staff who had been involved with the inspection for their hard work. **Action: Executive Director of Nursing to share recommendations and action plan following the CQC MHA inspection at LWH.** A Non-Executive Director (TD) asked about medication incidents. The Executive Director of Nursing stated that the data would be more accurate if it were reviewed on a quarterly basis. The Executive Director of Nursing referred to a letter received from NHS Improvement (NHSI) regarding never events and patient safety alerts. The Committee was assured that all processes and monitoring required was in place. It was agreed that the action in place would be closed.	**Executive Director of Nursing**

	The Executive Director of Nursing stated that there were a number of changes taking place around the Nursing and Midwifery Council's standards and guidance. It was stated that the changes were helpful and placed real emphasis on clinical skills and good practice. The Executive Director of Nursing suggested that it would be useful to have a focus session in Quality Committee with the Clinical Education team. It was agreed that an overview of the changes would be made available to a future Committee meeting. A Non-Executive Director (TD) asked about Band 5 nursing vacancies. The Executive Director of Nursing confirmed that interviews were taking place and that they were continuing to work on successful recruitment. <u>Clinical Leads' quality reports</u> *Specialist services* The Executive Director of Nursing referred to the awards and recognition that had been received and highlighted the continuing good work within the business unit. It was also noted that focus was continuing on statutory mandatory training. The Chair thanked the Executive Director of Nursing for the report.	
Quality Committee work plan		
2018-19 (26a)	**Future work plan** It was agreed that the frequency of reporting on outcome measures would be updated in the work plan. **Action: Interim Company Secretary to update the work plan with the frequency of reporting on the Trust's outcome measures approach** The Executive Director of Operations asked about the young people's takeover event being a part of the November Committee. The Chair agreed and asked that the young people were fully briefed before the event. **Action: Executive Director of Operations to ensure that the Youth Parliament is fully briefed before the takeover event in November 2018.** **Action: Chair to ensure that the agenda for the November 2018 Committee is framed around the Youth Parliament's participation.**	**Interim Company Secretary** **Executive Director of Operations** **Chair**
2018-19 (27)	**Matters for the Board and other Committees including assurance levels** It was agreed that the Deputy Chair would provide an update to the Board at the meeting on 3 August 2018.	
2018-19 (28)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 23 July 2018 Monday 24 September 2018 Monday 22 October 2018 Monday 26 November 2018	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (63aii)

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

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Angela Gregson	Interim Clinical Lead for Specialist Services
	Diane Allison	Interim Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Nikki Stubbs	Interim Professional Lead for Nursing
	Gill Warner	Service Manager, Health Case Management Service (Item 30a)
	Victoria Storton	Operational Lead, Health Case Management Service (Item 30a)
	Janette Hughes	Management Support Officer, Health Case Management Service (Item 30a)
Observing	Helen Rowland	Senior Quality Lead for Children's Services
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies		

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (29a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed the members. There were no apologies received.	
2018-19 (29b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (29c)	**Minutes of meeting held on 25 June 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following amendments: <u>Item 2018-19 (22) Business unit focus: Children's Services</u> *Amend wording:* In response to a question from a Non-Executive Director (TD), the Service Manager for CAMHS stated that future direction for the service would see ~~integration~~ pathway development by working alongside schools. *Amend wording:* In response to a question from the Trust Chair, the Head of Service for Health Child Pathway confirmed that ~~the merger~~ pathway development would provide far greater flexibility and access.	

	Amend wording: The Head of Service for Healthy Child Pathway stated that the head lead commissioner was looking at models of care and a pilot was being rolled out ~~to peer model London with Pudsey~~ from the Imperial Model from London to Pudsey. Item 2018-19 (23) Quality Assurance focus: Mortality Review *Amend wording:* The Committee noted that the deaths reviewed were largely related to deaths in adulthood. There was a ~~legal framework~~ Child Death Overview Panel (CDOP) in place for investigating child deaths. Item 2018-19 (25a) Director of Nursing quality and safety report key issues *CQC inspection update* *Insert wording:* The Executive Director of Nursing updated the Committee on the CQC inspections in month and highlighted the short notice system wide inspection of Children's Safeguarding and Looked After Children's Services (LAC) including ***visits to*** the Sexual Health Service and CAMHS. *Amend wording:* The Executive Director of Nursing stated that there were a number of changes taking place around the Nursing and Midwifery Council's standards and guidance. It was stated that the changes were helpful and ~~restored the~~ placed real emphasis on clinical skills and good practice. The Executive Director of Nursing suggested that it would be useful to have a focus session in Quality Committee with the Clinical Education team. It was agreed that an overview of the changes would be made available to a future Committee meeting. **Action: Overview of the changes to the Nursing and Midwifery Council's standards and guidance to be made available to a future Committee meeting.** Item 2018-19 (27) Matters for the Board and other Committees including assurance levels *Insert wording:* It was agreed that the ***Deputy*** Chair would provide and update to the Board at the meeting on 3 August 2018.	**Executive Director of Nursing**
2018-19 (29d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. 2017-18 (37a) Outcome measures The Trust Chair asked for assurance that the September 2018 timescale would be met for this action. The Committee discussed factors that had previously affected progress and were provided with assurance that the project was once again on track. 2017-18 (79b) Director of Nursing report: (CQC/HMIP report on young Offenders' Institute The timescale was amended to September 2018. 2018-19 (14) Performance brief and domain reports: Additional narrative on run chart trends The action was completed. 2018-19 (15) (i) Board Assurance Framework 2018-19: Patient engagement strategy The Committee Chair requested that the action be tabled on the agenda for the meeting in September 2018.	

	2018-19 (11a) Board meeting 25 May 2018: Reporting of serious incidents on the StEIS system The Executive Director of Nursing gave an update on the commissioner's stance in regard to reporting on the Leeds CCG Strategic Executive Information System (StEIS). The action was completed. It was agreed that an update on the reporting would be included in future Director of Nursing reports. **Further action: Executive Director of Nursing to include updates on StEIS reporting in future Director of Nursing reports.** 2018-19 (22) (i) Business unit focus: Children's Services. Update on Hannah House leadership The Executive Director of Operations confirmed that the action plan for Hannah House would be tabled at the private section of the Board meeting in August 2018. It was agreed that the an update on the action plan would be included in the Director of Nursing reports going forward so that the Committee could be assured of future progress. The action was completed. **Further action: Update on the Hannah House action plan to be included in future Director of Nursing reports.** 2018-19 (22) (ii) Business unit focus: Children's Services. Feedback on June 2018 Quality Committee workshop The Executive Director of Operations gave feedback from the attendees' experience of the Quality Committee focused workshop in June 2018. It was agreed that the update in regards to Hannah House had been scheduled too early in the presentation and noted that more direction beforehand would have been useful in prioritising the subjects. The action was completed. 2018-19 (25) Director of Nursing report: CQC Mental Health Act inspection of Little Woodhouse Hall The action was completed. 2018-19 (26a) (ii) Future work plan: Children's takeover event The Senior Quality Lead for Children's Services gave an update on the progress in preparing for the takeover event in November 2018.	**Executive Director of Nursing** **Executive Director of Nursing**
Service Spotlight: Adult Business Unit		
2018-19 (30a)	**Health Case Management Team** The Executive Director of Nursing introduced colleagues from the Health Case Management Team; Gill Warner, Service Manager, Victoria Storton, Operational Lead and Janette Hughes, Management Support Officer. The Committee members and attendees introduced themselves. The team gave an overview of the service including progress since the service was launched ten months ago, staff engagement and feedback, service user feedback and improvement plan and priorities. *Opportunities and challenges*: Opportunities • Increasing older population with more complex needs • Increasing number of individuals now recognised as in a terminal final	

	phase of life and requiring case management support • Development of personalised case management within Health Challenges • Developing and maintaining Social Work professionals within the service • Meeting agreed targets with Clinical Commissioning Group (CCG) if demand continues to rise – currently no set ceiling or floor numbers on End of Life Case Management activity. It was noted that the main driver for the service was the National Framework for NHS Continuing Healthcare and NHS funded Nursing Care (2012). From 1 October 2018, the revised National Service Framework (NSF) would be implemented. The main aim was to have 70% of patients being treated at home by March 2019. In response to a question from the Head of Medicines Management, it was confirmed that there were approximately 340 passive and 340 active patients within the service. The Trust Chair gave a scenario whereby there would be a safeguarding issue should a patient be discharged from hospital, and asked how such a challenge would be addressed. It was confirmed that should the patient be fast tracked and given health funding, it would be possible to work with colleagues such as night sitters to ensure that appropriate care was given. The care planning would begin with meetings in the hospital to look at all options subject to funding. There was a discussion about the eligibility for an individual health plan. A Non-Executive Director (TD) asked if the service offered hands on care. It was confirmed that this was not the case; the service works with patients to agree how they want their care to be provided. It was noted that the average caseload for each care manager was approximately twenty. A Non-Executive Director (TD) asked what the expectations were from commissioners or the Trust in terms of demonstrating added value and outcomes beyond patient experience. It was confirmed that there were clear measures and targets in place following the 'You Said We Did' work at the end of the year, taking into consideration the views of patients. In response to a question from the Trust Chair, it was confirmed that the service did not get involved in appeals processes. The Committee Chair thanked the attendees for their presentation.	
2018-19 (30b)	**Team presentation template** The Executive Director of Nursing presented the template and stated that the slides had been issued to clinical and quality leads for consultation. The main requirements from the presentation were: • Principles • Key Quality Indicators • Voice of the patient • What do we want to escalate to the Quality Committee	

