Board Meeting (held in public)
Friday 7 December 2018, 9.00am – 12.00noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2018-19 (65)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2018-19 (66)	Declarations of interest	Neil Franklin	N
9.10	2018-19 (67)	Questions from members of the public	Neil Franklin	N
9.15	2018-19 (68)	Patient's story: Community Falls Service	Steph Lawrence	N
9.30	2018-19 (69)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 5 October 2018 b. Actions' log c. Minutes from the Annual General Meeting held on 18 September 2018	 Neil Franklin Neil Franklin Neil Franklin	 Y Y Y
		Quality and delivery		
9.40	2018-19 (70)	Chief Executive's report	Thea Stein	Y
9.50	2018-19 (71)	Committees' assurance reports: a. Charitable Funds Committee: 30 October 2018 b. Nominations and Remuneration Committee: 2 October 2018 c. Audit Committee: 19 October 2018 d. Quality Committee: 22 October 2018 and 26 November 2018 e. Business Committee: 24 October 2018 and 28 November 2018	 Brodie Clark Neil Franklin Jane Madeley Ian Lewis Brodie Clark	 Y Y Y Y Y
10.10	2018-19 (72)	Performance brief and domain reports	Bryan Machin	Y
10.25	2018-19 (73)	Significant risks and assurance report	Thea Stein	Y
10.35	2018-19 (74)	Neighbourhood teams' activity	Sam Prince	Y
10.40	2018-19 (75)	Serious incidents summary report	Steph Lawrence	Y
10.50	2018-19 (76)	Patient experience report	Steph Lawrence	Y
10.55	2018-19 (77)	Freedom to Speak Up Guardian Report	Thea Stein	Y
11.05	2018-19 (78)	Guardian for Safe Working Hours Report	Turlough Mills	Y
11.15	2018-19 (79)	Health Education England self-assessment return	Ruth Burnett	Y
		Strategy and planning		
11.25	2018-19 (80)	Professional strategy	Steph Lawrence	N
11.30	2018-19 (81)	Well Led Framework self-assessment update	Thea Stein	Y
		Reports		
11.40	2018-19 (82)	Equality and diversity report	Jenny Allen/Laura Smith	Y
		Governance		
11.50	2018-19 (83)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2018-19 (84)	Approved minutes (for noting): a. Quality Committee: 24 September 2018 and 22 October 2018 b. Business Committee: 26 September 2018 and 24 October 2018 c. Audit Committee: 19 July 2018 d. Charitable Funds Committee: 22 June 2018 e. Leeds Health and Wellbeing Board: 5 September 2018 f. Leeds Safeguarding Adults Board: 20 July 2018	Neil Franklin	 Y Y Y Y Y Y
12.00	2018-19 (85)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public) Friday 1 February 2019, 9.00am - 12noon v6 28 11 2018

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

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

AGENDA ITEM 2018-19 (69a)

Friday 5 October 2018, 9.00am – 11.45am

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Interim Executive Medical Director
	Steph Lawrence	Acting Executive Director of Nursing
	Jenny Allen	Director of Workforce, Organisational Development (OD) and System Development
	Laura Smith	Director of Workforce, Organisational Development (OD) and System Development
Apologies:		
In attendance:	Diane Allison	Company Secretary
	Jaquie Clark	Clinical Quality Lead (North) (for Item 49)
	Sam Whitehead	Health Case Manager Assistant (for item 49)
Minutes:	Liz Thornton	Board Administrator
Observers:	Roohi Collins	Insight Programme participant
	Philip Wyre	HR Advisor
Members of the public:	No members of the public in attendance	

Item	Discussion points	Action
2018-19 (46)	**Welcome and introductions** The Chair welcomed Board members and observers to the meeting. **Apologies** None. **Opening remarks** The Chair welcomed Steph Lawrence, Acting Executive Director of Nursing who was attending her first meeting as a member of the Board.	

2018-19 (47)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2018-19 (48)	**Questions from members of the public** No members of the public were in attendance. No questions had been notified in advance of the meeting.	
2018-19 (49)	**A patient's story** The Acting Executive Director of Nursing introduced the patient's story item and welcomed Jaquie Clark, Clinical Quality Lead (North) and Sam Whitehead, Health Case Manager Assistant to the meeting to speak about the Health Case Management Service and provide feedback from a service user on their experience of the service. The Clinical Quality Lead explained that the Health Case Management Team was a relatively new service which operated seven days a week, providing timely case management for patients who had complex needs and were eligible for NHS fast track and continuing healthcare funding. The patient was too ill to attend to tell his story but had shared his reflections with the team and agreed that this feedback could be presented to the Board. The patient had been discharged from hospital and was receiving end of life care. He wanted to continue to live as fully as possible and participate in all the social activities he and his partner enjoyed. He was particularly pleased about the holistic nature of the support the team provided at home which included medical, nursing, and social care and the range of equipment which the team had sourced to make him more comfortable. He said that the staff had been proactive, responsive and honest about the nature of his condition and pragmatic about the support they could provide. Overall the patient felt he had a far better quality of life than he had ever envisaged when he had woken up in the intensive care unit at Leeds General Infirmary in February 2018. Within the physical limitations of his disease he said that he was living a full and rewarding life thanks to the support he received from all aspects of the Health Case Management Service. He was confident that that this support would continue as his condition deteriorated and his needs changed. The patient had made some observations about what could be better and asked that these also be shared with the Board. He had highlighted the difficulties he had experienced in replacing certain medications for example on one occasion he bought syringes himself because a supplier had failed to deliver them. He also said that there was a lack of clarity as to what items he had to pay for himself or the neighbourhood team, sleep service or GP surgery could provide. In response to a question from a Non-Executive Director (RG), the Clinical Quality Lead said that currently the team were managing approximately 400 patients with a combination of nursing, long term and end of life care needs. Board members were interested to learn more about recruiting staff to the service and asked what kind of qualities were needed by staff working in the team. The Clinical Quality Lead explained that a mix of social workers and clinical staff had transferred from the Joint Care Management Service when the Health Case Management Service had been established. Most staff recruited to the team had background and experience in adult social care but there was also a focus on the development and progression for staff internally within the service.	

	The Trust Chair thanked the team on behalf of the Board for taking the time attend and provide an impressive account about the support they provided to patients with serious and complex health problems.	
2018-19 (50)	**Minutes of the previous meetings held on 3 August 2018 and 7 September 2018 matters arising**	
(50a)	**Minutes of the meeting held on 3 August 2018** The minutes were reviewed for accuracy and agreed to be a correct record. **Minutes of the meeting held on 7 September 2018** The minutes were reviewed for accuracy and agreed to be a correct record.	
(50b)	**Items from the actions' log** The completed actions from previous meetings were noted. There were no other matters arising from the minutes.	
(50c)	**Assurance reports from sub-committees** **Item 50c(i) – Quality Committee held 24 September 2018** The report was presented by the Chair of the Committee and Non-Executive Director (IL) who highlighted the key issues discussed, namely: • **Service spotlight –** the Committee had received a presentation from the Community Falls Team. The Service provides a single point of referral for non-urgent falls, including a triage process to ensure patients were provided with the most appropriate service to meet their needs. The Committee had heard how the team received approximately 180 referrals per month and the increasing complexity of the assessments and interventions required was a challenge. • **Performance brief August 2018 (safe domain) –** the Committee was advised that 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. • **Hannah House –** the Committee was maintaining a focus on Hannah House and received a report at each formal meeting. The Committee had been pleased to learn that there had 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 was now much more positive. • **Clinical Outcomes Programmes –** the Committee received an update on the Clinical Outcomes Programme. The Committee heard that the programme had been embedded into the Trust's 'plans on a page', and linked to the CQC's effectiveness domain. The Committee also received examples of good practice, including the CAMHS Service and Podiatry. A further paper would be presented to the Committee in November 2018 as a more defined and shorter term plan was required. **Item 50c (ii) – Business Committee held 26 September 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 the report and preliminary action plan provided reasonable assurance. • **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. • **Productivity –** the Committee received an update from the newly established Productivity Group. The group's initial focus would be on services where a number of measures were a cause for concern to consider whether any additional support was required. • **E-rostering –** the Committee had learned that since it had approved the the business case for the 'Allocate' rostering system in June 2018, the project has been in mobilisation phase in readiness for implementation in a number of teams across the Trust. The Committee agreed that Non-Executive Director (RG) would review the project initiation document and he would provide feedback to the Committee. The Trust Chair noted the recent positive developments on the implementation of the e-rostering project and asked that the Board receive regular update reports on progress. **Action:** Update reports to the Board to be included in the assurance reports from the Business Committee. **Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted.	**Company Secretary**
2018-19 (51)	**Chief Executive's report** The Chief Executive presented her report which included: • Annual General Meeting held on 18 September 2018 • Community Dental Service (CDS) contract • Emergency planning major incident response • Winter planning – agreed winter plan *CQC Local System Review of Health and Social Care in Leeds* In response to a question from a Non-Executive Director (JM), the Executive Director of Operations reported as part of the CQC Local System Review of Health and Social Care in Leeds the team of inspectors would be visiting the neighbourhood teams, SPUR and the bed bureau, holding focus groups with staff and conducting one to one interviews with a number of directors. Initial feedback from the review would be provided at the end of the visit and a full report provided to the Leeds Health and Wellbeing Board. The Executive Director of Operations agreed to e-mail a copy of the final report and outcomes to Board members when it was made available. **Action: The Executive Director of Operations to circulate a copy of the final CQC system review outcome report to Board members.** *Winter planning* The Executive Director of Operations reported on the winter planning programme and drew Board members' attention to the six key work streams and the Senior Responsible Officers. No further 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 Operations**

2018-19 (52)	**Leeds Providers Integrated Care Collaborative – Committees in Common: Draft Memorandum of Understanding** The Chief Executive presented the draft Memorandum of Understanding (MOU) for the Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common (CiC) for discussion and final approval. The Company Secretary highlighted some minor changes in format which had been requested by the Board at Leeds and York Partnership NHS Foundation Trust and these were noted by the Board. A Non-Executive Director (BC) said that he was generally supportive of the process and procedures laid out in the MOU but had concerns about the failure to consult and engage with the community and public in Leeds during its development. He also noted that the proposal was for meetings of the committee to take place in private. The Chair said that he would be Chairing the next LPICC CiC and would raise the Board's concerns about engagement and involvement at that meeting. **Outcome:** The Board approved the LPICC CiC Memorandum of Understanding.	
2018-19 (53)	**Leeds General Practice Confederation/Leeds Community Healthcare – Committees in Common: Memorandum of Understanding** The Chief Executive presented the paper which formally outlined how the two organisations could work together on an agreed set of work priorities within their own governance arrangement. Also included in the paper were the Terms of Reference which outlined how the Committees in Common (CiC) would function. The Chief Executive informed the Board that the Memorandum of Understanding (MoU) was not a legal contract but a formal agreement between the two partners. A Non-Executive Director (IL) felt that the name of the collaborative should be reviewed and changed to better reflect the vision of closer working between community teams and GP practices. The Chief Executive agreed and reported that this would be considered at a development session planned for 6 November 2018. The Board discussed the proposal made by the two parties in the collaborative that the Committees in Common (CiC) received delegated approval to commit up to £500,000 for any business case that the CiC considered. In response to a question from Non-Executive Director (JM), the Executive Director of Finance and Resources advised that that the Trust's current scheme of delegation would need to be reviewed and amended to reflect the £500,000 limit. The Chief Executive was very clear that if the Trust's scheme of delegation needed to be reviewed to reflect the greater value proposed then the details would be put to the Trust Board for approval. **Action:** Further work to be undertaken to review the Trust's internal governance arrangements and scheme of delegation. Proposed changes to be presented to the Board for approval in November 2018. **Outcome:** The Board: • agreed in principle to the request for a delegated financial approval limit of £500,000 subject to further work to clarify the Trust's internal governance arrangements and scheme of delegation and any changes approved by	**Executive Director of Finance and Resources**

	the Trust Board in November 2018. • approved the MoU for the CiC to be signed at the CiC meeting scheduled for 27 November 2018.	
2018-19 (54)	***Performance brief and domain reports August 2018*** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during August 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 3 or 4 pressure ulcers reported in August 2018. There were nine admissions which qualified for a VTE assessment in August all with all nine recorded as complete. The Executive Director of Operations reported that since the Performance Brief had been drafted, a MRSA review meeting had determined that a death would be attributed to a community acquired infection although the source could not be determined or attributed to the Trust. ***Caring*** The Trust had inpatient beds in both specialist and children's business units. The percentage of inpatient respondents recommending care had regained its 100% position following a drop in June 2018. The percentage of respondents who would recommend care in the community remained above average. **Effective domain** The measures in this domain are reported quarterly. ***Responsive*** The Trust had performed well in respect of its indicators relating to waiting lists and all were rated green for August 2018. Patient contacts were reported as -14% below profile in August and -7.6% below the position reported in August 2017. ***Well-led*** Appraisal rates had demonstrated an improvement of 4.7% in August 2018, achieving an overall organisational level of 83.26%. The sickness absence rate for August 2018 was 5.64% (1.57% short term and 4.07% long term), which remained below the outturn target for 2018/19 of 5.8%. Turnover and stability rates were better than for the same period in 2017. ***Financial position*** The Trust was £0.2m underspent at the end of August 2018. Pay costs were higher than July 2018 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 remained 15% below the agency cap for the year to date. Cost savings plans continued to be 4.5% below expected levels however savings in procurement occur as the year progresses. Cash was running £0.4m less than planned. The Board noted that the major financial risks related to the £1.2m unidentified	