	It was agreed that it was important that the presentation gave a clear description of the core purpose of the service including the number of staff. The Chief Executive commented that the quality of a service was directly related to how happy a team was, and how well it was managed. She was concerned that the presentation could potentially hide a deeply dysfunctional team. It was suggested that some reflection on ways of maintaining morale was included, using staff survey data and Friends and Family Test (FFT) results. The Executive Director of Operations stated that each team should address two to three 'obsessions' (priorities) from the staff survey results. It was noted that presentations and subsequent discussion should not be personal or cause embarrassment. It was agreed that the template should include a reminder to teams that the presentation would be shared with colleagues in the CCG and other key stakeholders. The Committee Chair asked the Clinical Service Leads about their own reflections on the presentations. The Clinical Lead for Adult Services suggested that more guidance would be helpful and that it was important that teams were aware that the presentation would eventually be included in public papers. The Committee Chair stated that using the template would enable the presentation to be included with the papers, giving members the opportunity to read it beforehand. It was suggested that inclusion of the service's patient leaflet with the papers would be useful. The Committee concurred. The Committee approved the template for use and agreed that its effectiveness would be reviewed at a future meeting.	
Performance brief		
2018-19 (31a)	**Performance brief and domain reports** The Committee reviewed the Performance Brief and the Executive Director of Nursing highlighted the following to note under the Safe, Caring and Effective domains: <u>Safe</u> The percentage of venous thromboembolism (VTE) risk assessments completed in June was reported as 50.0%, which was well below target. The reason for this anomaly was there had been a change in reporting processes with the use of the RIO system being discontinued. It was anticipated that there would be an improved position in July 2018. There were no other exceptions to report. <u>Caring</u> There was a small decrease in the percentage of respondents from the FFT who would recommend care in the community. The percentage of staff recommending care, taken from the Staff FFT test was reported at the end of Q1 and it was noted that the proportion had increased by 10%. A Non-Executive Director (TD) referred to the Performance by Business Unit data	

	and queried the response rate of CBU inpatients at 350%. It was confirmed that this figure was misleading and the calculation behind this would be amended. Effective The measures were reported for Q1. It was noted that services were on track to achieve compliance with National Institute for Health and Care Excellence (NICE) guidance. It was noted that Clinical Supervision was below target and would need more focus. A Non-Executive Director (TD) referred to Compliance with Clinical Supervision and asked what could be done to improve the position by the end of the year. The Executive Director of Nursing confirmed that staff continued to be reminded of what constitutes 'clinical supervision' and was encouraging them to capture this information accurately. It was noted that self-reporting on the Electronic Staff Record (ESR) would be rolled out to staff although there was no timeline in place for this as yet. A Non-Executive Director (TD) asked about the progress in regards to NICE guidance 43 (transition from children's to adults services). The Head of Medicines Management stated that services were doing all they needed to do despite it being a complex, citywide project. The Committee Chair asked how much discussion was taking place with other organisations at a senior level. The Executive Director of Operations confirmed that significant discussions were taking place. It was noted that commissioning was an issue and that the range of services commissioned in adulthood were very different to those in Childrens' services. It was agreed that an update should be given to the November 2018 Committee following the Transitions Conference being held in in October 2018. **Action: Executive Director of Operations to give an update to the Committee on progress following the Transitions Conference in October 2018.** Responsive It was reported that the Trust had performed well in its indicators relating to waiting lists. It was noted that no patients were waiting more than 6 weeks for diagnostic tests. It was also noted that both Improving Access to Psychological Therapies (IAPT) measures remained above target. Well led The Executive Director of Nursing stated that the Business Committee would focus on the figures for this domain. It was noted that work was required to increase the appraisal and statutory mandatory training rates. **Outcome:** The Committee agreed **reasonable assurance** was provided by the Performance Brief.	**Executive Director of Operations**
Quality governance and safety		
2018-19 (32a)	**Director of Nursing quality and safety report** The Executive Director of Nursing presented the report, and stated that there were no new themes.	

	Monthly Clinical Governance Exception report – July 2018 (June 2018 data) The Committee Chair asked about the numbers of pressure ulcers. The Executive Director of Nursing confirmed that as the investigations were completed and the review processes completed, this would alter the reported figures. The Executive Director of Nursing advised the Committee that the Performance Team and Clinical Effectiveness Team were working together to ensure data was consistent and accurate. *Safety Alerts (CAS)* Although no alert had been issued, the Executive Director of Nursing drew the Committee's attention to the issue of Graseby syringe drivers and confirmed that there had been a rapid review to identify any of those devices which may still be in existence in Trust properties. Initial findings were that no such drivers were either in use or stored in the Trust's estate. The Trust Chair asked about the current staffing levels in neighbourhood teams. The Executive Director of Nursing confirmed that the tracker was being reviewed on a daily basis and that staff were being moved to ensure staffing levels were adequate and essential work was being covered. It was noted that there are challenges around staffing levels at the moment. The Trust Chair asked if local leaders were being engaged and supportive of staff. The Executive Director of Nursing stated that team meetings and safety huddles were taking place and that she was engaging with the neighbourhood teams. Director of Nursing Report June 2018 *CQC Inspection update* The Executive Director of Nursing gave an update to the Committee following the CQC unannounced Mental Health Act (MHA) inspection. An action plan had been submitted within the timeframe. A Non-Executive Director (TD) referred to section 132 of the Mental Health Act on patients' rights in regard to the previously differing views on what constituted seclusion. In response, the Executive Director of Nursing confirmed that she had submitted a copy of the Trust's seclusion policy/guidelines to the CQC inspection team as requested. *Update in relation to launch and changes of Working Together 2018* The Executive Director of Nursing updated the Committee on the key changes arising from publication of the Working Together to Safeguard Children booklet. It was noted that the full document was available on the Trust website. The Committee Chair suggested using Safeguarding in a service spotlight in next year's Committee programme. **Action: Company Secretary to add a service spotlight on Safeguarding to the work plan for 2019/20** *Update on clinical audit actions* The Executive Director of Nursing summarised the actions and confirmed that the clinical audit plan had been completed. A Non-Executive Director (TD) asked about the action around services who had not submitted any audits for 2018-19 actions. It was confirmed that engagement	**Company Secretary**

	with the services was continuing. <u>Clinical Leads' quality reports</u> A summary of the reports appended to the Director of Nursing Report was provided by the Executive Director of Nursing. *Adult Services* The Clinical Lead for Adult Services updated the Committee on the issues with staff morale due to the number of Band 5 Registered Nurse (RN) vacancies. The Committee Chair asked how morale was impacting on patient care. The Executive Director of Nursing stated that the safe staffing report was showing an improvement. It was reported that there were monthly meetings with Quality Leads and focus was being kept on caseload reviews. The Clinical Lead for Adult Services informed the Committee that they were extending their Leadership Development Programme to experienced Band 5s who were approaching a point where they would seek promotion. The Clinical Lead for Adult Services expressed concerns about the impact on the Adult Business Unit (ABU) senior leadership capacity to support and lead the volume of internal and citywide pilots and work streams whilst maintaining day to day delivery. It was noted that there were the same pressures citywide and work was underway to try and alleviate this by prioritising the high impact work streams. *Children's Services* The Senior Quality Lead for Children's Services stated that there was nothing to update the Committee on other than the ongoing improvement plan at Hannah House and the Commissioning for Quality and Innovation (CQUINS) which were on track to deliver. The Executive Director of Nursing referred to Evidencing Learning from Incidents and commented that it was good to see the evidence of learning and positive feedback from the family concerned. The Trust Chair referred to Information Technology and asked if the current strategy of a programme of replacement was sufficient. The Executive Director of Operations updated the Committee on the current plan. It was noted that there was a need for some reconfiguration in the Integrated Children's Additional Needs (ICAN) group, which was included in the plan. *Specialist Services* The Interim Clinical Lead for Specialist Services stated that there was nothing to escalate to the Committee. The Committee's attention was drawn to the positive work around research, awards, and lectureship taking place within the business unit, which was bolstering staff morale. **Outcome:** The Committee agreed **reasonable assurance** was provided.	
2018-19 (32b)	**Quality improvement priorities (QIP) position** The Executive Director of Nursing presented the paper. *Hannah House* All original actions have been completed, however an additional action plan is now in place and this remains a key area of focus.	

	The Executive Director of Nursing informed the Committee that Berry Rose from the Care Quality Commission (CQC) had returned from maternity leave and would join the engagement meeting in August 2018. *Little Woodhouse Hall* It was reported that two of the three outstanding actions from the "Must do" list had been completed and focus would continue on improving statutory mandatory child safeguarding training. *Leeds Sexual Health* The actions continued to be monitored and final actions, which were related to statutory/mandatory training, were being completed. *Safeguarding training* The Executive Director of Nursing reported that, in relation to ESR, good progress was being made with the phased programme of work and it was hopeful that the final actions would be closed. The Committee Chair asked about non-compliance of statutory mandatory training at Little Woodhouse Hall and how it was addressed. The Executive Director of Nursing stated that she expected to see completion by the end of September 2018. It was noted however, that this would not be possible if there was any sickness absence on the day of the training. It was agreed that the Executive Director of Nursing would include a report by exception in the Director of Nursing Report in September 2018 if the training was not completed. **ACTION: Executive Director of Nursing to include a report by exception on statutory mandatory training in the Director of Nursing Report in September 2018 if the Little Woodhouse Hall child safeguarding training is not completed.** **Outcome:** It was agreed to close the QIP with exception reporting as discussed.	**Executive Director of Nursing**
2018-19 (32c)	**Guardian for Safe Working Hours** The Executive Director of Nursing presented the report. It was noted that there were no new themes or trends identified, however, there were some challenges around doctors in training and vacancies in medical roles within the Child and Adolescent Mental Health Service (CAMHS). The Committee Chair asked about provision of support to the Guardian for Safe Working Hours. It was noted that the Human Resources Advisor who had supported the Guardian for Safe Working Hours was no longer in post and that this was a cause for concern with the Senior Management Team. **Action: Executive Director of Nursing to request an update from the Director of Workforce in regard to the recruitment of a HR Advisor to support the Guardian for Safe Working Hours.**	**Executive Director of Nursing**
2018-19 (32d)	**Risk register** The Interim Company Secretary introduced the risk register and highlighted that there were three new risks to note: • Staff capacity in Speech and Swallowing teams • Myplan self-harm risk assessment tool used within CAMHS • Reduced staff capacity within CAMHS outreach service	

	It was noted that the four significant risks remained on the register. The Chair referred to a discussion that had taken place at the Audit Committee. It had been suggested that where high risks remained on the register, it would seem that they were not being actioned. The Chief Executive responded that mitigating actions were in place and any additional actions would be reported. The Committee discussed risk scores and the level of scrutiny required. *Risk 872: Difficulties recruiting to and retaining staff within neighbourhood teams* The Trust Chair asked if the retention figures had improved. It was suggested that recruitment should be separated from retention as a risk. *Risk 939: New CAMHS Tier 4 building costs* The Chair asked if the above was a high risk. It was noted that the risk would mitigate and will change relatively quickly. *Risk 942: Staffing capacity in the Speech and Swallowing Team* The Interim Clinical Lead for Specialist Services confirmed that the team was now fully staffed and so the risk should be closed by September 2018. *Risk 944: Myplan self-harm risk assessment tool used within CAMHS* The Executive Director of Nursing reported that a programme of work would take place in August 2018 to agree how the tool would be used and to train staff accordingly. The Executive Director of Nursing stated that she considered the tool to be robust. *Risk 945: Reduced staff capacity within CAMHS outreach service* A Non-Executive Director (TD) asked what was being done to replace the absent clinical leader. The Senior Quality Lead for Children's Services stated that the Band 7 had been supporting the clinical leader role for the past two years and queried the current score.	
2018-19 (32e)	**Medical Director revalidation report** The Head of Medicines Management presented the report and confirmed that it had been viewed by the Interim Medical Director, who would present it at the Board meeting in August 2018. The Executive Director of Nursing stated that she would work with the Head of Medicines Management to review some of the phrasing and terminology before the report was presented to the Board. The Clinical Lead for Adult Services asked what the circumstances would be if someone wanted to defer their revalidation. It was confirmed that there would need to be sufficient evidence to support the request. The Committee Chair expressed concern about the job plan figure of 84%. It was agreed that a breakdown of the figures would be provided prior to presentation at the Board meeting. **Action: Head of Medicines Management to ensure a breakdown of job plan figures is provided before the report is presented at the Board meeting.**	**Head of Medicines Management**
Clinical effectiveness		
2018-19 (33a)	**Clinical Audit Programme 2017-18 update** The Executive Director of Nursing presented the report and stated that the audit plan had been successfully completed.	

	It was acknowledged that the approach to the report was very different with more of an emphasis on learning. A Non-Executive Director (TD) suggested that learning and improvements identified in the 2017/18 audit programme should be reported in subsequent updates. The Committee Chair asked how information from the national clinical audits was to be used. The Executive Director of Nursing agreed to review and confirm this. **Action: Executive Director of Nursing to confirm how the Trust will use information from the national clinical audits.**	**Executive Director of Nursing**
2018-19 (33b)	**Patient group directions (PGD)** The Executive Director of Nursing confirmed that all PGDs had been through the correct processes and recommended all for ratification. **Outcome:** The Committee ratified the five approved PGDs: • 001-18 Administration of Seasonal Influenza vaccine for staff • 127-01 Supply of Melatonin prolonged-release 2mg (Carcadin®) tablets • 128-01 Administration of Human Papillomavirus (HPV) vaccine (Gardasil®) for men who have sex with men • 129-01 Supply of Raltegravir 400mg tablets and Tenofavir 245mg/Emtricitabine 200mg tablets (as either three or a five day Post-Exposure Prophylaxis starter pack) • 130-01 Administration of Hepatitis A and B combined vaccine for adults (16 years and older)	
2018-19 (33c)	**Research and Development Strategy update** The Head of Medicines Management presented the report and confirmed that the strategy was due for review in 2018/19. There was a discussion around the Trust's level of ambition and the level of its engagement with academic partners, and whether services have capacity to carry out research. It was suggested that the Trust should support two to three key areas of academic partners work. The Executive Director of Nursing expressed concern about the uncertainty around finances and asked if there was a better way forward in the new strategy. It was agreed that the Head of Medicines Management would discuss the issue with the Head of Research and Development. **Action: Head of Medicines Management to discuss with the Head of Research and Development how the Trust should maximise contact with academic partners and the issue of uncertainty around finances**	**Head of Medicines Management**
Policies, reports and minutes for approval or noting		
2018-19 (34a)	**Board members' service visits** The Board workshop on 6 July 2018 included a discussion on the purpose and format of Non-Executive Director visits to services. It was felt that by identifying what the Board wanted to achieve from an engagement visit, it may help the service to prepare for the visit. It was also thought that it may be valuable for Non-Executive Directors (NEDs) to explore leadership & culture when they are undertaking engagement and assurance visits, and to consider whether there was also an appetite for NEDS visiting key corporate services.	