	savings in respect of the CCG decommissioning plan and any shortfall in the delivery of planned cost savings. In response to a question from a Non-Executive Director (JM), the Executive Director of Finance and Resources reported that to date no written confirmation had been received from the CCG in relation to mitigating the loss of £1.2 million of income. The Executive Director of Finance and Resources reported on an offer from NHS Improvement (NHSI) to convert a £0.5 million additional revenue underspend in this financial year into a £1.5 million additional capital resource in 2019/20. He sought approval from the Board to accept the offer from NHSI. A Non-Executive Director (JM) sought assurance that increasing the control total during this financial year would not impact on services. The Chief Executive advised that the Senior Management Team had considered the offer form NHSI in detail. As a result of the successful award of the 0-19 service and Community Dental tenders, SMT were confident that any increase in the control total would not adversely impact on services as resource held against the risk of losing those services could now be released. **Outcome:** The Board approved acceptance of the offer from NHSI to convert a £0.5 million additional revenue underspend in this financial year into a £1.5 million additional capital resource in 2019/20. **Outcome:** The Board noted the Trust's performance for August 2018.	
2018-19 (55)	**Report on 2018-19 Operational Plan Priorities** The Executive Director of Finance and Resources presented the report which provided an overview of progress towards achieving the Trust's priorities set out in the 2018/19 operational plan at the end of month five and a forecast for the year-end. The Board noted that good progress had been made across most priorities and that the report had been considered in detail by the Senior Management Team and the Business Committee. In response to a question from a Non-Executive Director (IL), the Acting Executive Director of Nursing reported that work was underway to ensure that there was a clear link between clinical audit and quality improvement and regular progress update reports would be made to the Quality Committee. Referring to Priority 9: Neighbourhood Team self-management model, a Non-Executive Director (JM) observed that a significant amount of progress would need to be made to achieve green status by the end of the year. **Outcome:** The Board noted the assessment of progress at the end of August 2018 and the forecast for the year end.	
2018-19 (56)	**Organisational development strategy: draft framework document** The Director of Workforce, OD and System Development (LS) presented the paper which provided an update on the development of the Trust's workforce strategy which would be the successor to the existing Organisational Development Strategy (2017-19). She informed the Board that the framework had five key pillars or key themes: organisational development and improvement, resourcing, workforce, systems and	

	intelligence, human resources and system development. Each pillar would have a set of objectives and 'deliverables' and key performance indicators would also be developed. The new strategy had been shared with staff and feedback so far had been positive. A further version of the draft strategy would be brought back to the Board in February 2019 for approval. A Non-Executive (BC) advised that the Business Committee had considered the draft Workforce Strategy at its meeting in September 2018. He welcomed the development of a strategy which was simple and clearly aligned to the Trust's strategic objectives, corporate priorities, vision and values. **Action:** A further version of the draft strategy to be brought back to the Board in February 2019 for approval. **Outcome:** The Board noted the development of the Workforce Strategy (2019-21) and its schedule for engagement and completion.	**Director of Workforce, OD and System Development**
2018-19 (57)	**Workplace Race Equality Standard (WRES) update report** The Director of Workforce, OD and System Development (JA) presented the paper. She reminded the Board that the WRES was introduced in 2015 as part of the standard NHS contract to enable NHS employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. The Director of Workforce, OD and System Development (JA) advised that the Trust were required to report to NHS England and publish against the nine indicators; four related specifically to workforce data, four were based on the NHS staff survey and one considered BME representation on boards. The Board noted the increasing focus within the Trust on the WRES, including staff workshops, external networking events and the successful application to become one of NHS Employers Diversity and Inclusion Partners. The Director of Workforce, OD and System Development (JA) drew the Board's attention to the overarching WRES action plan and supporting detailed action plans which set out the key areas of focus across the nine indicators. She added that the plans would be subject to refinement and regular updates would be provided to the Business Committee. The Trust Chair noted and welcomed the appointment of a black, Asian and minority ethnic (BAME) Project Officer to support work on the WRES. **Outcome:** The Board endorsed the overarching WRES action plan and the supporting detailed action plans and offered their support to drive this agenda forward.	
2018-19 (58)	**Emergency preparedness and resilience report and major incident plan report 2017/18** The Executive Director of Operations presented the paper which provided the Board with an overview of emergency preparedness, resilience and response (EPRR) activity over the last year and identified priorities for 2018/19. The Executive Director of Operations advised that, in addition, the Trust had been required to undertake a self-assessment against the national 2018/19 EPRR core standards and to complete a statement of compliance identifying the organisation's overall level of compliance. The outcome of the self-assessment was also summarised in the paper.	

	The Board noted the three core standards considered 'not fully compliant' and reviewed the Trust's associated action plan; two related to having sufficient trained loggists on a 24/7 basis and one related to the Director of Operation's attendance at the regional meetings. The Executive Director of Operations advised that when she was not able to attend regional meetings the Operational Support Manager attended in her place. The Chair of the Business Committee, Non-Executive Director (BC) advised that the Committee had considered the EPRR annual report 2017/18 at its meeting in September 2018 and had recommended that the Board approve the submission of an overall assessment of 'substantially compliant' against the standards. The Board noted: • The self-assessment proposed that the Trust was compliant with 51 of 54 core standards and all eight of the deep dive standards being compliant. • The EPRR policy which had been developed by the Trust as a new requirement in the 2018/19 standards. • There were three core standards where the Trust was considered 'not fully compliant' and had reviewed the associated action plan. • Approved the recommendation to submit an overall assessment of 'substantially compliant' against the standards (in line with national guidance).	
2018-19 (59)	**Infection prevention and control annual report 2017/18** The Acting Executive Director of Nursing presented the report which provided information and assurance to the Board in relation to infection prevention and control activities within the Trust and assurance that the organisation was compliant with current legislation, best practice and evidence based care. The Trust Chair commended the work of the team particularly in achieving 75% uptake in the staff flu campaign; the top community trust in England in 2017/18. The Executive Director of Finance and Resources noted that the Quality Committee had determined that the report provided a reasonable level of assurance and the Board considered what more could be done to achieve substantial assurance. The Chair of the Quality Committee and Non-Executive Director (IL) observed that in his opinion the level of assurance could be raised if the Trust's Infection Prevention and Control Service was subject to an external review. This could equally apply to judgments made about many other services across the Trust. **Outcome:** The Board approved the infection and prevention control annual report 2017/18 and approved the work programme for 2018/19.	
2018-19 (60)	**Safeguarding annual report 2017/18** The Acting Executive Director of Nursing presented the report which reflected the close partnership working between the Trust's frontline services, the multi-agency partnership particularly commissioners, Leeds Safeguarding Children Partnership, Leeds Safeguarding Adults Board and Safer Leeds. The Chair of the Quality Committee and Non-Executive Director (IL) advised that the Committee had reviewed the report and noted that whilst the Children's safeguarding section was rich in data, the Adult's safeguarding section did not provide the same level of detail for assurance purposes. The Committee had asked for more data to be included in future reports to improve the level of assurance it provided.	

	Outcome: The Board approved the safeguarding annual report 2017/18.	
2018-19 (61)	**Significant risk and Board Assurance Framework** The Company Secretary presented the report which comprised: • the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures. It also provided an analysis of all risk movement, presented the risk profile, identified themes and linked risks to the strategic risks on the board assurance framework. • the board assurance framework (BAF) summary report which gave an indication of the current assurance level determined for each of the Trust's strategic risks. The Board noted there were four risks with a current score of 15 or above relating to: • Reduced level of care due to prevalence of staff sickness in particular services and or across the Trust • Difficulties recruiting to and retaining staff within neighbourhood teams • New CAMHS Tier4 building • Risk of delays to new CAMHS Tier 4 service model The Board discussed the scoring of individual risks and in particular how target scores against each risk were determined. It was agreed that more narrative should be included in reports to the Board to explain the discussion around target scores at committee level. More narrative should be included in reports to the Board to explain how escalated and target risk scores have been derived. **Action:** Future risk register reports to include more narrative on calculation of escalated and target risk scores. **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	**Company Secretary**
2018-19 (62)	**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 (63)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information: a. Quality Committee: 25 June 2018 and 23 July 2018 d. Business Committee: 27 June 2018 and 25 July 2018 e. Leeds Health and Wellbeing Board minutes: 14 June 2018	
2018-19 (64)	**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 7 December 2018, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair:
Date: 7 December 2018

AGENDA ITEM 2018-19 (69b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 7 December 2018

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting Friday 5 October 2018				
2018-19 (50c)	**Business Committee Assurance report:** *e-rostering project:* The Board to receive regular updates on progress via Business Committee assurance reports.	Company Secretary	Ongoing	
2018-19 (51)	**Chief Executive's report:** *CQC Local System Review of Health and Social Care in Leeds*: a final copy of the CQC report to be circulated to Board members when available.	Executive Director of Operations	When the report is available Ongoing	
2018-19 (53)	**Leeds General Practice Confederation/Leeds Community Healthcare – Committees in Common:** Memorandum of Understanding: Further work to be undertaken to review the Trust's internal governance arrangements and scheme of delegation. Proposed changes to be presented to the Board for approval in November 2018.	Executive Director of Finance and Resources	Trust Board in November 2018 – if required	Completed
2018-19 (56)	**Organisational development strategy: framework document:** Further draft to be presented to the Board for approval in February 2019.	Director of Workforce, OD and System Development	Trust Board 2 February 2019	
2018-19 (62)	**Significant risks and Board Assurance Framework (BAF) report:** Future risk register reports to include more narrative on calculation of escalated and target risk scores.	Company Secretary	Trust Board December 2018	Completed

Actions on log completed since last Board meeting: 5 October 2018	
Actions not due for completion before 7 December 2018; progressing to timescale	
Actions not due for completion before 7 December 2018; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 7 December 2018; not having met agreed timescales and/or requirements	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (69c)

Leeds Community Healthcare NHS Trust
Annual General Meeting – 2016

Thackray Medical Museum, Beckett Street, Leeds LS9 7LN

Thursday 18 September 2018, 1.00pm – 2.00pm

Present:	Brodie Clark	Trust Board Vice Chair
	Thea Stein	Chief Executive
	Dr Tony Dearden	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	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:	Neil Franklin	Trust Chair
	Marcia Perry	Executive Director of Nursing
	Jenny Allen	Director of Workforce, Organisational Development (OD) and System Development
In attendance:	Diane Allison	Company Secretary
Minutes:	Liz Thornton	Board Administrator
Observers and members of the public:	86 members of staff and members of public attended	

Item	Discussion item
1.	**Welcome and introductions** The Trust Vice Chair welcomed everyone to the Trust's 2017/18 Annual General Meeting (AGM) on behalf of the Board of directors. He advised that he was deputising in the absence of the Trust's Chair, who was unable to attend the meeting but had conveyed his best wishes for the AGM. The Trust Vice Chair said that 2017/18 had been a great year for the Trust in terms of the significant improvements made in the standards of care and managing within its allocated finances whilst continuing to keep the patient at the heart of its business. Early last year, as a result of an inspection by the CQC the Trust was judged as a 'Good' organisation overall with a number of key areas of its work being singled out as exceptional in both the quality and effectiveness of delivery. He said that this was a tough

	test and the result was well-earned across the organisation. The Trust Vice Chair said that staff in Trust should be proud of their achievements and thanked them for their hard work and determination to provide the most effective care for the people of Leeds and beyond often in very difficult circumstances. He said that the challenges facing the NHS nationally and locally were complicated and uncertain in terms of re-organisation and re-structuring but the Trust would not lose sight of its responsibilities to the community and the people it served. He spoke about the priorities of maintaining the highest quality services for the people of Leeds; the importance of effective partnerships with other health and social care providers and the importance of exploring new and effective ways of delivering our work, such that ensures we continue to work within our allocated funds. The Trust Vice Chair briefly outlined the format for the formal part of the meeting. The Chief Executive would present a review of the 2017/18 year and the Executive Director of Finance and Resources would present the Trust's 2017/18 annual accounts. A number of the Trust's Executive and Non-Executive Directors were present and there would be an opportunity for questions at the end of these presentations. The Trust Vice Chair advised that, as the Annual General Meeting was a formal meeting of the Leeds Community Healthcare NHS Trust Board, it would minuted in the same way as all Board meetings, the minutes would be published on the Trust's website in the papers for the Board meeting on 7 December 2018.
2.	**Chief Executive's presentation – reviewing the year 2017/18** The Chief Executive presented a review of the previous 12 months. She said that she particularly welcomed this opportunity to reflect on the past year and to recall her aspirations when she had joined the Trust four years ago as Chief Executive; when she had welcomed the opportunity to be part of an organisation which had a clear vision which was used every day to guide the Trust. The Chief Executive said there were many highlights she wanted to speak about and focused on some of the Trust's significant achievements over the past year. The Chief Executive said she and other Board members were impressed by the feedback from the Care Quality Commission about the outstanding compassionate care provided by the Trust. The Chief Executive referred to the recent announcement that the Trust had won the tender for the 0-19 services for the city of Leeds which would be launched in April 2019 and encompass health visiting and school nursing services. The UNICEF gold accreditation received by the health visiting service during World Breastfeeding Week; school nurses delivering 54,000 flu vaccinations, the excellent work undertaken to improve waiting times for first assessments by the child and adolescent mental health service (CAMHS); the speech and language therapy staff who had revolutionised the way they worked and shortening waiting times and providing new innovative services to schools and the excellent work undertaken in the neighbourhood teams which was being considered as best practice by other organisations. She expressed her thanks to all community staff and their managers for the resilient manner in which they had faced the challenges 365 days a year.

	This year the Trust had been nominated for a number of Health Service Journal (HSJ) awards including; two nominations in the Compassionate Patient Care category and two nominations for Clinical Leader of the Year. The Chief Executive said that she was also proud of the individual awards won by colleagues such as Jo Reynard who won the national NHS flu fighter award for her efforts in helping the Trust achieve a vaccination rate of 76.8%. In conclusion, the Chief Executive said that 2017/18 had been an exciting year, the Trust had achieved a great deal to be proud of and she looked forward to even greater progress in 2018/19. The Trust Vice Chair thanked the Chief Executive for her report.
3.	**Executive Director of Finance and Resources** **Presentation of annual report and accounts 2017/18** The Executive Director of Finance and Resources provided a presentation and overview of the Trust's annual report and accounts for 2017/18. The Executive Director of Finance and Resources was pleased to report that although the national financial position in the NHS had been placed under considerable pressure, the Trust had maintained financial stability and had met all its key financial duties. The Trust had achieved a surplus of income over expenditure of just over £3 million in 2017/18, exceeding the income and expenditure surplus target set by NHS Improvement by £1.6 million. The Executive Director of Finance and Resources said that the Trust's financial results were only achieved through the hard work of all the staff; balancing their desire to continue to provide high quality care within a finite budget that requires further efficiency savings every year. The Trust was fortunate to have been allocated £13 million of capital resources to develop an in-patient facility for children and young people with mental health needs. The Trust's plans for 2018/19 included the preparation work with a start date for construction early in the new calendar year. The Executive Director of Finance and Resources observed that 2018/19 would be another challenging year financially for the NHS but the Trust was determined to maintain good financial health in order to focus on the delivery of quality of care. The Trust Vice Chair thanked the Executive Director of Finance and Resources for his presentation.
4.	**Question and answer session** The Trust Vice Chair opened this section of the meeting by inviting questions and comments. He said that Trust Board members were in attendance and would assist in answering questions. **Question:** A member of the public was concerned about the services provided to patients who were unable to administer their own medication. Her experience as carer suggested that nurses were only able to undertake initial assessments and did not have time to assist with administering for example eye or ear drops which the elderly and frail sometimes had significant difficulty in doing themselves.