	Non-Executive Directors agreed to trial being part of the Quality Challenge+ inspection programme. The Trust Chair and the Committee Chair will take part in upcoming inspections and will feed their experience back to the Committee and the Board. The Committee reviewed the reports received from Non-Executive Directors Ian Lewis, who visited the Chapeltown Neighbourhood Team and Brodie Clark, who visited the nutrition and dietetics service. The Executive Director of Operations advised the Committee that she was in the process of responding to Brodie Clark about his service visit report. The Committee agreed that it should acknowledge Non-Executive Directors reports by thanking the author of the report and confirming any subsequent action it intends to take as a result of the information provided. The Committee should invite the report author to advise the Committee if its response is not robust enough.	
2018-19 (34b)	**Clinical Effectiveness Group minutes: 21 June 2018** The Head of Medicines Management presented the minutes and it was highlighted that Group members had had a discussion with the Head of Information Governance around the Data Protection Act 2018, including how this may impact on the Trust, particularly in terms of accessing clinical records for purposes other than clinical care (e.g. for audit). It was noted that this was already on the Trust risk register and a programme of work was underway to map data processing across the organisation. A Non-Executive Director (TD) asked about the high number of apologies for the meeting. The Head of Medicines Management confirmed that the internal auditors were reviewing the membership of the Group.	
2018-19 (34c)	**Safeguarding Children's and Adults Group minutes: 14 June 2018** The Executive Director of Nursing presented the minutes and highlighted the following: • Work undertaken in working to ensure ESR accurately captures and reflects safeguarding training • Work plans on track across safeguarding domains • Initial verbal feedback had been received following the CQC inspection which had commenced 4 June 2018 and the safeguarding team were reviewing this in relation to work plans. A factual accuracy check of the CQC report was likely to be available the end of July 2018.	
2018-19 (34d)	**Mental Health Act Governance Group minutes: 15 June 2018** The minutes were received by the Committee.	
Quality Committee work plan		
2018-19 (35a)	**Items from work plan not on agenda** i. Patient Safety and Experience Group minutes: 24 May 2018 – meeting cancelled ii. CCG Quality and Performance minutes: June 2018 – meeting cancelled	
2018-19 (35b)	**Work plan** The Interim Company Secretary made a request for papers to be submitted in	

	good time. The Executive Director of Nursing informed the Committee that the Quality Committee's workshop in October 2018 would include an update on the recent Patient Safety Congress	
2018-19 (36)	**Matters for the Board and other Committees including assurance levels** It was agreed that the Deputy Chair of the Quality Committee would provide an update at the Board meeting on 3 August 2018, highlighting the following: • Service spotlight on Health Case Management Service presentation • Little Woodhouse Hall CQC visit • Clinical Audit • Quality Improvement Plan (QIP)	
2018-19 (37)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 24 September 2018 Monday 22 October 2018 Monday 26 November 2018	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (63bi)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 27 June (9.00am – 11.30 am)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Laura Smith	Director of Workforce (LS)
Apologies:	Tony Dearden	Non-Executive Director (TD)
	Richard Gladman	Non-Executive Director (RG)
	Diane Allison	Interim Company Secretary
Apologies:	None	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(19)**	The Chair welcomed everyone to the meeting. **19a - Apologies**: Please see above. **19b - Declarations of Interest**: None recorded. **19c - Minutes of last meeting** The public and private minutes of the meeting dated 23 May 2018 were approved by the Committee. **19d – Matters arising from the minutes and review of actions** *Item 2018/19 (10dii) – Productivity programme group update (PPG)* The Executive Director of Operations said that the key indicators in a number of services were to be reviewed for productivity opportunities, guided by the information available, eg. ratios, DNA rates, reference costs, etc. Those services would then be invited to a deep dive discussion focusing on the shaping of the productivity programme. The Chair was content with the actions put in place and welcomed a substantive report in September 2018 after the PPG meeting in July 2018. **Action:** A full/comprehensive report to be received by the Committee in September 2018.	BM

	2017/18 (97b) – Draft key performance indicators It was noted that a report of productivity outcomes was due in October 2018 at both the Quality Committee and Business Committee. The Chair said he would discuss with the Chair of the Quality Committee whether to receive this at both the Committees.	
2018/19 **(20)**	**Service area focus** **Timetable of service presentations** A verbal update of future service presentations was provided to the Committee by the Executive Director of Operations. The Committee agreed to allow an hour to focus and reflect on the service presentations. The Executive Director of Operations suggested a number of service areas that may be suitable for deep dives later on in the year. She said that there were enduring issues with access to Leeds Sexual Health service. The contract requires the Trust to run drop in sessions and appointments. The drop in sessions appear to be very popular with the public, thus making waiting times longer, and complaints were being received. The Continence, Urology and Colorectal Service (CUCS) have a consistent problem with waiting times. The Executive Director of Operations suggested scheduling attendance at Business committee in November 2018. The Executive Director of Operations said that a wound management framework had recently been introduced in the neighbourhood team which is a good quality tool. However she suggested that Business committee could aid thinking on how to embed best practice in a busy and ever-changing environment. Concerns remained with the pattern of recruitment within the neighbourhood teams. The Trust was in a similar position to last year; waiting for newly qualified students to join the Trust. The children's community nursing area was being reviewed. The quality improvement approach was being considered to merge four teams together but this could be another area the Business committee considers. The Chair proposed a discussion with the Non-Executive Directors to ascertain how a more comprehensive review of the neighbourhood teams might best be carried out. **Action:** • The Executive Director of Operations was asked to invite the sexual health service to the Committee in September 2018. • A date to be agreed to facilitate a longer discussion on neighbourhood team. **Outcome:** The Committee agreed to a broader programme of future service presentations with a proposition for a fuller review of the work and delivery of neighbourhood teams along with their key partners.	SP
2018/19 **(21)**	**Project management** **Digitally enabled, estate lite programme**	

	The Executive Director of Finance & Resources presented a report providing an overview of the Trust's major change projects and issues for escalation. A report on the progress of each of the projects highlighted the benefit from the development of an overall programme and shared conversation. One of the issues considered was the need for processes for students and staff employed through CLaSS to be streamlined and crossover work with e-rostering. It was noted that an update on e-rostering was on the agenda for September 2018 Business Committee meeting. The resetting of estates rationalisation time line had been reflected in the Senior Management Team meeting and will be on the agenda for the meeting in July 2018. **Action:** Estates rationalisation timeline item to be added to the agenda for the next meeting in July 2018. **Outcome:** The Committee received the report. No issues had been escalated from the projects.	BM
2018/19 **(22)**	**Business and commercial developments** **22a – Leases with Community Health Partnership (CHP)** The Committee was asked to review the lease agreement that set out the costs involved and any issues following a detailed legal review. The Committee discussed the case for entering into a lease arrangement with Community Heath Partnerships in respect of five Leeds Community Healthcare NHS Trust LIFT properties. The Executive Director of Finance & Resources said that the terms of the LIFT Under Lease Plus Agreements (ULPAs) allows the Trust to hand back lettable units, part of LIFT building, to CHP. It was noted that the Trust would be committed to a minimum of three years charges before a break in a lease could be enacted. The Executive Director of Finance & Resources said that the Trust had negotiated the best possible position with regards to breaks and commitments and was asking the Committee for approval to recommend to the Trust Board to sign the leases. After further discussion it was noted that, within the timescale, there were no other alternatives nor were the leases at odds with current Trust service plans or the estate strategy. The Chair suggested that in terms of recommending to the Trust Board it would be helpful to reflect on the proposition and options within an annex or appendix to this document about the alternatives within the next 3 years and looking for better ways of running some of these buildings. **Action:** The Executive Director of Finance & Resources was asked to put a note together for the Chair of the Trust and the Non-Executive Directors to include the points raised in the meeting today. **Outcome:**	BM

	The Committee agreed to recommend to the Trust Board the approval of the lease. **22b – 0-19 tender submission** (Please see private minutes). **Improving Access to Psychological Therapies (**IAPT) (Please see private minutes). **22c - Child and Adolescent Mental Health Services Tier 4** (CAMHS): (i) CAMHS Tier 4 contract (ii) New build (Please see private minutes).	
2018/19 **(23)**	**Performance management** **23a - Performance brief and domain reports** The Committee considered the performance brief and domain reports. The cover report provided a summary of performance during May 2018 against targets and indicators and highlighted areas of note. The Executive Director of Operations said that there were no specific issues raised at the Quality Committee meeting on 25 June 2018. The Director of Workforce (LS) said that work was underway to focus on recruitment, retention and appraisals. An equality and diversity measure would be included in the performance brief from September 2018. The Committee was concerned about the deterioration in the corporate directorate on staff appraisal rates. The Director of Workforce (LS) assured the Committee that work was continuing with planning and better focusing on appraisal meetings as part of normal processes. **Finance** The Executive Director of Finance & Resources said that at this early point in the year the Trust was slightly underspent, as a result of vacancies. The forecast outturn demonstrated there were some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks include the pay-award, mitigating the loss of £1.2m of income from the Clinical Commissioning Group and delivery of the planned cost savings. These will continue to be monitored closely as the year progresses. **23b - Operational and non-clinical risks register 8+** The report provided a description of risk movement since the last risk register report received by the Committee in May 2018. This summary report showed changes to note to non-clinical risks on the risk register as follows: • One new risk • One risk having an increased score • Four extreme risks in total (scoring 15 or more). The Chief Executive referred to risk 934: risk of cyber threat through presence of unsupported software, which had an increased score. **Action:**	BM