The Executive Director of Operations said that the Trust supported many patients with medicine prompts and the administration of medication where there was a clinical need. She said that staff also worked with patients, their families and adult social care providers to support them with the administration of medication in the short and long term. She offered to speak to the lady following the meeting to learn more about the particular problems she had encountered.

Question:
A member of the public who was a member of the Leeds Deaf and Blind Society asked what the Trust was doing to improve the way in which it communicated with deaf and blind patients.

The Chief Executive acknowledged that the Trust needed to work more proactively with the deaf and blind community and their representative groups. She said that the Trust's Assistant Director of Workforce was undertaking some work to try and ensure that the Trust forged stronger links with the deaf and blind community and she would ask her to make contact to discuss this further following the meeting.

Question:
A member of the public asked about the Improving Access to Psychological Therapies (IAPT) service across the city, the progress being made to ensure that care records were more streamlined across all providers and what the Trust's involvement was in social prescribing.

The Chief Executive said that work was underway to develop the Leeds Care Record which would give clinical and care staff the ability to view health and care information across all care providers. More investment would be needed before the system was ready to use across all organisations.

The Chief Executive said that the Trust was not commissioned to provide social prescribing but staff were able to 'signpost' patients to other services which might improve their health and wellbeing.

Question:
A member of the public was pleased to see the planned investment in mental health services for children but was concerned that many adults had to pay for private therapy sessions.

The Chief Executive said that the vast majority of adult mental health services were provided by Leeds and York Partnership NHS Foundation Trust with Leeds Community Healthcare providing support through IAPT services. She acknowledged that the provision for seeing adults in an emergency crisis situation was not good enough and required more investment but unfortunately there was no quick solution to the problem.

Question:
A member of the public raised concerns about children accessing the Community Adolescent Mental Health Service (CAMHS) and cited her personal experience of a child who had waited a significant length of time for a referral. She had also attended a presentation about the proposed new unit and was disappointed that there was no funding for a Section 136 facility.

The Chief Executive said that she was concerned to hear about the delay in accessing the CAMHS service said she would like to discuss this further after the meeting.

The Executive Director of Finance and Resources said he was hopeful that the

	opportunity might still arise for the new unit to include a Section 136 facility but confirmed that this was not currently part of the funding package. **Question:** A member of the public cited his personal experience of care across a number of providers in the city and said that communication between organisations was particularly poor and following discharge from hospital finding out how to access support and further treatment had been very difficult. The Chief Executive said that the Trust was working proactively with other organisations across the city to improve care for the people of Leeds but she agreed that treatment pathways were not always clear to patients when they were discharged from hospital. She hoped that feedback from patients, carers and families at events such as this would help to inform improvements in the future. The Trust Vice Chair concluded the session by reflecting on some of the common themes that had arisen through the questions. Particularly issues around the need for an improved 'joining up' of services and agendas; the importance of the proposed CAMHS Tier 4 Unit and the need to better identify Leeds Community Healthcare within the community. He concluded the session by commenting positively on the quality and importance of the questions and thanked those who had raised such relevant and pertinent issues.
5.	**Close of the 2016/17 Annual General Meeting** The Trust Vice Chair thanked everyone for attending and closed the formal part of the meeting. He the invited the audience to stay and view a short animation produced by a member of the Trust's Communication 'A Lifetime of Care' Team which showcased some of the services provided by the Trust.
	Date, time and venue of the Leeds Community Healthcare NHS Trust 2018/19 Annual General Meeting: **To be confirmed**

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (**70**)

Meeting: Trust Board 7 December 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. The report aims to highlight areas where the CEO and senior team are involved in work that is taking forward the strategic work of the Trust particularly focussed on system leadership, integrating care, highlighting the key role of community services in keeping people safe at home and ensuring we are working with key stakeholders both locally and nationally.

This month's report continues to report on the key work being undertaken to develop our integration with primary care. This is a key focus of our overall strategy enabling us to drive both better clinical care and ultimately efficiency in the system.

Main issues for consideration

The main features of the report are:

- CQC system review initial feedback
- Leeds Transfer of Care Policy
- GP Confederation and LCH joint workshop
- Preparing for 'Well led' (peer review)
- Overt and Covert recording

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

Recommendation

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategy and particularly our work with stakeholders

Chief Executive's report

1. Trust business

1.1 CQC system review initial feedback

Recently, the Care Quality Commission (CQC) visited Leeds as part of a system review of how health and social care work together in the city to support people over the age of 65. They looked at three things:

- Keeping people at home
- Supporting people at times of crisis
- Helping people get home again after hospital

They have given some initial feedback which has included a number of positive reflections on the work of our own teams. These are:

- Leeds has a strong embedded neighbourhood model which is considered a real strength
- The frontline has a positive approach
- There is good Occupational Therapy support in the community
- There is good end-of-life care, with 85% of people dying in their preferred place
- There is good multi-disciplinary working in Recovery Hubs
- Relationships are strong and there is a collective purpose

The full CQC report will be published in mid-December 2018.

1.2 Leeds Transfer of Care Policy

The Leeds Transfer of Care Policy review has been undertaken by the health commissioners of Leeds on behalf of all health and adult social care organisations within the city as part of the Leeds resilience plan.

The key elements of the policy that have significantly changed are:

- The early conversation and letters to be given to all patients that explain that if the service/equipment required on discharge isn't immediately available, the patient will be required to transfer to a care home facility to await the service.
- At the confirmation of the discharge plan, the patient will be given a formal letter further explaining the need to transfer out of the hospital
- Where a patient requires a care home, the relatives will be given a letter to explain that they have 7 days to come back to discharge staff and social workers with the name of the care home they have identified.
- If the care home identified is not available or cannot take the patient at the time of the decision to discharge, then the patient will be expected to transfer to another care home to await the care home of choice.

This policy has now been accepted by the senior leaders of Leeds health and social care organisations; this was agreed at the Partnership Executive Group (PEG) in September 2018. This is a key plan of the system wide strategy to ensure people receive care in the best place possible.

1.3 **Winter and planning**

The Trust considers maintaining organisational readiness and resilience, and responding to operational pressures to be a year-long function. However, an additional focus is required during the winter period, when it is recognised that demand for services is likely to be at its highest level. The Trust is an active member of the System Resilience Assurance Board (SRAB) which has responsibility for assuring the coordination and delivery of a sustainable system to maintain all health and care services throughout the year including delivery of the Emergency Care Standard. (4-hour A&E target).

SRAB is underpinned by a number of groups with specific responsibilities:

- The Operational Resilience Group (ORG) is an operational multi-agency system group, with responsibility to deliver mandated actions from SRAB
- The Operational Winter Group (a sub group of ORG) has been established with the primary function of supporting the delivery of winter 2018/19 by reviewing the past 7-14 days
- The Operational Delivery Group is a multi- agency group with a focus on discharge
- The 'Hospital Avoidance Group' is a new group which focuses on why people attend the hospital and consider actions necessary to avoid attendances and admitting people to hospital who do not require acute in-patient care.

Internally a winter steering group is now meeting on a fortnightly basis. A winter manager is in place. Priorities for winter 2018/19 include:

- Agreeing how the Trust responds to system pressure. The Trust is part of the mutual aid and escalation arrangements in the city. This has meant detailed negotiations with each partner on how we can support/be supported by other organisations.
- Considering all services within the Trust in terms of requirements to continue during periods of increased demand/reduced capacity. Work continues with each service to determine how staff can best be deployed to meet flow requirements when necessary.
- Working with the short term resourcing group to look at requirements for staffing over the winter period. The group's remit includes working with agencies to provide contracted cover, improving the internal bank (CLASS) offer, recruitment campaign, exploring skill mix opportunities for non-registered staff etc
- Ensuring processes around referrals and allocation are as timely and effective as they can be (eg referral processing time in SPUR is less than 2 hours; pick up of referrals by neighbourhood teams for non-urgent work is within 24 hours)
- Implementing a wide range of staff health and wellbeing measures to ensure staff feel supported throughout the period
- Good communication internally, with partners and with the public
- Ensuring Team LCH volunteers are ready to support services through updating training and offering shadow shifts

A paper has been presented to Quality Committee to ensure that the issues of how quality is ensured during the winter months of increased pressure. The QC will look at some key indicators to monitor quality of care during the winter months and we

continue to consider the best ways of getting patient and carer feedback during this time.

1.4 **Flu vaccine campaign**

The Trust has launched its seasonal flu campaign as part of the Trust's approach to planning for additional service pressures this winter. Year on year, the Trust wishes to see more frontline staff vaccinated to help protect staff, families, communities and vulnerable patients. This year's campaign is well underway and, as at 28 November 2018, 54% of frontline staff have taken up the offer of vaccination. This represents a huge effort by the Trust's infection prevention and control team, and commitment by staff to keep everyone safe and well this winter.

1.5 **Preparing for 'Well led'**

Cambridgeshire Community Services NHS Trust kindly agreed to carry out a peer review of our Trust's Well led self-assessment over two days in November 2018. The Cambridgeshire team reviewed our self-assessment of the CQC's Well led framework and conducted a number of interviews with key members of our staff also meeting with staff and managers in focus groups in order to test the information.

The Freedom to Speak up Guardian is currently working with the Guardian at another local community health provider, Locala to create and deliver mutual peer reviews starting late January.

A verbal update on these two reviews will be provided at the Trust Board meeting.

1.6 **GP Confederation and LCH joint workshop**

Board members from the Leeds GP Confederation and from Leeds Community Healthcare NHS Trust held a joint workshop on 6 November 2018. This was an opportunity for both organisations to come together in an informal setting and discuss their mutual interests and how they can work more effectively together to improve patient outcomes and experience.

Key areas where there was good progress included: work on joint wound care protocols and care, integrated nursing and therapy services in Holt Park, understanding our data to underpin population health management approaches and aligning budgets, development of a joint Bank for staff.

1.7 **BREXIT**

BREXIT is currently an uncertain situation however the Department for Health & Social Care (DHSC) has asked all NHS Trusts to undertake a detailed review of the impact of a no-deal Brexit on their supply chains. Guidance issued to the NHS specifically states that Trusts should not stockpile medicines. Pharmaceutical suppliers have been asked to stockpile an additional six weeks supply of medicines in the UK on top of their usual stock levels. Prescribers have been advised not to write longer prescriptions than normal and patients are being assured, via central routes, that the government has in hand plans to continue medical supplies from the moment the UK leaves the EU. In discussion with LTHT, our largest supplier of the medicines we use for patient care, DHSC advice is being implemented, and any supply issues that arise will be dealt with in the usual way by the specialist pharmaceutical procurement team. We do not envisage the care we provide to patients being compromised.

An initial assessment of what Brexit could mean for our workforce has not identified major risk to the Trust however there could be an extrinsic risk to the Trust regarding domiciliary staff working within social care.

1.8 **Leeds Autism Drop-In Service.**

The ICAN Specialist Health Visiting Team are working with local education and third sector services to provide additional support, advice and signposting for parents and carers as part of the Leeds Autism Drop-In Service.

1.9 **Staff survey response rate**

The current overall LCH response rates stand at 51% (29/11/2018), which is slightly down from the final response rate achieved in 2017 of 54%. The national NHS average currently stands at 40%, and LCH has performed consistently above the national average throughout the 'live' administration phase.

1.10 **Overt and Covert recording**

There is a growing national trend of families covertly recording the care being provided to patients in their homes. Whilst we accept that families are generally within their rights to do this, the Trust does have concerns about safeguarding, privacy and dignity of patients and staff, and the possibility of inappropriate sharing of information. An interim policy based on current guidance is being developed to ensure that risks to patients and staff are managed in consultation with staff-side and union colleagues.

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1.11 **Accreditation of safety huddles**

The Trust has been recognised for the great work that has taken place across the neighbourhood teams with the introduction and accreditation of safety huddles. We are the first organisation in the country to have safety huddles accredited in community settings.

This is excellent work and aligns closely with our quality account priorities and focus on safety and quality improvement

2. News and awards

2.1 **Thank you events**

The annual thank you events are underway with nearly 100 entries across all categories. Members of staff have taken the time to nominate colleagues, projects and teams to celebrate all the great work going on within the Trust. Nominations are now closed, judging has commenced and visits to winners will take place during the first week of December.

2.2 **The Inclusive Top 50 UK Employers List**

The Trust has been named as one of the nation's most inclusive organisations. The Trust has entered the Inclusive Top 50 UK Employers list – after being revealed as number 49, in recognition of its dedication to workplace diversity. This demonstrates the value we place on equality, diversity and inclusivity. The 2018 list, for which there were more than 1,000 entries, was unveiled at the Inclusive Companies Awards in Manchester. The Inclusive Top 50 UK Employers is a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within an organisation. We know we have a lot

further to go but this is a good recognition of the steps we have taken this year and its importance we place on this agenda.

2.3 **Looking back on NHS@70 conference and AHPs Day**

The Trust's NHS@70 conference ***'Then, now and what the future holds'*** took place on Monday 15 October. 125 clinical staff attended including AHPs, student nurses, community nurses and colleagues in primary care including practice nurses. The event included a talk by Betty Smithson who spoke to attendees about what it was like to be a student nurse in 1948 when the NHS was introduced. The day also included discussion about integration and the future direction of nursing and therapy.

2.4 **CAMHS Young People's Engagement Event**

The Trust hosted a creative workshop for young people with some experience of CAMHS to help shape the interior design of the proposed new inpatient unit. The workshop focussed on what colours, furniture styles, and types of flooring young people would want. There was also an opportunity to look at and discuss the layout of bedrooms, day spaces and dining areas.

2.5 **National award for LCH Consultant Clinical Psychologist**

LCH Consultant Clinical Psychologist Sue Ranger has been awarded the Outstanding Contribution to Applied Practice award by the British Psychological Society's Children, Young People & Families Faculty. The award is an outstanding career award for psychologists who have achieved an eminent contribution to the applied practice of psychology for children and/or young people and/or families.

2.6 **Dietetics' Building Better Healthcare awards**

A digital innovation from our Nutrition and Dietetics Service won two awards win at the 2018 Building Better Healthcare Awards in London. The service, supported by the LCH Service Improvement Team and in collaboration with healthcare IT specialists AireLogic Ltd, created an electronic pre-assessment tool for patients seeking dietary treatment for Irritable Bowel Syndrome (IBS). The Functional Gut Disorder (FGD) form allows patients to enter their information via the online tool which is then reviewed by a dietitian prior to their first appointment – saving time on form-filling during appointments and empowering patients.

2.7 **Diabetes Award**

The Trust's work on diabetes has been recognised at the Annual CCG Star Awards in the category of 'Putting Patients First'. This is an award won by the CCG but it recognises the work across the whole pathway – LTHT/LCH and Primary Care. It is a great example of a collaborative approach to developing integrated service pathways.

3. Recommendations

3.1 The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategy and particularly our work with stakeholders

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (71a)

Report to: Trust Board: 7 December 2018
Report title: Charitable Funds Committee 30 October 2018: Committee's Chair assurance report
Responsible director: Chair of Charitable Funds Committee **Report author:** Acting Executive Director of Nursing
Previously considered by: Not applicable

Purpose of the report

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 30 October 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Charitable development updates

There remained a number of outstanding issues from the previous meetings – partly due to a lack of clarity in expectation; partly due to a changeover of key lead personnel and partly due to other Trust pressures.

The key priorities remain,

- Progressing work on an in house lottery scheme. Already some impressive work had moved forward and it now needs to be led more robustly to a successful conclusion.
- Review of the current position as regards the Charitable Funds development Group and its future role is a matter of some urgency. This, in concert with a refocusing of the Trust's approach to patient involvement is an undoubted and immediate requirement.
- The 'More than a Welcome' programme had stalled and the physical aspects of Health Centre 'customer improvement' needed would be grafted into the estates remit alongside the fit for purpose work.

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

Charitable funds: financial report

The Finance report was taken – and reflected a satisfactory position – with most incoming funds and spend directed towards children areas.

The annual report and accounts were signed off and the audit process by the Trust was confirmed as satisfactory.

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

Purpose and direction of the Charitable Funds Committee

The links with the Leeds Cares charity need to be tested further and a meeting was scheduled for such a conversation. The new leadership to the charitable venture was clear on the remit and a December meeting would look to identify progress accordingly.

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

NHS
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AGENDA ITEM 2018-19 (71b)

Report to: Trust Board - 7 December 2018

Report title:
Nominations and Remuneration Committee - 2 October 2018
Committee Chair's Assurance Report

Responsible director:
Chair of Nominations and Remuneration Committee

Report author:
Director of Workforce

Previously considered by: Not applicable

Purpose of the report

This paper outlines the key issues for the Board arising from the Nominations and Remuneration Committee held on 2 October 2018.

Approach to Board appointments and succession planning
The Committee received a paper which provided an update in respect of two Executive Board level posts – this included interim cover for the Executive Director of Nursing role and the absence of the Executive Director of Nursing; and interim cover for the Executive Medical Director role, following confirmation of the retirement of the Executive Medical Director. The Committee agreed to the proposed remuneration for the Acting Executive Director of Nursing, as set out in the paper.

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

Changes to HR policies
The Committee noted that whilst there were no changes to the HR policies to report, some extensions to the review dates of some policies were requested and agreed at a recent JNCF meeting.

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

Clinical Excellence Awards (CEAs) – launch of the 2017/18 process
The Committee noted the outcomes of the 2016/17 CEA process; and received an update on the process to be followed for the 2017/18 CEA process. Action was agreed with respect to maximising CEA application take-up from eligible consultants, particularly amongst underrepresented groups.

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

The Committee also reviewed and approved the work plan for 2019-20.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (71c)

Report to: Trust Board (circulated by email)
Report title: Audit Committee 19 October 2018: Committee's Chair assurance report
Responsible Director: Chair of Audit Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Summary
This paper identifies the key issues for the Board arising from the Audit Committee on 19 October 2018.

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

- Clinical Effectiveness Group
- Estates Management
- Complaints Management.
- Payroll –follow up audit

All had received reasonable assurance.

The Committee expressed particular concern about the range of issues raised in the Complaints Management audit report and thought the implementation timetable associated with the management responses would not address the issues quickly enough. The Chair of the Committee asked that the report be made available to the next Quality Committee and a verbal update provided by the Chair of the Quality Committee to the Audit Committee on 14 December 2018.

The Payroll follow-up audit showed that six of the seven recommendations from the original audit had been implemented. The Chair of the Committee asked for a further update and revised implementation timetable for the outstanding recommendation, which will require a change in the national ESR software, to be provided to the Audit Committee on 14 December 2018.

Counter fraud mid-year update
The Committee received a mid-year report from the Local Counter Fraud Specialist (LCFS); the report included a schedule of training and communications actions to raise awareness of counter-fraud and bribery prevention amongst staff. The Committee noted there were no formal investigations so far in 2018/19 although the LCFS noted that referrals had been made but that none of them required an investigation. The Committee noted that TIAA Cyber specialists had undertaken a Cyber Security Maturity Assessment on how Cyber risks are managed in the Trust. The Chair of the Committee asked for the report on their findings to be made available to the Audit Committee on 14 December 2018.

Data Security & Protection Toolkit baseline assessment
The Committee received assurance that the Trust has a plan in place to achieve the necessary compliance with the Data Security and Protection Toolkit. The Data Security and Protection (DSPT)Toolkit replaces the IG Toolkit as a mechanism for NHS organisations to asses

themselves against the standards of compliance with information governance. The Committee approved the submission to NHS Digital of the Trust's baseline assessment showing compliance with eight out of thirty-two mandatory assertions within the ten data standards by 31 October 2018. Full compliance is required by 31 March 2019.

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

General Data Protection Regulation (GDPR)

The Committee received a progress report on the Trust's actions to achieve compliance with GDPR legislation, which provided assurance that the Trust's GDPR plans are robust and being delivered. The Committee was informed that significant progress had been made with regard to the data mapping exercises throughout the organisation, with 65% completed by the 31 October 2018 and it received assurance that all exercises would be completed by mid-November 2018 which would allow publication of the Trust's data processing activities by 30 November 2018.

The Data Protection Officer confirmed that she believed that the Trust could demonstrate to the Information Commissioner's Office (ICO), if requested, that it is making sufficient progress with the requirements of GDPR. The Data Protection Officer will attend the Audit Committee meeting in December 2018 to provide the Committee with a further update, by which time an internal audit report on progress will have been completed.

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

NHS
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AGENDA ITEM 2018-19 (71di)

Report to: Trust Board (circulated by email)
Report title: Quality Committee (workshop) 22 October 2018: Committee's Chair 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 focussed workshop held on 22 October 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

The Committee has previously agreed to reformat its work plan and to hold of six 'business' meetings linked to Board and four 'focus based' workshop style meetings per year, as this would allow the Committee to focus more sharply and effectively on key items. The October 2018 Quality Committee meeting was a focussed workshop with subjects on learning themes taken from the recent Patient Safety Congress and an overview of the Adult Business Unit.

Patient Safety Congress.
The Committee heard feedback from staff who had visited the Patient Safety Congress. General feedback was that the event confirmed to them that most Trusts faced similar challenges, and that they were assured that LCH was doing the right things. Staff reported that they felt valued by the Trust, in being allowed to attend the conference, and as they worked in an isolated service, they appreciated the opportunity to network with other Trust colleagues and the wider NHS.

Three key themes from the conference were then discussed at the Committee workshop:

- A 'Just Culture' – how we can move beyond blame and seeing people as the solution, not the problem. This approach was used recently in improvement processes at Mersey Care NHS Trust. The Committee considered how a shift to a more just culture could be monitored through Quality Committee using existing measures and perhaps introduce some new ones.

- Deteriorating patients'. The workshop heard about recent developments to the 'NEWS' (National Early Warning Score) tool, which helps to identify when patients are becoming increasingly unwell. This new version is being introduced currently into ABU and CBU are looking into a Children's version.

- The third theme was about how the Trust could capture and share the great stuff it is doing. The workshop heard about St George's Hospital NHS Trust who developed 'Great-ex', a system that captures good practice and shares it widely. The Committee agreed that an LCH version should be trialled, called 'Fabuleeds' which will be led by the Clinical Governance Team.

Adult Business Unit
The Committee was provided with some context of the ABU including their plans on a page, team structure and size, and information on the number of referrals, contacts, complaints, compliments and incidents. The Committee was informed about the business unit's approach to recruitment and retention and its ongoing work to support winter pressures including admission avoidance and discharge support. Challenges for the ABU were: having the capacity for new developments and initiatives, recruitment and retention issues, and leadership capacity and experience, as there are a number of new leaders in post. The Committee heard about initiatives such as the self-management programme, and some excellent

work around pain assessment in patients with cognitive impairment. The Committee recognised that much of the work undertaken by the ABU lends itself to Quality Improvement initiatives and health services research, both of which should be pursued.

Performance brief and domain reports

Safe

It was noted that safe-staffing fill rates have dropped below target. The Committee was advised that this was at Hannah House, and that there has been no adverse impact on patient care. All other indicators within the 'Safe' domain provided reasonable assurance.

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

Caring

The Committee queried the robustness of the FFT (Friends and Family Test) process, as there are fluctuations in the timings of receipt of completed surveys. The Acting Executive Director of Nursing advised the Committee that more work was being done on feedback processes. Overall the percentage of patients that would recommend LCH services is very high, and the Committee received reasonable assurance from this.

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

Effective

The measures in this domain are reported quarterly therefore there was no data to review this month.

Clinical Governance Report (previously known as the Director of Nursing Report)

- Specialist Business Unit

The nine month waiting time within the IAPT service for people seeking level 3 interventions was brought to the Committee's attention. The Committee was advised there is a recovery plan in place with actions to address the issues. It was recognised that the commissioning arrangements were not adequate for the demand on the service. The Committee have requested more oversight on this issue. These are difficulties retaining staff in Cardiac Services due to pay band issues, increased waiting times in the Diabetes Service – where internal analysis is being carried out to determine the cause of increased waiting times, and Dietetics staffing capacity, where there is now an intent to submit a business case for additional staff.

- Children's Business Unit

The Committee discussed Hannah House eligibility criteria, which the commissioners are amending. The Committee remains concerned with the commissioners' decision to bring the upper age limit down to 18 years. The Committee noted that safe-staffing fill rates have dropped at Hannah House; however it was assured that there has been no impact on patient care.

- Adult Business Unit

Key challenges were around clinical capacity within the neighbourhood teams, specifically in band 5 nursing roles.

Inaccurate training and appraisal information reported on ESR

The Committee discussed an issue raised previously by the Specialist Business Unit concerning inaccurate training and appraisal data on ESR. The Clinical Lead for Specialist Services advised the Committee that ESR data had improved this month, and the 'PIP2' (performance information portal) was now being used, which appears to have resolved the problem. The Committee was advised that SMT now received a weekly report on statutory/mandatory training in order to sense-check the information.

CQC city-wide system review

The Executive Director of Operations advised the Committee that she had received initial feedback of the CQC system review of the city. The CQC saw evidence of a well embedded neighbourhood team model and Executive Director of Operations said the teams should be very proud. The full report will be available in due course and will be shared with the Committee.

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AGENDA ITEM 2018-19 (71dii)

Report to: Trust Board 7 December 2018
Report title: Quality Committee 26 November 2018: Committee's Chair 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 meeting held on 26 November 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

The Committee has previously agreed to reformat its work plan and to hold six 'business' meetings aligned with Trust Board meetings and four 'focus based' workshop style meetings per year, as this would allow the Committee to focus more sharply and effectively on key items. The November 2018 Quality Committee meeting was a business meeting.

Service spotlight: Virtual Respiratory Ward
The Committee received a presentation from representatives from the Virtual Respiratory Ward, who provided some context and the background to the service. The Committee was advised that respiratory illness was one of the major causes of surge escalation in the system. The service model and funding was agreed in December 2017 and the service has been in operation since June 2018. Key achievements include a reduction in bed-days and improvements to patients' lives as well as admission avoidance and early discharge. Challenges and risks were discussed with the Committee. These include the pace of developing the new integrated service, recruitment and development of specialist staff particularly as there are national shortages of physiotherapists, obtaining consultant support, understanding the impact on 'flow', and occasional dissatisfaction expressed by some patients about the high frequency of home visits required. The Committee discussed how success could be measured in terms of outcomes. The Committee recognised the importance of this work to relieve winter pressures and Committee members offered direct support to the service in order to address some of the challenging areas.

Hannah House Improvement Plan Update
The Committee was encouraged by the news that a Quality Challenge+ visit had recently taken place at Hannah House and whilst it is recognised that the unit is still on its improvement journey, the Quality Challenge+ team who visited the unit found many positives. The Committee was advised that the current leadership of the unit was very effective and there was much better engagement with parents**.** This update provided the Committee with reasonable assurance.

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

Quality Priorities quarterly position
The Committee was presented with the quarter two position on progress with the Quality Account Improvement priorities. The Committee learned that there are six indicators progressing well, which will be completed within the 2018/19 reporting period. The Committee was apprised of two areas where there is concern; these are waiting times for Autistic Spectrum Disorder assessment in pre-school children within the ICAN service and the number of services using outcome measures:

- **Waiting times for Autistic Spectrum Disorder assessment**

Waiting list initiatives began in September 2018, and additional staff are being recruited.

- **Outcome measures.**

The Committee was advised that a 2-3 year outcome measures project plan had been drafted and presented at SMT. SMT has requested further information regarding the implications for resource including project team staff. The Committee will receive a further update in January 2019.

Safeguarding action plan from CQC looked after children's review

The Committee reviewed the action plan that was produced following the CQC Review of health services for Children Looked After and Safeguarding in Leeds. The Committee noted that many of the recommendations concerned processes. The Committee agreed that the update provided reasonable assurance.

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

NICE guidance – transition

The Committee discussed the progress being made towards Nice Guidance 43: Transition from children's to adults' services for young people using health or social care services (published in February 2016). For the purposes of the Committee report, any guidance published more than two years ago where services are still working towards compliance with relevant recommendations is highlighted to the Committee. The Committee was advised that Nice Guidance 43 is wide-ranging guidance affecting health and social care, with implications for commissioners and providers. The guidance requires multiple partners to agree implementation of action. A successful conference took place on 24 October 2018 with partners across the city to progress this work. A further update will be provided to the Committee in January 2019.

Non-Executive Director visits to services

The Committee received four reports from Non-Executive Directors who have recently visited LCH services. The Committee appreciated the excellent feedback that these reports and subsequent service responses provided. The Committee noted that the report on the service visit to IAPT was to be discussed at the November Business Committee meeting.

Performance brief and domain reports

The Committee reviewed the Performance Brief data, which is supplemented by additional clinical governance data in the Clinical Governance Report.

- **Safe and caring Domains**

All KPIS in these two domains are currently being achieved. The Committee noted the improved position on compliance with safeguarding training.

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

- **Effective**

The measures in this domain are reported quarterly therefore there was no data to review this month.