	The Executive Director of Finance & Resources agreed to review risk 934. **Outcome:** The Committee noted the recent revisions made to the risk register. **23c - Internal audit reports** **Cyber security maturity assessment** The report provided a summary of the outcome of the completed internal audit of cyber security maturity. The Committee considered the aspects of the report relating directly to the role and functions of the Business Committee. The responsibility of cyber security maturity assessment audit was part of the Audit Committee work stream. The Executive Director of Finance & Resources said that the Audit Committee had considered whether to change its terms of reference to include cyber security as a specific thing to be focusing on. **Outcome:** The Committee noted the content of the internal audit report.	
2018/19 **(24)**	**Business Committee work plan** The work plan was reviewed by the Committee and no changes were requested.	
2018/19 **(25)**	**Matters for the Board and other Committees** • LIFT contract lease to sign off • Business and commercial update • Performance management	
2018/19 **(26)**	**Any other business** The Chief Executive asked to be invited to a Business Committee pre-meeting to have a reflective conversation about Business Committee's role in overseeing the work with the NHS Confederation and to consider the work programme. **Action:** The Chief Executive to be invited to a future Business Committee agenda setting meeting.	RL

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (63bii)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 25 July 2018 (9.00am – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD)
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Laura Smith	Director of Workforce (LS)
	Diane Allison	Company Secretary
	Richard Worlock	Equality and Diversity Manager (for item 27d(i) only)
	Trina Glynn	BME Project Officer (for item 27d(i) only)
	Peter Ainsworth	Operational Support Manager (for item 30b only)
	Dan Barnett	Head of Business Development (for item 31 only)
Apologies:	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
Observer:	Dr Tan Boon	Lead FME for Policy Custody Medical Services
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(27)**	The Chair welcomed Dr Boon to the meeting as an observer. **27a - Apologies:** Please see above. **27b - Declarations of Interest:** None recorded. **27c - Minutes of last meeting** The public and private minutes of the meeting dated 27 June 2018 were approved by the Committee. **27d – Matters arising from the minutes and review of actions** *Item 2018/19-27d(i) – Workforce race equality standard (WRES) update* The Committee was updated on the Trust's current WRES performance against the nine indicators. The Director of Workforce (LS) said that this followed the Trust Board workshop on equality and diversity on 2 May 2018 and presented the new WRES indicators that were proposed to replace the black and minority ethnic (BME) target. The Equality and Diversity Manager said that WRES has been developing since 2015 and it was now gathering momentum nationally. He recommended that the Trust's performance target around the BME representation of the organisation should be adopted from standard one of the WRES indicators to link directly with national reporting.	

	The Equality and Diversity Manager said that the key action identified at the Board workshop was around mentoring. This was a resource heavy programme to match people to outcomes. The Chair thanked the representatives from the Equality and Diversity team. He was very disappointed that the Trust was in such a poor position against the benchmarking figures of other community healthcare trusts and in most aspects had shown deterioration over the past twelve months. The Chair said that the paper provided a position statement of where the Trust was but seemed less helpful with identifying the actions that would be considered or where the investment was being made to reverse that trend and deal with the issue of gender, colour and ethnicity in the organisation. A Non-Executive Director (TD) asked about examples of best practice from other organisations. The Director of Workforce (LS) said some of the issues relate to having the right data on reasons and solutions for analysis. She suggested that the Trust gained a better understanding of mentoring of BME staff in bands 8 to 9. The Committee discussed the data analysis in the staff survey, broken down into departments and areas and whether there were any indication suggesting issues in a particular area. The Equality and Diversity Manager said that the percentage decrease in the performance and the experience of BME staff percentage was a national trend. He hoped that with the inspiration of the BME Project Officer in post more people should complete staff questionnaires. He said there needs to be more investment in cultural competence in the organisation. The BME Project Officer added that to identifying specific areas to work, it takes time for people to come together with their different experiences and to have a level of confidence. She said that work was underway in the BAME network to establish trust and gather ideas. The Chair understood that it wasn't a particularly easy task but he still required greater clarity on the steps and measures that were being delivered in order to have a direct impact on the trends that currently exist. He was looking forward to receiving further information at the next meeting in September 2018. The Director of Workforce (LS) said that there was a meeting taking place on 26 July 2018 to progress actions from the Trust Board WRES/WDES/Disability workshop on some of those equality and diversity issues, and to put an action plan together. The Executive Director of Operations suggested there was an action for the executive team about the diversity and the broader agenda. **Action:** • A target in the well-led section of the performance brief was to be included from September 2018. • Further meaningful evidence including a concrete and deliverable action plan, to be presented at September 2018 Business Committee. **Outcome:** The Committee received limited assurance from the WRES update. *<u>2018/1-27d(ii) – Neighbourhood teams activity targets</u>*	LS

	The Executive Director of Finance & Resources provided an update on the current activity target for neighbourhood teams and advised the Committee why it was not an appropriate way in which to assess neighbourhood team activity. The slide presentation described the neighbourhood teams' activity improvement facts and his conclusion. The Executive Director of Finance & Resources said within the neighbourhood team referrals were constant, vacancy levels had improved but sickness levels remained a concern and the face to face contact had fallen significantly. He said that a significant work had been undertaken to prove some of the data and the narrative and that the focus was now to move forward. The Chair was pleased to note that some of the specifics in the presentation built towards a helpful narrative. He concluded that the reduction in activity could be justified. The Executive Director of Operations said that she still had concerns with staff being over stretched and that the sickness levels were higher than benchmarked. This was a challenge for the teams. She said it would be good to show this data to teams to understand the stability. The Executive Director of Operations was content with the outcome; the pattern of recruitment in the neighbourhood workforce had gaps over the summer months and then improved in September when newly qualified joined the Trust. The Chair asked about how availability was evened out to match capacity and demand. The Executive Director of Operations said that the next stage of development was with local care partnerships to support individual needs and to invest in change. The Executive Director of Operations said that she was in the process of planning for winter months to have a stable workforce in place and was considering introducing a premium to attract people. The Chair said that he recognised that something had to be done and welcomed support and encouragement. He noted the presentation covered a wide range of developments on productivity, Carter review and narrative, mitigating BAF risk, getting to excellence and updates in future and next steps. **Action:** It was agreed that the overarching and best evidenced narrative would be available for the September 2018 meeting. **Outcome:** The Committee noted the update on the current activity targets for neighbourhood teams.	BM
2018/19 **(28)**	**Service area focus** **28a – Neighbourhood teams next steps** This item was discussed as part of item (27d) above. **28b – Podiatry service update** The Executive Director of Operations introduced an updated paper following the service deep dive visit to the Committee in January 2018. The Executive Director of Operations said all current milestones for the service were being met and significant progress had been made to develop an integrated foot protection service. She said referrals were steadily increasing and positive patient feedback was noted. There were no concerns to raise	

	around waiting times. The service had been identified as one of the first services to participate in a joint Leeds Community Health/Commissioner 'Roadmap' review. This was a significant piece of work which commenced in May 2018 to comprehensively review all aspects of the service and to influence the podiatry service development and improvement plan going forward. The Executive Director of Operations updated the Committee on the £1.5m de-commissioning matter. The Trust was to work with the Commissioners to look at areas of service provided as a gold standard and podiatry was one of those areas to concentrate on. The Executive Director of Operations said that information was still being gathered about the elements of this service to be de-commissioned. **Outcome:** The Committee noted the content of the report.	
2018/19 **(29)**	**Business planning** **29a – Operational plan 2018/19 update** The Executive Director of Finance & Resources introduced a new style of presentation of the operational plan. The report provided an overview of progress towards achieving the Trust priorities set out in the 2018/19 operational plan at the end of the first quarter and a forecast for the year-end. The main issues for consideration were the fourteen priorities towards the Trust's four strategic goals. An overall RAG status reflected an overall assessment of progress and performance in relation to the priorities. It was noted that ten of the fourteen priorities were on track and all fourteen priorities were forecast to be green at year end. The Chair was concerned about a number of areas beyond quarter one still not defined to have a success measure. The Chair also noted that the paper referred to the sickness review by a third party commentator, and not to the programme with NHS Improvement. **Outcome:** The Committee noted the assessment of progress at the end of quarter one and the forecast for the year-end. **29b – Board assurance framework 2018/19 (BAF)** The paper provided the Committee with details of the revised BAF for 2018/19 and the responsibilities of the Committees and the Board. The main issues for consideration were for the Committee to satisfy itself that the sources of assurance listed should provide it with enough information to evaluate whether the strategic risks assigned to the Committee are being managed. The Company Secretary said that some strategic risks have few sources of assurance. The Executive Director of Finance & Resources said that the Audit Committee on 20 July 2018 reviewed the BAF process. He said that some of the scoring needed to be reviewed. The SMT had been tasked to review this. A Business Committee working group is to be convened to review the BAF risks assigned to the Business Committee, before the next meeting of the Business Committee. The Committee was asked whether the controls in place justified the current	