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AGENDA ITEM 2018-19 (71ei)

Report to: Trust Board (circulated by email)
Report title: Business Committee 24 October 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 24 October 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service Support Session: Learning and Development
Representatives from Learning and Development attended Business Committee for the service support session agenda item, which replaces the services presentation item. The aim of the session is 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 Committee raised a number of areas for further clarification:

- The capacity and capability of the Trust to run this programme of development training alongside other Trust developments and initiatives
- The apparently 'generic' nature of the programme – for all levels of management
- The level of perhaps unrealistic ambition to cover all aspects over a short series of events
- Ensuring mandatory attendance

The presenting teams agreed to give consideration to the scope of the development works.

Neighbourhood Team Activity Report
The Committee was pleased to learn that the commissioners have agreed to change the activity profile to one that was more reflective of the way the service has transformed to provide fewer, more qualitative and therefore longer visits, rather than focussing on the number of visits achieved. The Committee was advised that time was being used more effectively by teams to include safety huddles and caseload review. There was still a need for a more compelling and marketable narrative in the work of the Neighbourhood Teams.

Business and Commercial Development Report
The Committee was advised that the 0-19 service contract officially started on 1 October 2018. The Community Dental Service has been offered a 5 year contract, which ends the uncertainty around this service. The Committee was concerned about the anticipated retendering of the IAPT service, expected later this financial year, given the current concerns about waiting times in this service. The Committee was pleased to note the development of services. The Committee also was informed about the progress with traded services, which was an encouraging development, and discussed the risks and benefits of this relatively new part of the business.

Liaison and Diversion Services
The Committee was apprised of a decision made to bid in partnership for the Liaison and Diversion Services. The Committee was advised these services are a natural complement to the Trust's existing police custody healthcare services, giving it a unique opportunity to integrate and streamline systems and assessments. The Trust is bidding in partnership with Community Links and Foundation for North Yorkshire and Humberside.

Projects:
The Committee was advised that the Change Programme Board was more established, and was scrutinising the four main programmes. It was also considering whether other change programmes should be included. The Committee was uncomfortable that less information was being received at Business Committee meetings, as there was no evidence base for which the Committee could provide assurance to the Board. It was agreed that the Committee would in future receive evidence in the form of a 'plan on the page'.

Electronic Patient Record Project
The Committee was advised that the EPR project team had reduced in size in line with the current requirements of the project, and the number of business analysts had increased accordingly. Many of the service areas involved are now at, or nearing the completion stage, which means their training is completed, the IT is in place and the services have been assessed as being competent to use EPR in a business as usual way, with some limited support. The Committee was assured that different strategies were aligned so that there was sufficient software interface to make sure future processes worked together. The Committee agreed that this update provided it with substantial assurance.

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

e-rostering
The Committee was advised that the Change Programme Board had reviewed the project highlight report, and there had been successful recruitment to the project team. A Non-Executive Director (RG) has reviewed the project initiation document and will be having a follow-up meeting with the project lead. The software provider 'Allocate' is initialling developing system use in three service areas of the Trust. The Committee determined reasonable assurance from this information.

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

Performance Brief
IAPT waiting times were reviewed and a discussion on the reasons for excessive waiting times took place. A project manager is leading the recovery plan.

The Committee reviewed sickness absence data and learned that the pattern of short term sickness absence is tracking a similar pattern to last year. The main causes of absence in the Trust are the same across the wider NHS. Examples of good practice have led to improved attendance in some areas of the Trust.

The Committee was advised that the way in which statutory and mandatory training data is captured is under review in order to clarify which staff should be included in compliance figures.

The Committee was satisfied with most areas of progress in the Performance Pack, which provided reasonable assurance.

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

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AGENDA ITEM 2018-19 (71eii)

Report to: Trust Board 7 December 2018
Report title: Business Committee 28 November 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 28 November 2018 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service Support Session:
Representatives from Continence, Urology and Colorectal Service (CUCS) attended Business Committee for the service support session agenda item, which is a shared problem-solving session. The service provided the Committee with a briefing paper in advance of the meeting, which gave some background and contextual information about the service and described the challenges with waiting list management and product spend. The Committee heard about the positive work being done to manage waiting lists (there are now no patients waiting over 18 weeks). The Committee supported the service's approach to redesigning its staffing structure. The service had already secured significant cost reduction through tighter control on product issues and was looking to reallocate those savings to additional staff recruitment. The Interim Medical Director offered to support conversations with GPs around this subject. The service had secured an additional 'sponsored' staff member. The Committee reflected on the excellent leadership of this service; it invited the service to focus further on productivity issues and it confirmed it would provide strong support for these very positive developments.

Digital Strategy
The Committee noted the positive progress being made with implementing this strategy. As well as providing an update, the report described a number of new strategic priorities which had arisen since the strategy was adopted by the Board, including Local Care and Health Record Exemplars, cyber security, the shared city platform, and the conclusion to the regional procurement process which will see a replacement to our existing network connection. The new priorities and the developing Trust strategy will shape the next major revision of the Digital Strategy. The Committee discussed the need for the strategy to have a customer service approach so that staff could understand how digital innovations could help them to improve patient care. The Committee recommended that technical innovators should explain the possibilities to staff, as well as support being available to assist and empower staff to use new and complex software. The Committee agreed that the current update provided them with reasonable assurance. It also recommended that the developing strategy should, in due course, be brought to Trust Board.

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

Future IT infrastructure
The Committee received a report proposing an approach to an aspect of the Trust's IT infrastructure. The Committee noted the benefits outlined and approved the recommended approach.

Change Board (Projects)
The Committee received an overview of the Trust's major change projects. One issue escalated to the Committee was that the Patient Admin Review project team requested that a consultation commenced on the most senior roles within the Admin structure to bring additional leadership to the project. The Committee endorsed this approach. Overall the Change Board report provided the Committee with reasonable assurance.

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

Patient Admin review project
The Committee received a presentation on progress including engagement events, improved communication methods, workshops, and the development of shared service models and key work streams which have been established. The Project Team described the challenges, including the time and resource required, the need for clarity of roles and responsibilities, and changes within services, which has meant some disruption to developing the models. Some of the options papers are now being drafted and considered. The mobilisation phase is anticipated to start in April 2019.There was an intimation of slippage to the project delivery. The Committee acknowledged that the project was now at a more difficult stage, and the update provided only limited assurance.

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

Estates Strategy and Rationalisation Plan
The Committee received a draft Outline Business Case for the next stage of implementation of the Estates Strategy. The Committee was advised that the Estates Strategy was to be refreshed, although the key principles would be the same. The revised strategy will be presented to Business Committee and then Trust Board. The 2018-20 estates programme will continue to implement projects that meet the Trust's strategic objectives. The update provided the Committee with reasonable assurance.

Assurance level							
Substantial		Reasonable	X	Limited		No	

CAMHS Tier 4 build
The Committee received an update on the CAMHS T4 scheme. The Committee Chair will apprise the Board of its discussion during the private Board meeting.

Performance Brief
The Committee was satisfied with most areas of progress in the Performance Brief. The Committee was advised that the Senior Management Team had noted concern about the number of staff leaving the Trust within the first 12 months of employment and had asked for further review of this over the next month. The Director of Workforce, OD & System Development advised that this appeared to a wider issue in the NHS, and will provide an update at the Board meeting. The Committee was pleased to learn that there had been good engagement between the CCG and the Trust and the CCG had agreed to adjust the Neighbourhood Teams' activity levels profile. An update paper will be provided at the Trust Board meeting. The improved position is reflected in the October performance data. The Committee reviewed the IAPT waiting times information and noted the improvement plan which was provided in an additional, accompanying paper.

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AGENDA ITEM
2018-19
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Meeting: Trust Board, 7 December 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, 21 November 2018 Quality Committee, 26 November 2018 Business Committee, 28 November 2018	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust as at October 2018.

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

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

Main issues for consideration

A particular highlight this month is the significant improvement in performance on compliance with the new inter-collegiate guidance on safeguarding training. Our staff and managers have recognised the importance of meeting these requirements and have prioritised this amongst many other priorities. It will remain a focus until our target is fully met and the monitored in line with other statutory and mandatory training requirements.

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

Of particular note this month within the well-led domain is the level of turnover of staff within their first year of employment with the Trust. A closer look at this issue will be taken over the next month.

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

Recommendations
The Board is recommended to:

- Note present levels of performance

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, October 2018

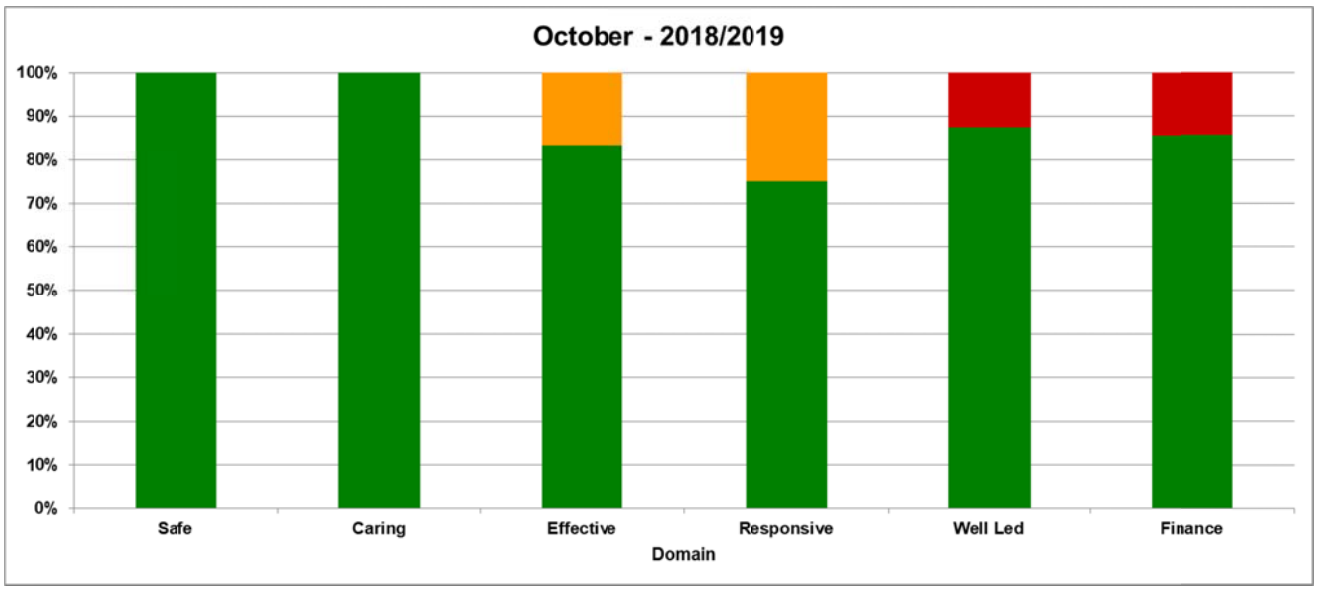
Senior Management Team – 21st November 2018
Quality Committee – 26th November 2018
Business Committee – 28th November 2018
Trust Board – 7th December 2018

1. High Level Performance Summary

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.



Overall performance remains good.

A particular highlight this month is the significant improvement in performance on compliance with the new inter-collegiate guidance on safeguarding training. Our staff and managers have recognised the importance of meeting these requirements and have prioritised this amongst many other priorities. It will remain a focus until our target is fully met and the monitored in line with other statutory and mandatory training requirements.

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

Of particular note this month within the well-led domain is the level of turnover of staff within their first year of employment with the Trust. A closer look at this issue will be taken over the next month.

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

In **Safe** and **Caring**, where all KPIs are being achieved, further detail this month is provided in the Clinical Governance report presented to Quality Committee on 26 November

In the **Responsive** domain it is pleasing to report once again that The Trust has performed well in its nationally reported indicators relating to waiting lists with all rated as green for October. There were no patients waiting more than 52 weeks for consultant led services. Since the beginning of the current financial year, there has been a general downward trend in the measure of patients waiting less than 6 weeks for a diagnostic test however in October this is reported as 100% The low volumes entering the audiology diagnostic service mean that the cancellation of a clinic due to sickness absence can lead to a breach in the target. The service is reviewing processes to try and improve resilience in this area.

Commissioners approved a jointly produced and presented proposal at their Contract Development and Intelligence Group (CDIG) on 22 October 2018 to adjust the profile for Neighbourhood Teams. This new profile has been included in this report with the result being that October is reporting a 0.2% above profile position and demonstrates the large amount of activity resulting from our Neighbourhood Teams. Longer term we would welcome a move to outcomes based commissioning which would account for the quality and productivity of new ways of working and integrated care. The lowered profile is useful but collaboration as to a helpful suite of measures would be very useful to take forward (linked to productivity work which the Business Intelligence Team is progressing).

Both Children's (4.4% above) and Specialist (2.5% above) Business Units are reporting a positive variance from the patient contact profile.

99.5% 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. October is reporting the same percentage as September. 71.3% of patients are treated within 6 weeks of referral which is a position below the target of 75.0% the first time this has happened since April 2017. A separate report is provided on the range of IAPT targets

98.1% of patients are waiting 18 weeks or less (excludes CAMHS waits) which remains above the target of 95.0% Since April 2017, the process is in control but September and October 2018 have produced two points below the lower control limits.

The measures in the **Effective** domain are reported quarterly; there are no issues to report this month.

In **Well Led**, the overall trend in terms of the current key workforce indicators is positive. Turnover continues below target at 14.16%, sickness absence is also below last year's outturn figure of 5.8% whilst both appraisal and statutory and mandatory training figures continue to rise.

Further analysis, however, reveals specific areas upon which more focus is being placed and this includes the incidence of staff leaving within 12 months of joining the organisation which continues an upward trend throughout the 18/19 financial year – work is underway to understand this better.

Our sickness absence whilst within last year's outturn is still outwith the benchmark figures of our peers – further work is being undertaken to understand and analysis this trend over time and identify hotspots as well as areas of good practice that we can learn from.

This month has seen the refinement of measurement for both the universal statutory and mandatory training requirements as well as appraisal to remove those individuals out of the business – this has resulted in a slight improvement but we are yet to hit the 95% target and there is a continued push to do so and what we know is with some focussed effort e.g. in the area of Children's Safeguarding training significant improvements can be made.

Overall therefore there continues to be a drive for improvement and in using the data to identify where improvements can be made and over time how they might be made. This combined with a continued focus on qualitative feedback and information through our various engagement approaches should facilitate the provision of a richer workforce picture across the Trust.

Finance performance remains good. The Trust's surplus is £0.3m more than planned at the end of October. The Trust's forecast outturn continues to be £4.0m which includes £1.2m original control total, £0.5m additional surplus from the release of a redundancy provision no longer required and £2.3m of Provider Sustainability Funding (PSF) from NHS Improvement. A significant income risk associated with the NHS Leeds CCG contract this year has been resolved.