	risks of 12 and over. The Executive Director of Finance & Resources said that he had asked internal auditors to audit partnership working and how to better manage contracts. **Action:** BAF scoring to be reviewed by a working group before Business Committee meeting in September 2018. **Outcome:** The Business Committee noted the revised BAF 2018/19 and the sources of assurance for the strategic risks assigned to the Committee. **29c – Major incident plan** (Please see private minutes).	DA
2018/19 **(30)**	**Project management** **30a – projects report** The Executive Director of Operations presented a paper outlining the discussions held at the recent Change Board meeting. The conversation was on the different elements of the four specific projects coming together. Topics discussed: • The overall branding of the programme fitting within a framework of creating the working life expected. • The approach to the use of Skype with three key objectives agreed and to fund a project post to support these. • An update was received on each of the four key projects; administrative review, e-rostering, EPR and estates. **Outcome:** The Committee received the report. **30b – Estates strategy and rationalisation plan presentation** The Executive Director of Finance & Resources presented the six monthly estates strategy progress update. The update also included details of projects that had been completed successfully and projects that were ongoing. The Executive Director of Finance & Resources said that there had been little progress into how estates influenced working lives, but there was further development with the frame work. The Committee approved the general approach of the estates strategy. The Executive Director of Finance & Resources said that the change potentially placed the Trust in a competitive position when bidding for services. The capability and capacity to turn a plan into a project and then implement it was discussed. The Operational Support Manager said that the programme up to now had generally been a success story with the support of staff, public and commissioners but the next set of projects may not have universal support and engagement. The Operational Support Manager agreed to provide a local plan based on the information covered in the slides on each of the wedges of the city before the two parts of the plan came together. This would be without the citywide delivery programme between Leeds City Council, Leeds York Partnership NHS Foundation Trust, acute Trust and Leeds Community Healthcare NHS Trust. He said that significant work would be needed to work with all the partners in Leeds to formulate a wider plan.	

	The Chair said it would be helpful for the Committee to receive a phased approach plan to visualise methods of working prior to being received at the Trust Board. **Action:** A draft plan is to be received by the Committee in September 2018. **Outcome:** The Committee received the presentation on the six monthly estates strategy update.	BM
2018/19 **(31)**	**Business and commercial developments update** (Please see private minutes).	
2018/19 **(32)**	**Performance management** **32a – Performance brief and domain reports** The Committee considered the performance brief and domain reports. The cover report provided a summary of performance during June 2018 against targets and indicators for consideration. The Quality Committee focussed on caring, safe and effectiveness domains at its meeting on 23 July 2018. **Responsive Domain** The Trust had performed well in its indicators relating to waiting lists with all rated as green for June 2018. **Well Led Domain** Staff turnover had increased from last month and rated as amber. Further discussions were to be held outside the meeting regarding turnover rate within corporate services being higher than other areas at 24.7% in June 2018. The percentage of staff reported as having had an appraisal continues to be below the target of 95% and was reported at 79.9% in June 2018. **Finance Domain** The Executive Director of Finance & Resources said that at the end of quarter one the Trust was slightly underspent year to date. The forecast outturn demonstrated some financial risks in delivering the control total set by NHSI of £2.541m for the year. Additional risks included the pay-award, mitigating the loss of £1.2m of income from the CCG and delivery of the planned cost savings; these will continue to be monitored closely as the year progressed. The Executive Director of Operations introduced a six monthly report on waiting times to give an overview of the Trust's position. There were no concerns to raise. The Committee noted the sustained good performance on access to first appointment and the position on access to Child and Adolescent Mental Health Services. **Outcome:** The Committee noted the current levels of performance. **32b – Workforce quarterly report** The Director of Workforce (LS) introduced the workforce quarterly report. The report summarised the work undertaken to progress current priorities for the workforce directorate during April to June 2018, outlining key impacts and risks. The strategic and delivery priorities were being aligned to the strategy and priorities of the organisation which would be reflected in the structure of both	

	monthly well-led reports and quarterly workforce reports. Positive progress was noted in key areas including retention and engagement. The Director of Workforce (LS) said that a paper would be presented to the next Trust Board meeting on 3 August 2018 recommending a refreshed version of the organisational development strategy. The Director of Workforce (LS) said that the key focus was to see improvements in performance deterioration following engagement with NHSI on the retention plan and work on the key priorities. She said that the Trust was not performing well in sickness absence, appraisal, and statutory and mandatory training. This was picked up in last month's well-led report by the Business Committee and the level of scrutiny was being maintained by the senior management team. In respond to the Chair's question about the sickness absence project, the Director of Workforce (LS) said that sickness absence tracked in a similar pattern compared to other community trusts. The health and wellbeing project planned to take a different approach under the national NHSI programme, and a task and finish group will also be associated with it. It was noted that an external senior workforce director had agreed to provide support guidance and challenge around sickness absence to the Trust. **Action:** A report is to be received by the Committee in October 2018 following the development work with NHSI. **Outcome:** The Committee noted positive progress in quarter one in key areas of retention and engagement. Focused attention was being directed at areas of particular risk or deterioration. **32c – Operational and non-clinical risks register 8+** The report provided a description of risk movement since the last risk register report received by the Committee in June 2018. The summary report showed changes to note to non-clinical risks on the risk register. The Company Secretary said that a report was submitted to the Audit Committee to provide assurance on the general data protection regulation risks. A further report was requested by the Audit Committee for its meeting in October 2018. **Outcome:** The Committee noted the recent revisions made to the risk register. **32d – Internal audit reports** The report provided details of the completed internal audits for audiology data quality and IT procurement. The Committee considered the aspects of the report relating directly to the role and functions of the Business Committee. The Company Secretary advised that updates on actions were received by Audit Committee. **Outcome:** The Committee noted the content of the internal audit reports.	LS

2018/19 **(33)**	**Business Committee work plan** **Future work plan** The Executive Director of Finance & Resources agreed to review the proposal to integrate the business development strategy and the business and commercial developments reports.	BM
2018/19 **(34)**	**Matters for the Board and other Committees** • Workforce WRES report (limited assurance) • Neighbourhood team development • Podiatry service (reasonable assurance) • Operational plan (reasonable assurance) • Estates review • Business and Commercial development report (substantial assurance) • Performance brief and domains report • Workforce quarterly report (reasonable assurance).	
2018/19 **(35)**	**Any other business -** None discussed.	

HEALTH AND WELLBEING BOARD

THURSDAY, 14TH JUNE, 2018

PRESENT: Councillor R Charlwood in the Chair

Councillors S Golton, P Latty and E Taylor

Representatives of Clinical Commissioning Group
Dr Gordon Sinclair – Chair of NHS Leeds Clinical Commissioning Group
Phil Corrigan – Chief Executive of NHS Leeds Clinical Commissioning Group
Dr Alistair Walling – Chief Clinical Information Officer of Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Cath Roff – Director of Adults and Health
Chris Dickinson – Children and Families

Representative of NHS (England)
Anthony Kealy - NHS England

Third Sector Representative
Heather Nelson - Black Health Initiative

Representative of Local Health Watch Organisation
Dr John Beal - Healthwatch Leeds

Representatives of NHS providers
Dr Phil Wood - Leeds Teaching Hospitals NHS Trust

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

1 Welcome and introductions

The Chair welcomed all present to the meeting and brief introductions were made. Noting the new Board membership, Councillor Charlwood thanked former Board members, Dr Jason Broch, Tanya Matilainen, Nigel Gray and Councillor Coupar for their work on the Board.

Additionally, the Chair welcomed the news that former Board member Councillor G Latty is the 2018/19 Lord Mayor had chosen St Gemma's Hospice as the Lord Mayors Charity for this year.

Councillor Charlwood welcomed new Board members Councillors P Latty and E Taylor and Dr J Beal to their first meeting, along with Jim Barwick and Dr Alistair Walling as new appointments made by the Board.

2 Appeals against refusal of inspection of documents

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

3 Exempt Information - Possible Exclusion of the Press and Public

The agenda contained no exempt information.

4 Late Items

No formal late items of business were added to the agenda, however the Board was in receipt of an additional appendix to Item 9 "Priority 2 – An Age Friendly City where people Age Well" which had been omitted in error from the agenda papers. (minute 9 refers)

5 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interest.

6 Apologies for Absence

Apologies for absence were received from Councillor Mulherin, Moira Dumma, Steve Walker, Sara Munro, Julian Hartley, Thea Stein and Supt. Sam Millar. The Board welcomed Chris Dickinson (LCC Children & Families) and Dr Phil Wood (LTHT) as substitutes.

7 Open Forum

Older People references - John Puntis, Leeds Keep Our NHS Public, welcomed the Age Friendly discussion but expressed his concern that the language used to describe older people in the media and publications suggesting that older people were the cause of the ill health of the NHS was factually incorrect. He sought support for further emphasis on the valuable contribution older people make and for this to be recognised throughout the media and relevant publications.

8 Minutes

RESOLVED – That, subject to an amendment to the attendance list to correctly refer to Hannah Howe, the minutes be agreed as a correct record.

9 Priority 2 - An Age Friendly City Where People Age Well

Lucy Jackson, Consultant in Public Health (Older People), introduced the report which focussed on Priority 2 of the Leeds Health and Wellbeing Strategy and highlighted the work streams and consultation undertaken with older people. It was reported that 31,000 older people lived in the most deprived areas of Leeds, and their priorities and needs were very different depending on where they lived. A focus for the Health and Wellbeing Board (HWB) would be to reflect the Strategy seeking to make the health of the most deprived improve the fastest.

The International Day of Older People would be celebrated on 1st October 2018 and members noted the request for them to sign up in support.

Joanne Volpe reported on the Memorandum of Understanding – part of a 5 year partnership between LCC, Leeds Older Peoples Forum and the Centre for Better Ageing. Of the seven key issues identified by the World Health Organisations, 3 priority areas had been identified by Leeds older people:

Community Transport – Consultation had identified that there were a number of providers which presented older people with a complicated contact process for booking journeys. A business case for funding had been submitted to Leeds Passenger Transport Improvement programme (LPTIP) seeking to implement a pilot scheme to bring all the providers under one telephone number contact point to better connect service users with multiple providers. The Board was assured that the scheme would not replace existing provision and were asked to consider how members could support this.

The Board noted that Leeds Teaching Hospital Trust (LTHT) was undertaking a review of patient transport which could link to the initiative, and noted comments seeking assurance that the pilot scheme would take account of local needs. Comments identified that although St James's and Leeds General Infirmary provided shuttle buses for staff between the two sites, patients had to use public transport; community transport provision buses had limited space for wheelchair users; and the new contact number should not have multiple choice questions.

Community Contributions – Statistics showed that the uptake of volunteering was lower in areas of deprivation. The Board was asked to consider how it could encourage informal volunteering and how the findings could inform the evolving Local Care Partnerships.

Comments reiterated that the involvement of the Third Sector was at the core of the Local Care Partnerships, but identified that it would be useful for the Board to receive a breakdown of the data to identify those areas where Board support could bring added value. Discussion considered the process for volunteers to get involved; the role of Leeds Carers Association; local faith communities and the involvement of younger and older people.

Housing Strategy – The key issue raised was that most older people preferred to remain in their own home for as long as possible; and sought to ensure that older people knew the options available for them and where to access information/support to remain at home.

Discussion identified the need to respond to older peoples' housing needs in the local Development Plan documents for Leeds, to encourage development of a mix of suitable homes, including bungalows, with a higher volume of affordable, accessible homes and an adequate private-rented sector. The Board noted comments that developers did not regard this provision as commercial, however wider discussions on how the population will age and how support for older people's independence is provided could draw them into the ambition. There is a need to consider the wider design of communities – thinking beyond the dwelling to the neighbourhood – when planning for later life. Future work must consider the wider aspects of wellbeing. The Board noted the intention to provide approximately 1000 extra care homes/units during the next 2 years and considered whether it would be appropriate for a housing representative to join the Board.

The Board additionally identified that the Age Friendly Charter:

- provided an opportunity to focus attention and raise issues over how the Board aims to achieve Age Friendly Leeds;
- promotes inter-generational work, ensuring older people are aware of their responsibilities as well as young people acknowledging their future responsibilities;
- challenges stigma.

Come in and Rest Campaign – Led by Time To Shine, which sought to encourage older and socially isolated people to come into town - through the provision of "rest-stops" for older people to take short breaks - 117 businesses and organisations had signed up to the initiative. Further information on other use-able buildings for the initiative from members would be welcomed. Dr Walling suggested that this be promoted in every GP practice in Leeds and Jim Barwick offered to help publicise the campaign in GP surgeries and it was suggested that the LCC Community Committees could also publicise the initiative.

Measuring achievement – Monitoring of the Age Friendly pledges would allow measurement of achievements, and seek to ensure that signatories understood their commitment to the Charter and acted upon it.

Digital Literacy – The Age Friendly documents should reference the importance of digital literacy for older people for them to connect with services, commissioning and education, particularly the move to Person Held Records

RESOLVED -

a) To recognise the impact of the Age Friendly programme of work as detailed in the Annual Report.
b) To recognise that the Age Friendly programme of work is a good example of cross council and partnership working to maximise impact and outcomes for the citizens of Leeds.
c) To consider specifically how the partnership with the Centre for Ageing Better could use the findings from its research on community contribution to support 'Leeds Left Shift' ambition to motivate and boost the abilities of communities to increase wellbeing of local older people from BME communities.
d) To consider how the partnership work on community transport could align with and strategically inform any future plans for transport within health.
e) To consider what key issues are needed to shape the Information and Advice on Housing Options work programme, and specifically how this can be integrated with health and care services.

10 Leeds Commitment to Carers

Val Hewison, Chief Executive of Carers Leeds, introduced the report which detailed the variety of activity that has taken place since the HWB endorsed the Leeds Commitment to Carers campaign in February 2017.

Key milestones included:

- The campaign now had 45 pledges from businesses and organisations across the city;
- The Leeds CCG provided funding for a participation worker to be employed by Carers Leeds;
- Understanding that the average age of a career in Leeds is between 35 and 55 years old, which dispels the myth that carers tend to be elderly, and presents an argument to further consider the financial impact on carers of working age;
- The Carers Action Plan 2018-20 was recently published by the Department of Health and Social Care, which details 64 actions across 5 priorities;

The Chair queried how Carers are identified and was informed that schools and GPs are currently the main source of referrals. The Chair reinforced the Board's support to Leeds Carers' week which was currently taking place, and informed members of the intention to take a report to Leeds City Council's Executive Board on 27th June 2018 to seek further support for unpaid carers in Leeds and the crucial role they play in sustaining health and social care in the city.

RESOLVED –

a) To note the progress to date that has been made by the Leeds Carers Partnership;
b) To note the opportunity to advance the carers agenda provided by the development of Local Care Partnerships;
c) To note that the Leeds Commitment to Carers is not the only way we are improving identification, recognition and support for unpaid carers in Leeds.
d) To encourage Health and Wellbeing Board member organisations to promote the Leeds Commitment to Carers.

11 Update on the Leeds Cancer Programme

The Board considered the report of the Leeds Integrated Cancer Services Programme Board, presented by Professor Sean Duffy and Doctor Sara Forbes.

Following the launch of the National Cancer Taskforce Strategy in 2015, the cancer system across Leeds signed up to working as an integrated system to deliver change. The report shared progress to date in response to the local and national challenges set; public and patient engagement and work programme updates. The key priorities were highlighted as:

- Prevention and awareness
- Early diagnosis
- Living beyond cancer
- Provision of a high quality modern service

Additionally, support was sought to explore the opportunity to develop cancer aware communities aligned with the emerging primary care delivery models through Local Care Partnerships. The Board's discussions covered the following matters:

- The correlation between diagnosis and areas of deprivation, and how the use of statistical information will inform use of resources
- The impact of new developments in medication and treatment on future treatment sites
- The role of pharmacists and dentists in early diagnosis
- Community engagement, noting that some community uptake was low, with language perhaps being a barrier to access.