Although there are 94 wte vacancies for the month; temporary staffing is in place to mitigate the impact on service delivery and no material impact on the quality of services provided is being reported although this has been and will continue to remain a key focus of attention

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2. Contractual Issues

No contract related performance issues this month. Contract monitoring continues and regular contract management reports are held with commissioners. The latest Contract Management Board meeting with NHS Leeds CCG was held on 27 November 2018. This was a productive meeting across a range of quality and business issues. Progress on some issues that have been discussed at Board level, notably Neighbourhood team activity profiles and a non-recurrent financial issue were resolved and are referred to in this Performance Brief.

Leeds Community Healthcare NHS Trust

Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		Target	YTD	Q1	Jul	Aug	Sep	Q2	Oct	Forecast	Rolling 12 Month Trend
Overall Safe Staffing Fill Rate - Inpatients	2018/19	>=97%	-	101.1%	104.0%	104.3%	95.1%	101.1%	97.5%	●	
	2017/18		-	97.7%	102.5%	97.5%	96.1%	98.7%	94.2%		
Patient Safety Incidents Reported in Month Reported as Harmful	2018/19	0.56 to 1.1	0.90	0.86	0.92	0.75	0.87	0.85	0.89	●	
	2017/18			0.92	0.71	0.95	0.93	0.86	0.84		
Potential Under Reporting of Patient Safety Incidents	2018/19	1.16 to 2.74	1.91	1.85	2.00	1.42	2.04	1.82	2.01	●	
	2017/18			2.22	2.24	2.22	2.14	2.20	2.22		
Serious Incident Rate	2018/19	0 to 1.79	0.05	0.04	0.08	0.05	0.02	0.05	0.02	●	
	2017/18			0.05	0.00	0.08	0.08	0.05	0.07		
Percentage VTE Risk Assessment Completed*	2018/19	>=95%	100.0%	79.2%	100.0%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18			-	-	-	-	-	-		
20% Reduction in Avoidable Category 3 Pressure Ulcers	2018/19	10	3	1	0	1	1	2	0	●	
	2017/18			2	1	4	1	6	1		
0 Avoidable Category 4 Pressure Ulcers	2018/19	0	0	0	0	0	0	0	0	●	
	2017/18		12	0	0	0	0	0	1		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2018/19	100%	100.0%	100.0%	100.0%	100.0%	100%	100%	75%	●	
	2017/18		100.0%	100%	100%	100%	100%	100%	100%		

Caring - staff involve and treat people with compassion, kindness, dignity and respect		Target	YTD	Q1	July	Aug	Sept	Q2	Oct	Forecast	Rolling 12 Month Trend
Percentage of Staff Recommending Care (Staff FFT)	2018/19	>=73%	-	83.0%	82.4%			82.4%		●	
	2017/18		-	81.0%	75.0%			75.0%			
Percentage of Respondents Recommending Inpatient Care (FFT)	2018/19	>=95%	-	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18		-	100.0%	100.0%	100.0%	90.0%	96.7%	100.0%		
Percentage of Respondents Recommending Community Care (FFT)	2018/19	>=95%	-	95.9%	96.8%	96.8%	97.0%	96.9%	96.0%	●	
	2017/18		-	95.3%	94.5%	96.1%	95.8%	95.5%	96.2%		
Written Complaints - Received	2018/19	<211	84	44	10	17	13	40	22	●	
	2017/18			50	23	18	16	57	21		

1. Areas for further investigation and analysis within this report are as follows:

- Increase in moderate harm incidents
- Increase in non-LCH incidents
- Decrease in STeIS reportable incidents – all of these will be investigated and reported on further in future reports as more information is available.

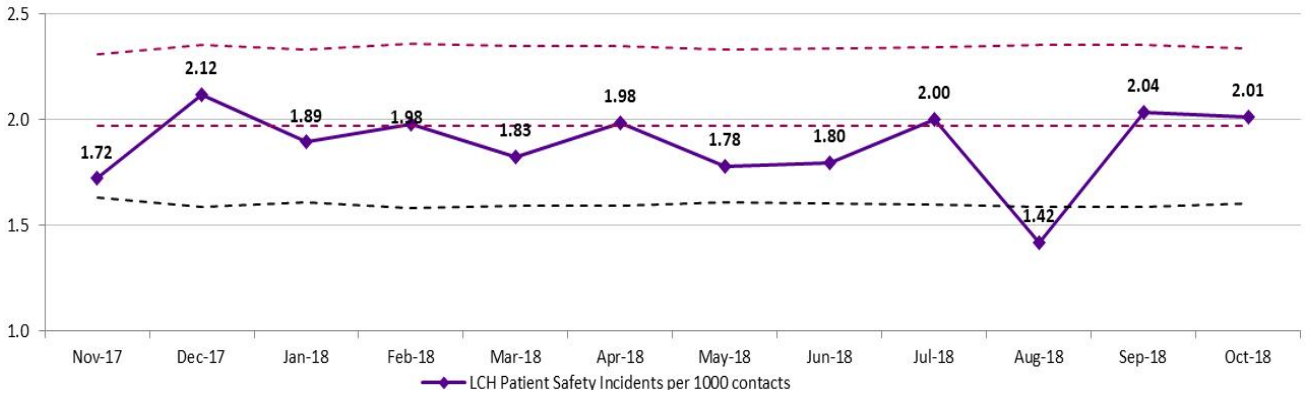
2. All Incidents – Year on Year Comparison October 2016, 2017 and 2018

Incident reports have increased year on year. This month 595 were reported on Datix.

A comparison of previous October data (2016 and 2017) shows that staff are reporting more incidents of low/no harm. They are also reporting more incidents originating from other NHS providers; currently 29%.

2.1 Patient Safety Incidents (LCH only)

There were a total of 268 LCH patient safety incidents reported in October 2018. The LCH Patient Safety incidents per 1000 contacts data point for October is within the agreed limits (see chart below)



Action: Further checks to be undertaken on August data, results will be reviewed when report is refreshed in December.

2.2 Incidents causing harm (LCH only)

Harm incidents remain within control limits and are also similar in number to those reported in October 2017.

LCH Patient Safety Incidents by Degree of Harm

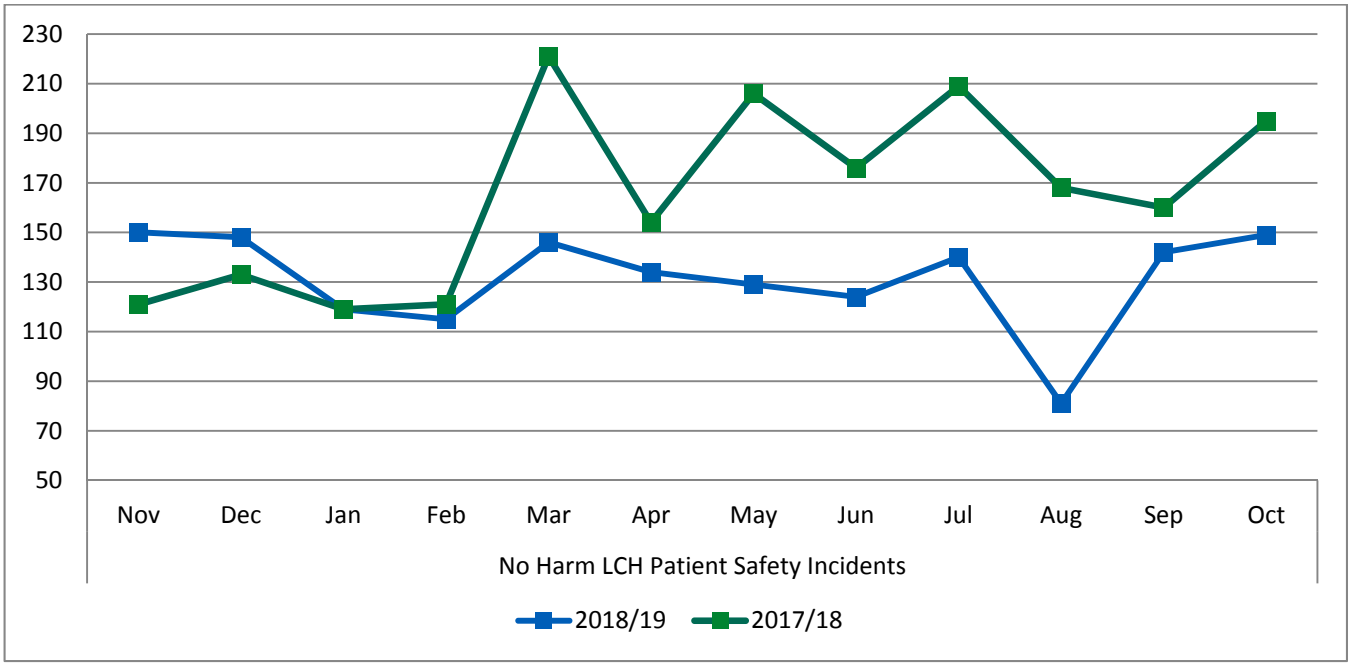
	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
No injury sustained	140	140	119	113	133	126	116	108	135	78	126	136
Minimal Harm	73	66	82	62	45	66	75	70	83	58	67	77
Moderate Harm	36	36	51	45	32	43	33	37	31	26	30	41
Major Harm	4	5	4	9	7	5	6	4	5	8	9	1
Death	10	7	0	2	13	8	12	16	5	3	14	13
Total	263	254	256	231	230	248	242	235	259	173	246	268
Ratio: (moderate/major incidents : minimal/no harm incidents for LCH Patient Safety Incidents)	1:5.3	1:5	1:3.7	1:3.2	1:4.6	1:4	1:4.9	1:4.3	1:6.1	1:4	1:4.9	1:5.1

2.3 Moderate & Major Harm Incidents

In October there has been a 4% increase in moderate harm incidents reported in LCH care. An assessment of this increase will be carried out over the next month to understand if remedial action is required.

2.4 No Harm incidents

This month there is no change in the reporting of no harm incidents (51%). The chart below shows an 8% reduction against October 2017 but the number of LCH patient safety incidents causing no harm per 1000 contacts in October is within normal process variation expectations.



2.5 Overdue Incidents

There are 487 live incidents in Datix as of 12/11/2018. Of these, 140 have breached the 15 or 30 day investigation time. The management team in the Adult Business Unit is monitoring this overdue data for their teams/services and offering support to ensure this is managed in a timely way.

3. Never Events

There have been no Never Events reported in October 2018. Leeds Community Healthcare has never had occasion to report a Never Event to our Commissioners.

4. Safety Alerts (CAS)

There were 7 Safety alerts issued which were due to be closed in October 2018. All were responded to and closed within the timescales.

5. Duty of Candour

Four incidents closed that were attributable to LCH of moderate harm or above. Three of these incidents have details of apologies given and options to receive a copy of investigations shared. Whilst one has not, resulting in 75% compliance, the reason for that is a local service decision not to apologise to the family of the patient who had recently passed away; the patient's death being unrelated to the harm incident. This will be reviewed to see if there is any learning to be shared across services.

6. Patient Experience

6.2 Friends and Family Test (FFT)

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 96.02% of Community patients and 100% of Inpatients responding in October 2018 would recommend LCH services. Performance by Business Unit is shown in the following table:

October 2018	% Recommended	Response Rate	Comments
ABU Services	93.33%	5.86%	168
CBU Services	96.91%	7.31%	809
CBU Inpatients	100%	100%	No data
SBU Services	96.17%	6.71%	730
SBU Inpatients	No data	No data	No data

7. Complaints, Concerns, PALS and Claims

Item	October 2018 Received	Comments
Complaints	22	No exceptions to report
Concerns	46	No exceptions to report
PALS Enquiries	8	No exceptions to report
PALS Signposting	13	No exceptions to report
Clinical Claims	0	No exceptions to report
Non-clinical Claims	1	No exceptions to report

Key Performance Indicators and Developments - Complaints	Status
Acknowledged within 3 days	**100%** Compliance
Responded to within 180 days	**100%** Compliance (closed complaints)
Active PET Caseload	**37** open complaints **16** open concerns
PHSO requests	**0**

Leeds Community Healthcare NHS Trust

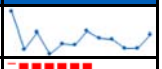
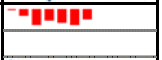
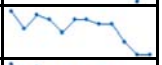
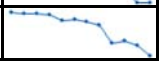
Effective Domain Report

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence		Target	YTD	Q1	July	Aug	Sept	Q2	Oct	Forecast
Compliance with Other NICE Guidance Within 2016	2018/19	39								
	Full Compliance		13	6	13			13		
	Action Plan in Place		4	-	1			1		
	Not yet due		14	33	26			26		
Number of Mandatory Audits	Due to start in Q	All audits started		48						
	Started in Q			48						
Number of LCH Generated Audits Started	2018/19	>=80%	-	100.0%						
	2017/18		-							
Compliance with Clinical Supervision	2018/19	>=80%	-	81.9%	84.3%	82.7%	81.9%	83.0%		
	2017/18		-	80.0%	61.0%			61.0%	70.0%	
Number of Unexpected Deaths in Bed Bases	2018/19	No Target		0	0			0	0	
	2017/18		-	0	2			2	1	
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2018/19	No Target		5	4			4	3	
	2017/18		-	1	1			1	2	
Percentage of services rated good or outstanding following the Quality Challenge Peer Review	2018/19	>=70%		100.0%						
	2017/18		-	-	-			-	-	
Percentage of services rating themselves as good/outstanding through the Quality Challenge Self Assessment	2018/19	>=80%		82.0%						
	2017/18		-	-	-			-	-	

This domain is reported quarterly; there are no new issues to highlight this month, the information in this table is presented to enable a broad overview of trust performance to be maintained.