Members identified the following actions proposed to take forward work to support the Strategy:

- Presentation of the Strategy to LCC Community Committees to further engage and inform residents, particularly in areas of deprivation where there was a correlation with diagnosis
- Links to the elective prescribing system being developed by LTHT which could identify risky behaviours
- Links and contact details for local communities to be provided for future engagement work

RESOLVED –

a) To note the progress, outcomes and actions taken to date in the Leeds Cancer Programme
b) To note the contents of the discussions which may inform the development of a vision for cancer aware communities
c) To support engagement with communities and constituents

12 UNICEF UK Baby Friendly Initiative in Leeds

Sally Goodwin-Mills, Advanced Health Improvement Specialist (LCC), introduced the report highlighting the progress of work in relation to the UNICEF Baby Friendly Initiative (BFI) and how it supports the Health and Wellbeing Strategy 2016-21. Members were provided with a presentation outlining the long term benefits of breast feeding both for mother and baby, and the role breast feeding has in ensuring that every child has the 'best start' in life:

- Leeds breastfeeding rates were just below the national average,
- In Leeds 50% of mothers who breastfeed, continue to do so past 6 months
- The baby friendly initiative also provided advice and support for safe bottle feeding
- One of the aims of the presentation was to make the Board aware of the International Code of Marketing of Breastmilk substitutes, which regulates the marketing of breast-feeding substitutes and to highlight that the UK law is significantly weaker than the Code

In conclusion, the Board noted that as part of the UNICEF global programme, all Leeds Teaching Hospital Trust staff had received relevant training and joint work between Public Health and Health Visiting had been undertaken towards the BFI Gold Award.

The Chair commented on the importance of making space available for breast-feeding and noted there were a number of factors which prevented new mothers continuing to breast-feed once they were at home with baby.

Wider discussions should consider the support structure at home, the rest of new baby's family and what Board members and LCC could do to support the family.

RESOLVED -

a) To retain an awareness of the importance and value of breastfeeding for the health and wellbeing of families today and for future generations.
b) Noted the importance of promoting, supporting and protecting breastfeeding policy in all areas where appropriate.
c) Considered and noted the impact of implementing the Code of Marketing of Breastmilk Substitutes - to protect babies and their families from harmful commercial interests.
d) To take opportunities to promote a positive breastfeeding culture, to normalise and support city centre venues, public transport, and workplace.
e) To be aware of challenges and opportunities and communicate these to the BFI Guardian.

13 Annual Report of the Director of Public Health

Dr Ian Cameron presented his report – the Annual Report of the Director of Public Health – highlighting the key issues for Leeds as being infant mortality, alcohol related mortality, female alcohol related mortality, male drug related deaths and specifically in older heroin users, male suicides and self-harm by young women.

Dr Cameron also sought to ensure that the work of the Leeds Health and Wellbeing Board fed into the 12 Big Ideas contained in Leeds Inclusive Growth Strategy. In respect of specific statistics and issues contained in the Annual Report, the Board considered the following:

Chronic Vascular Disease (CVD) – In response to a query over what was being done to address CVD as the statistics showed Leeds to record a quarter more incidences than the national average, Dr Cameron provided assurance that Leeds had made improvements during the last 10 years, the gap had narrowed between the most deprived and the most well-off leading to some health improvements

Dental health and tooth decay – Dr Cameron reported that an Oral Health Strategy had been presented to Scrutiny Board (Adults, Health and Active Lifestyles), with work planned to review and compare Leeds results with other authorities – the findings to be reported to the Chair in the first instance with a view to reporting to the Board in the future

Cancer statistics – The lack of improvement in cancer was noted, along with the report that as national definitions were changing, it was not yet possible to undertake comparative work with other authorities

Suicide rates – It was noted that some initiatives were being undertaken, but their success on a local level had yet to be measured. Every suicide where the person was known to service providers triggered an investigation;

however, the numbers involved were too low to undertake a meaningful assessment of whether enough was being done to support those prior to taking their own lives. The Board also noted comments that there were lots of factors to each individual suicide. Looking ahead to the proposed July 2019 workshop (Held jointly with the Health and Wellbeing Board and the Children and Families Trust Board), consideration of the effect of parental suicide, parental health and choices on the children of the family was noted as a theme for discussion.

The Board also noted that the report sought support from members and partners to further reflect on gender differences in health within the services and monitoring arrangements provided by their individual organisations, having regard to the findings of the Annual Report.

RESOLVED –

a) To note the content of the Annual Report of the Director of Public Health and support the recommendations on infant mortality, alcohol related mortality, female alcohol related mortality, male drug related deaths, suicides in men; and self-harm by young women.
b) To request that Public Health consider the findings of the Public Health England national review into life expectancy and report back to the Board on any implications for Leeds.
c) To seek to ensure that gender differences in health, experiences and outcomes are incorporated into the forthcoming Joint Strategic Assessment and the subsequent recommendations
d) To consider how Board member organisations currently reflect gender differences in health in their services and what further actions are needed in relation to the Director of Public Health report.
e) To consider how Board member organisations currently reflect gender differences in health in their monitoring arrangements and what further actions are needed in relation to the Director of Public Health report.

14 West Yorkshire and Harrogate Health and Care Partnership Update

The Board considered the report of the Head of Regional Health Partnerships, Health Partnerships Team providing an update on the West Yorkshire and Harrogate Health and Care Partnership (WY+H HCP). The report noted that on 25th May 2018, NHS England and NHS Improvement jointly announced that WY+H HCP would be one of 4 areas to be part of the Integrated Care System (ICS) Development Programme and outlined some of the information about being part of the ICS in Development Programme.

Rachael Loftus presented the report, highlighting the intention for ICS to both improve outcomes and peoples experience of the care they receive. Additionally, development of the ICS will focus on:

- Sharing great practice from across the whole system – ensuring that we all benefit from the successful learning and innovation from our near neighbours
- Having a close eye on where there is variation in outcomes across different areas and taking action accordingly, as a system
- Analysing where further investment will significantly increase the pace of change.

Discussions identified the following issues:

- That this approach is about improving the outcomes and service offer for citizens and our communities
- One of the central principles of the partnership is to work locally wherever possible, and determine when we need a critical mass to work at a larger geographical scale
- A more in depth paper and conversation will be coming back to the September Board
- WY+H HCP is recognised as a partnership with strong local government, elected Member and Third Sector representation – this is part of what is allowing us to have the conversations and ability to shape the national agenda locally
- The vision of improving the health of the poorest the fastest is a vital part of the work of this Board; it is nationally recognised and has heavily influenced the approach at West Yorkshire and Harrogate level.

RESOLVED –

a) To note the decision by NHS England and NHS Improvement to include West Yorkshire and Harrogate Health and Care Partnership in the next wave of Integrated Care Systems in Development
b) To note the intention to provide a further report to the next meeting

15 For Information: iBCF (Spring Budget) Q4 2017/18 Return and BCF Performance Monitoring Q4 2017/18 Return

The Board received for information, a copy of the iBCF Spring Budget and the Better Care Fund 2017/18 Quarter 4 returns.

RESOLVED -

a) To note the contents of the Leeds iBCF Quarter 4 2017/18 return to the Ministry for Housing, Communities and Local Government and;
b) To note the content of the Leeds HWB BCF Performance Monitoring Q4 2017/18 return to NHS England.

16 For Information: Leeds Health and Care Quarterly Financial Reporting

The Board received, for information, a report from Leeds Health and Care Partnership Executive Group (PEG) which provided an overview of the financial positions of the health & care organisations in Leeds, brought together to provide a single citywide quarterly financial report.

RESOLVED – To note the 2017/18 end of year position and the 2018/19 financial plans.

17 For Information: NHS Leeds Clinical Commissioning Groups Partnership Annual Reports 2017-2018

The Board received an extract from the final NHS Leeds CCG Annual Report 2017-2018 entitles “CCGs role in delivering the Leeds Health and Wellbeing Strategy 2016-2021”, for information.

A final draft of the report had been shared with Members for comment prior to its submission to NHS England by 20th April 2018. The report provided assurance that all arrangements agreed at the HWBB meeting on 19th February 2018 had been actioned.

RESOLVED – To note the extract from the final NHS Leeds CCG Annual Report 20178-2018 “CCGs role in delivering the Leeds Health and Wellbeing Strategy 2016-2021”

18 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next formal Board meeting as 5th September 2018 at 10.00 am (with a pre-meeting for Board members at 9.30 am)