Leeds Community Healthcare NHS Trust

Responsive Domain Report

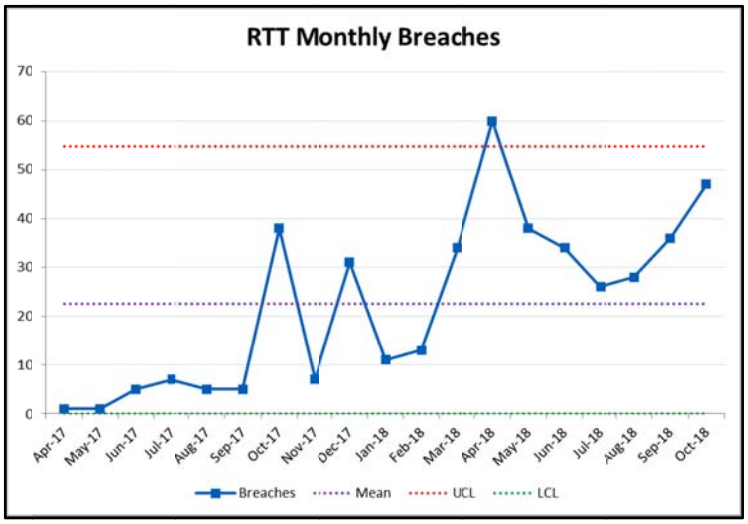
Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		Target	YTD	Q1	July	Aug	Sept	Q2	Oct	Forecast	Rolling 12 Month Trend
Patient Contacts - Variance from Profile*	2018/19	0 to ± 5%	-4.1%	-3.1%	-4.7%	-9.4%	-5.6%	-6.6%	0.2%	●	
	2017/18			-5.9%	-6.9%	-10.3%	-5.2%	-7.5%	-1.1%		
Patient Contacts - Variance from 2017/2018	2018/19	-	-	-4.2%	-5.9%	-7.4%	-8.4%	-7.2%	-5.5%	●	
	2018/19		-	392,454	129,516	121,984	121,773	373,273	133,161		
	2017/18		-	409,858	137,564	131,728	132,999	402,291	140,896		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2018/19	>=92%	-	97.0%	98.1%	98.0%	97.4%	97.8%	96.8%	●	
	2017/18		-	99.6%	99.4%	99.6%	99.6%	99.5%	99.5%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2018/19	0		0	0	0	0	0	0	●	
	2017/18		0	0	0	0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2018/19	>=99%	-	99.7%	98.1%	98.5%	94.5%	97.0%	100.0%	●	
	2017/18		-	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%		
% Patients waiting under 18 weeks (non reportable)	2018/19	>=95%	-	98.9%	98.8%	98.4%	98.1%	98.4%	98.1%	●	
	2017/18		-	98.8%	98.6%	99.0%	98.8%	98.8%	98.9%		
IAPT - Percentage of people treated within 18 weeks of referral	2018/19	>=95%	-	98.9%	99.4%	99.6%	99.8%	99.6%	99.5%	●	
	2017/18		-	100.0%	98.7%	98.9%	98.2%	98.6%	99.6%		
IAPT - Percentage of people treated within 6 weeks of referral	2018/19	>=75%	-	98.9%	79.2%	80.0%	77.2%	78.8%	71.3%	●	
	2017/18		-	96.1%	93.5%	95.6%	94.1%	94.4%	95.5%		

The Trust continues to perform well in its nationally reported indicators relating to waiting lists with all rated as green for October. There were no patients waiting more than 52 weeks for consultant led services. Since the beginning of the current financial year, there has been a general downward trend in the measure of patients waiting less than 6 weeks for a diagnostic test however in October this is reported as 100.0% The low volumes entering the audiology diagnostic service mean that the cancellation of a clinic due to sickness absence can lead to a breach in the target. The service is reviewing processes to try and improve resilience in this area.

At the end of October 2018, 47 patients had waited more than 18 weeks for treatment in consultant-led services. This is an increase of 11 from the previous month.

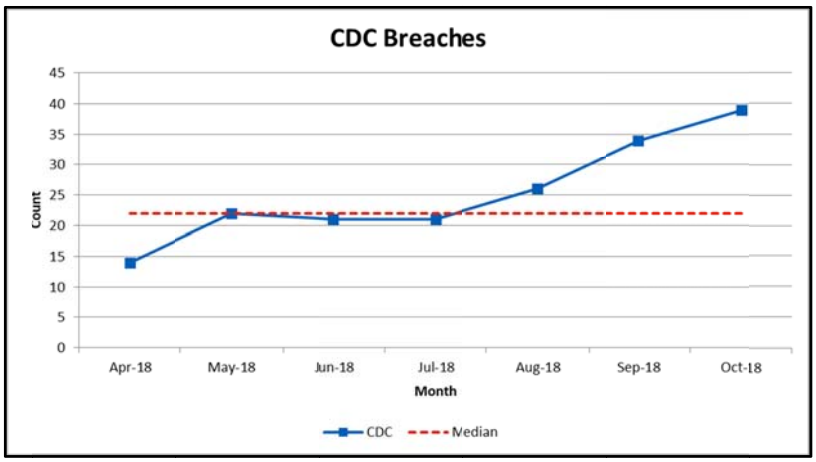
In the 2018-2019 Financial Year to date there have been a total of 269 breaches compared with 158 for the whole of FY 2017-2018 but **the Trust remains well above the target of 95.0% of patients waiting less than 18 weeks.**

The graph below shows a 19 month Statistical Process Control Chart (SPC) for RTT Breaches. Since March 2018 there have been 8 points above the mean denoting special cause variation in the process.



There were 39 waiters in Child Development Centre (CDC) in October. 1 waiter in Community Paediatric Clinics (CPC CHICS) and 7 in Paediatric Neuro Disability Clinics (PND) but all now have a scheduled appointment or have been seen.

Analysis shows that most breaches and long waiters are found in the CDC service. The chart below shows that although there is no statistical significance, yet, of points about the median line, but there is an upward trend this financial year. The reason for the significant increase in the CDC line is due to the increase in Complex Communication Assessment (CCA) referrals which is a national issue. The Trust is aware and the issue is being dealt with through the CCA waiting list initiative including monitoring reporting.



The CCG approved a jointly produced proposal at their Contract Management Group on 27 November 2018 to adjust the profile for Neighbourhood Teams. This new profile has been included in this report with the result being that October is reporting a 0.2% above profile position and demonstrates the large amount of activity resulting from our Neighbourhood Teams. Longer term we would welcome a move to outcomes based commissioning which would account for the quality and productivity of new ways of working and integrated care. The lowered profile is useful but collaboration as to a helpful suite of measures would be very useful to take forward (linked to productivity work which the Business Intelligence Team is progressing).

Both Children's (4.4% above) and Specialist (2.5% above) Business Units are reporting a positive variance from the patient contact profile.

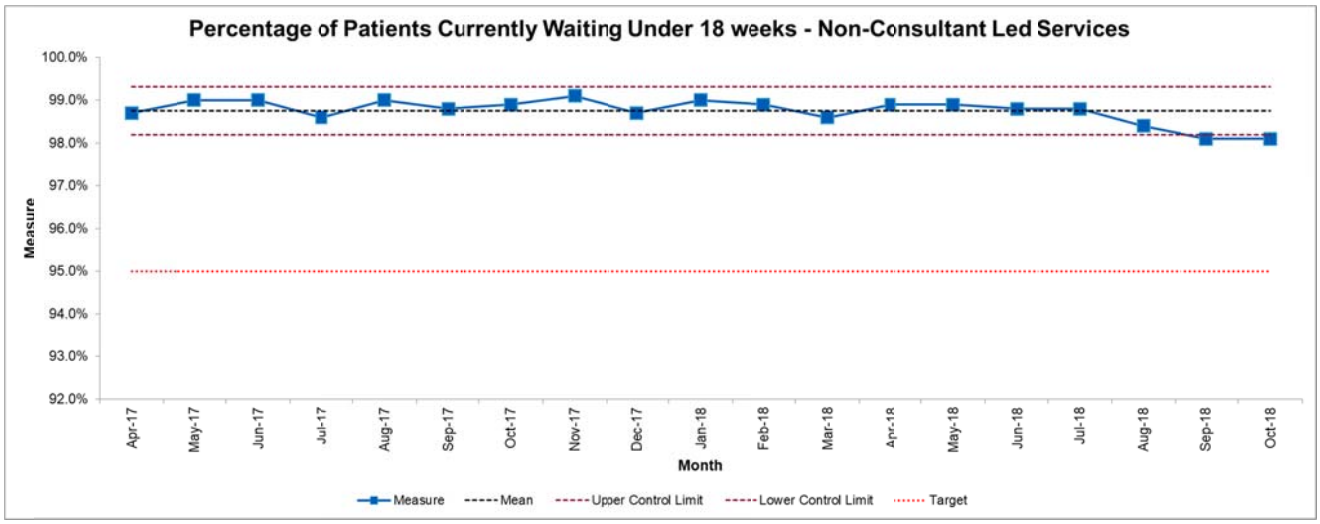
98.1% of patients are waiting 18 weeks or less (excludes CAMHS waits) which remains above the target of 95.0% Since April 2017, the process is in control but September and October 2018 have produced two points below the lower control limits.

The **IAPT** service is under extreme pressure and this is manifesting in long waits, particularly for Step 3 interventoions. The waits are being compounded by an increase in referral rates as a result of efforts to improve access. A range of initiatives is in place to streamline systems and processes and also to increase capacity in the service. It is too early to predict the impact of the initiatives but work is underway to agree an improvement trajectory.

In the **CAMHS** service, at the end of September there were 936 patients waiting at the end of the month and the reasons for this and actions taken by the Senior Management Team were reported in September's Performance Brief. Since then there has been continued increase in emergency and urgent referrals leading to less capacity for routine referrals. This pressure will be alleviated when the newly commissioned crisis team is operational; recruitment is in process. There continues to be some vacancies with new staff in post not yet up to full capacity.

The service continues to meet the emergency 4 hour and urgent 1 week referral target.

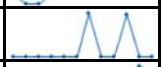
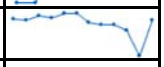
98.1% of patients are waiting 18 weeks or less (excludes CAMHS waits). The time series of this measure can be seen in the chart below.



Since April 2017, the process has been in control and subject to normal variation, but September and October 2018 have produced two points below the lower control limits. This measure remains well above the target of 95.0% but this change will be further investigated.

Leeds Community Healthcare NHS Trust

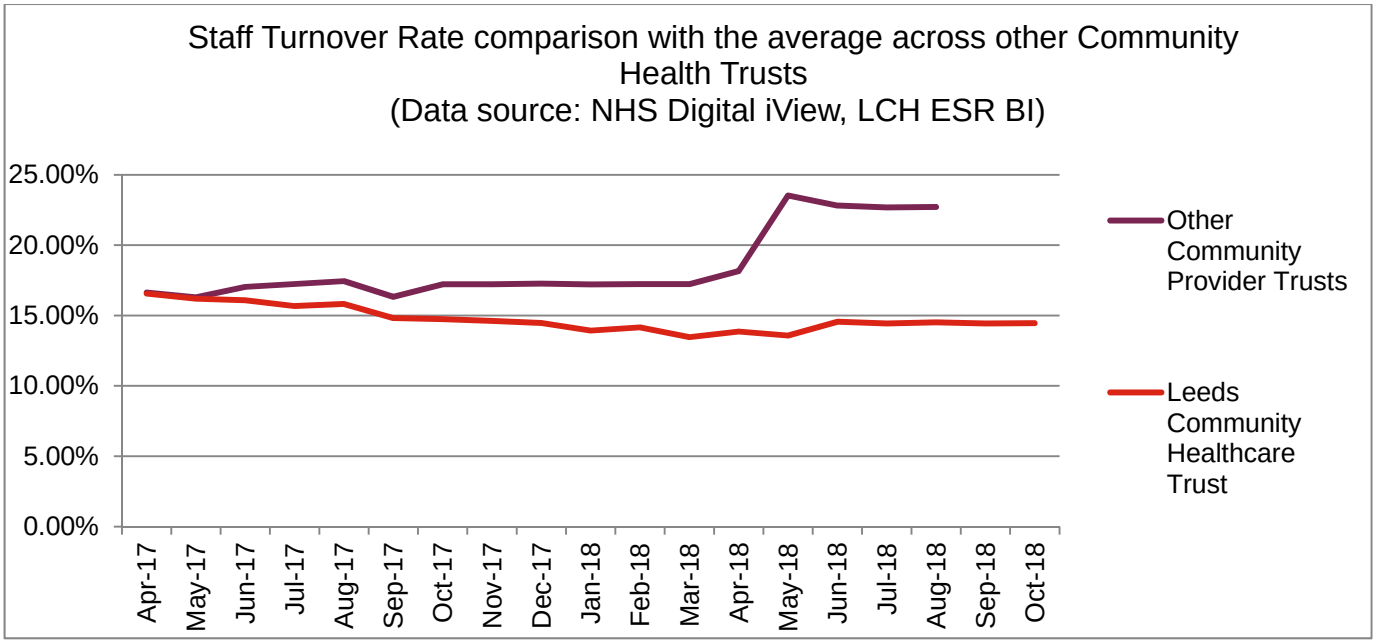
Well Led Domain Report

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	Q2	Oct	Forecast	Rolling 12 Month Trend
Staff Turnover	2018/19	<=15.0%	-	14.0%	14.4%	14.5%	14.4%	14.5%	14.5%	●	
	2017/18		-	15.2%	15.2%	15.1%	14.4%	14.4%	14.1%		
Reduce the number of staff leaving the organisation within 12 months	2018/19	<=20.0%	-	13.1%	13.6%	14.4%	15.2%	14.4%	15.7%	●	
	2017/18		-	16.3%	14.2%	13.5%	12.0%	12.0%	12.0%		
Executive Team Turnover	2018/19	<=14.5%	-	0.0%	0.0%	6.4%	0.0%	2.1%	0.0%	●	
	2017/18		-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Stability Index	2018/19	>=85%	-	85.5%	85.9%	85.9%	86.2%	86.0%	86.0%	●	
	2017/18		-	83.8%	83.8%	83.8%	82.5%	82.5%	84.9%		
Short term sickness absence rate (%)	2018/19	<2.2%	-	1.9%	1.5%	1.6%	1.8%	1.6%	1.9%	●	
	2017/18		-	1.8%	2.0%	1.9%	1.9%	1.9%	2.3%		
Long term sickness absence rate (%)	2018/19	<3.6%	-	3.5%	3.8%	4.1%	3.6%	3.8%	3.6%	●	
	2017/18		-	3.5%	3.8%	3.6%	3.4%	3.4%	3.5%		
Total sickness absence rate (%)	2018/19	<5.8%	-	5.3%	5.3%	5.6%	5.3%	5.4%	5.5%	●	
	2017/18		-	5.2%	5.8%	5.5%	5.4%	5.4%	5.8%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2018/19	>=95%	-	80.7%	78.5%	83.6%	84.9%	82.3%	87.5%	●	
	2017/18		-	86.6%	86.7%	85.0%	82.5%	82.5%	81.3%		
Medical staff appraisal rate (%)	2018/19	100%	-	100.0%	100.0%			100.0%		●	
	2017/18		-	100.0%	100.0%			100.0%	100.0%		
WRES indicator 1 - Percentage of BME staff in the overall workforce	2018/19	-	-			10.1%	9.7%		9.8%		
	-		-						91.5%		
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2018/19	-	-			3.1%	3.2%		3.2%		
	-		-						91.5%		
6 universal Statutory and Mandatory training requirements	2018/19	>=95%	-	90.3%	89.6%	88.7%	88.4%	88.9%	90.3%	●	
	2017/18		-	91.0%	91.0%	91.5%	90.5%	90.5%	91.5%		
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2018/19	>52.0%	-	63.0%	60.3%			60.3%	Staff	●	
	2017/18		-	54.0%	53.9%			53.9%	Survey		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2018/19	>52.0%	-	64.0%	65.1%			65.1%	Staff	●	
	2017/18		-	62.0%	60.0%			60.0%	Survey		
Sustain the time between placing adverts											
	Qualified Nurses	<= 112 Days	-							●	
	Administration	<=83 Days	-							●	
	Police Custody	<=145 Days	-							●	
Response Rate for Staff FFT	2018/19	>22.0%	-	24.0%	23.5%			23.5%	Staff	●	
	2017/18		-	22.2%	21.0%			21.0%	Survey		
Response Rate for Inpatient FFT	2018/19	23.1%	-	38.9%	88.2%	100.0%	100.0%	96.1%	100.0%	●	
	2017/18		-	15.4%	8.0%	12.6%	11.8%	11.8%	8.4%		
Response Rate for Community FFT	2018/19	6.8%	-	7.4%	5.6%	6.1%	7.0%	6.2%	6.8%	●	
	2017/18		-	6.9%	6.6%	5.2%	4.6%	4.6%	5.5%		
Total agency cap	2018/19	£3,739k	£3,153k	£1,403k	£394k	£462k	£507k	£2,766	£387k	●	
	2017/18		£6,089	£1,544k	£416k	£625k	£538k	£3,123k	£509k		
Percentage Spend on Temporary Staff	2018/19		7.1%	7.8%	5.0%	7.0%	7.1%	7.1%	6.1%		
	2017/18		8.0%	8.1%	6.8%	9.1%	8.7%	8.1%	8.0%		

1. Retention

The overall trend continues to be a positive one, with turnover at 14.46% which is slightly below the 2018/19 outturn target of 14.5%. The stability index in October remains within tolerance at 86.04% which is slightly above the trust target of 85%.

The Trust's turnover rate continues to benchmark favourably against its Community Trust peers who are reporting 22.71%.



The incidence of staff leaving the Trust within the first 12 months of employment remains higher than overall turnover at 15.69% but below target of 20%. Analysis undertaken in September 2018 has shown the main reason for leaving in this group is due to voluntary resignation (work life balance). We need to continue to monitor this and report the findings as well as alignment with other indicators and any areas of concern to the business units and SMT in December 2018.

The number and distribution of leavers across the Trust's Business Units and professional groups in October 2018 remain consistent with the month-on-month pattern seen throughout Quarter 2. The top 3 reasons for leaving in October were due to retirement, voluntary resignation (unknown) and promotion.

In response to the reasons for leaving reported in Quarter 1 and 2, work is underway to review clinical bandings across our neighbouring health providers as a number of discrepancies in the job matching/evaluation process has been reported.

A working group involving representatives from across the business units is also looking at developing our processes and approach to internal transfers (also referred to as an 'itchy feet' conversation).

It is anticipated that both the stability index and turnover levels will continue to be within target during 2018/19. Background detail associated with retention is at Appendix 1.

2. Health and Wellbeing

The sickness absence rate for October 2018 is 5.48% (consisting of 1.89% short term and 3.59% long term). The encouraging news for 2018, is that the overall sickness absence month on month has been below 2017/18 out-turn, with the exception of June and August. If the traditional pattern of sickness absence continues, we envisage an increase in absence during November – January (the winter period).

To ensure that managers feel well-equipped to support staff and manage sickness absence, there will be further promotion of sickness absence training courses in general. In addition be-spoke training will be taking place within the Children's Business Unit which has seen an increase in absence, which could be partly due to the change management processes associated with the securing of the 0-19 tender taking place there. As the Trust is experiencing a volume of management of change processes, there will also be further promotion to remind staff of the range of health and wellbeing support that they can access.

Work also continues on forging strong working links between operational areas and HR on sickness absence. The phase of the work around the Top 10 cases within Business Units has now been concluded, which identified staff are being appropriately supported, and that we have a number of staff with complex health issues. Support and guidance was given, and agreement reached on next steps – closer working between managers and HR will continue on sickness absence.

Additionally work has commenced on analysing and understanding sickness absence within a longer time series or frame in order to be able to better understand trends, reasons and hotspots to target.

3. Appraisal

This period we have refined the calculation of the '6 universal Statutory and Mandatory training requirements' and the' AfC Staff Appraisal Rate (12 Month Rolling - %)' to exclude those individuals who are new into the business, or out of the business. Appraisal rates stand at 87.5% this month.

There has been significant improvement in both Adult and Specialist Business Units since the summer position: 12.1% and 9.7% respectively. This improvement was being seen before the changes to the calculation highlighted above.

Business Unit	Target	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Overall	Imp Traj to 95%	81.88%	80.23%	79.89%	78.53%	83.26%	84.91%	87.51%
Adult		85.71%	82.02%	80.83%	78.64%	82.14%	86.31%	90.70%
Children's		83.38%	84.91%	83.57%	79.12%	83.42%	84.39%	84.25%
Corporate		56.40%	57.35%	64.76%	69.03%	81.63%	84.25%	85.11%
Operations		88.46%	90.82%	90.24%	87.89%	89.16%	88.00%	90.53%
Specialist		80.70%	77.14%	76.65%	77.58%	84.31%	82.89%	86.36%

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

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

4. Statutory and Mandatory training

Please note that the refinement of the '6 universal Statutory and Mandatory training requirements' has contributed to an overall slight improvement for these KPIs as well for this period. Overall performance against the target for compliance with universal statutory and mandatory training requirements during October was 90.3%.

The position for Operations is inaccurately low as this includes a number of staff from Assisted Living Leeds, who access training from LCC. Service managers have indicated the compliance level is higher and are providing evidence to support this, which will be reported next month.

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

The continuing focus on improving statutory & mandatory training performance remains:

- Statutory & mandatory training performance focus at Performance Panels, supported by more detailed information on performance at team level.
- A workforce information performance dashboard is currently being developed and tested which will give managers this information on an ongoing basis.
- Weekly update on performance to SMT, via Workforce Information reports
- Statutory & Mandatory Training Monitoring Group weekly focus on enabling actions to improve compliance rates, including ensuring availability of face to face training sessions.

5. Staff Survey

Staff Survey 2018 went live on 8 October. We have seen a very strong start in the initial weeks, with the LCH response rate at week 5 showing 40%, against a national average of 28%. Last year, 54% of LCH staff completed the survey.

There has been significant engagement across the organisation around the feedback from last year's survey, together with a focus on actions to address areas of concern. All Business Units have identified "enabling improvement at team level" as an obsession this year.

There has and will continue to be a series of actions in place to maintain momentum over the final 3 weeks of the survey, including:

- Weekly update to senior managers of current performance by business unit, with a request to cascade to all teams
- Performance thermometers on Elsie
- Blogs in Community Talk by key influencers: Thea, Staff Side, Chair of BAME network
- Presentation & Q&A session by Capita (administrators of the Survey) to explain the process, provide assurance of confidentiality at Leaders Network on 15 November

6. Feedback from Previously Highlighted Issues

Further investigation was carried out by the Workforce Information team to explain the increase in staff leaving within 12 months within the Corporate Directorate.

There are 209 people in this staff group. Usually between 2 and 5 leave per month, however 8 left in September, which is higher than normal and led to the high % turnover figure.

The 8 departures in September included 2 with fewer than 12 months service, both voluntary resignations. One of these was inside the first month of service, for "work / life balance" reasons; and the other left to take up education / training.

Overall, there are no common themes in reason for leaving amongst the 8; however 3 of them are from Assisted Living which looks to have a total workforce of 35, so quite high for just one month.

Leeds Community Healthcare NHS Trust

Finance Report

Finance		Target	YTD	Q1	July	Aug	Sept	Q2	Oct	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2018/19	£1.3m	£1.6m	£0.3m	£0.7m	£0.8m	£1.6m	£1.6m	£1.6m	●
	2017/18		-£3.3m	-£0.9m	-£1.2m	-£1.9m	-£2.1m	-£2.1m	-£2.4m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2018/19	£4.0m	£4.0m	£2.5m	£2.5m	£2.5m	£4.0m	£4.0m	£4.0m	●
	2017/18		-£3.3m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	
Forecast underlying surplus	2018/19	£1.4m	n/a	n/a	n/a	n/a	n/a	n/a	n/a	●
	2017/18		-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	
Capital expenditure in comparison to plan (£k) - YTD	2018/19	£593k	£989k	£303k	£85k	£90k	£87k	£574k	£415k	●
	2017/18		£1.4k	£0.2m	£0.2m	£0.3m	£0.3m	£0.3m	£0.4k	
Capital expenditure in comparison to plan (£m) - Forecast	2018/19	£3.4m	£3.4m	£3.2m	£3.2m	£3.4m	£3.4m	£3.4m	£3.4m	●
	2017/18		£1.4m	£1.8m	£1.8m	£1.8m	£1.8m	£1.8m	£1.8m	
CIP delivery (£m) - YTD	2018/19	£2.5m	£2.4m	£1.0m	£0.3m	£0.3m	£0.3m	£1.9m	£0.5m	●
	2017/18		£2.8m	£0.6m	£0.9m	£1.0m	£1.2m	£1.2m	£1.6m	
CIP delivery (£m) - Forecast	2018/19	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m	£4.7m	£4.5m	●
	2017/18		£2.8m	£3.4m	£2.8m	£2.9m	£2.9m	£2.9m	£2.9m	
Use of Resources Risk Rating (from Oct 2016)	2018/19	2	1	1	1	1	1	1	1	●
	2017/18		1	1	1	1	1	1	1	

1. Income & Expenditure Summary

At the end of October the Trust income and expenditure surplus is £0.3m more than planned. This includes all un-committed reserves which have been released into the position. The Trust's forecast outturn continues to be £4.0m which includes £1.2m original control total, £0.5m additional surplus from the release of a redundancy provision no longer required and £2.3m of Provider Sustainability Funding (PSF) from NHS Improvement.

Previous reports have referenced a financial risk in respect of the loss of £0.7m CCG income; the outstanding sum that remained from the work to identify decommissioning opportunities. This risk had reduced to £463k. At the Contract Management Board meeting on 27 November the CCG agreed to meet, non-recurrently, the 2018/19 outstanding financial risk associated with this issue.

2. Income

Year to date contract income continues to run slightly less than plan due to penalties for the police custody and community care beds contracts. Non-contract income continues to be as planned. Receipt of all CQUIN and PSF has been assumed.

Forecast income is £0.3m less than planned this will be mitigated by underspending on reserves expenditure.

3. Pay and Non-pay Expenditure & Vacancies

Year to date

Pay expenditure is £0.4m underspent at the end of October, this includes the impact of the medical pay award which has been actioned this month. The main driver for the underspending is the level of vacancies which are 94 wte (96 wte Sept), or 3.5% of establishment; this is after the budgeted vacancy factor reduction. Temporary staffing costs were £524k for the month slightly less than last month.

Agency staffing expenditure is 15.5% below the cap and not a concern.

Non-pay continues to overspend this is marginally less than last month; the overspending is 0.6% of expenditure and is not a risk to the overall financial position. Other non-pay costs include the as yet

un-identified corporate and Trust-wide CIPs which are resulting in the year to date overspending. Given the Trust's overall financial position it is not intended to pursue these this year but they do need to be delivered recurrently.

Forecast Outturn

The pay forecast underspending is £0.3m which is £0.1m more than last month it includes additional recruitment planned for the second half of the year in police custody, children's paediatrics and neighbourhood team services in particular.

The non-pay forecast overspend is £0.5m including a £0.2m overspending on interpreting services which is being investigated and the forecast cost of additional clinical contracts to increase capacity in the neighbourhood teams for winter.

4. Delivery of Cost Improvement Plans

CIP delivery remains consistent with last month; there is a 3.8% (£95k) shortfall in respect of the procurement savings at the end of October. Specific corporate support savings have not been identified however corporate pay continues to be underspent at the end of October so these savings are being made non-recurrently.

The forecast delivery of the procurement savings has been revised this month as it is unclear where these savings will be achieved this year. All other savings are forecast to be achieved this year. This will not impact on the delivery of the £.0m surplus as it will be mitigated by other non-recurrent savings.

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

5. Capital Expenditure

The Trust had planned for capital expenditure of £3.241m. The Trust now has an additional national allocation of £127k to enable public WiFi access in the Trust's premises. The Trust expects to spend the full £3.368m. The small year to date overspending is due to the timing of expenditure and is not a concern in respect of the overall position.

6. Cash

The Trust's cash position remains very strong at £25.2m, £1.1m less than planned as a result of net adverse payables and receivables variances.

7. Better Payment Practice Code

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

8. Use of Resources Risk Rating

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

Further detailed Financial Data Tables are available in Appendix 3.

FURTHER INFORMATION AND DATA PACK

Appendix 1 – Serious Incidents and Pressure Ulcers

Serious Incidents

There were 3 SI's reported to the CCG in October 2018 2 pressure ulcers and 1 fall

Three Serious Incident investigations were signed off/ closed in October.

1 was a pressure ulcer incident, found to be unavoidable; 1 fall and 1 patient confidentiality. Both of these were found to be avoidable to LCH.

Action Plans

All action plan leads receive an automated reminder of overdue actions.

Total SI's Closed	2016/17	2017/18	2018/19
	92	97	24(to date)
Total number of actions generated (from closed SI's)	221	373	92
Actions closed within timescale	88	105	32
Actions closed outside of timescale	133	196	13
Total actions closed	**221**	**301**	**45**
Number of SI's with current open action plans	**0**	**19**	**14**
Total number of actions currently open	0	72	47
Number of actions over deadline	0	67	14

Pressure Ulcers

New Pressure Ulcers in October

45 pressure ulcers (LCH PSI) were reported.

No category 4 ulcers reported in October.

On 1st November it was 38 days since the last category 4 pressure ulcer was reported and there have been no avoidable category 4 pressure ulcer incidents in this financial year.

Total Pressure Ulcers and Categories	Number of Pressure ulcers	Pressure ulcer Severity
Category 2	22	Minimum Harm
Category 3	12	Moderate Harm
Unstageable	11	
Category 4	0	Major harm
Total	45	

Closed Pressure Ulcers in October

34 LCH pressure ulcer incidents (all reported categories) were investigated and closed. One was found to be avoidable to LCH

Avoidable Pressure Ulcers investigated and closed in October

	Category 2	Category 3	Unstageable	Category 4	Total
Avoidable incident attributable to LCH Care	0	0	1	0	1
Avoidable incident attributable to patient or other care provider	0	2	1	0	3
Unavoidable incident or accident	22	5	3	0	30
Total	22	7	5	0	34

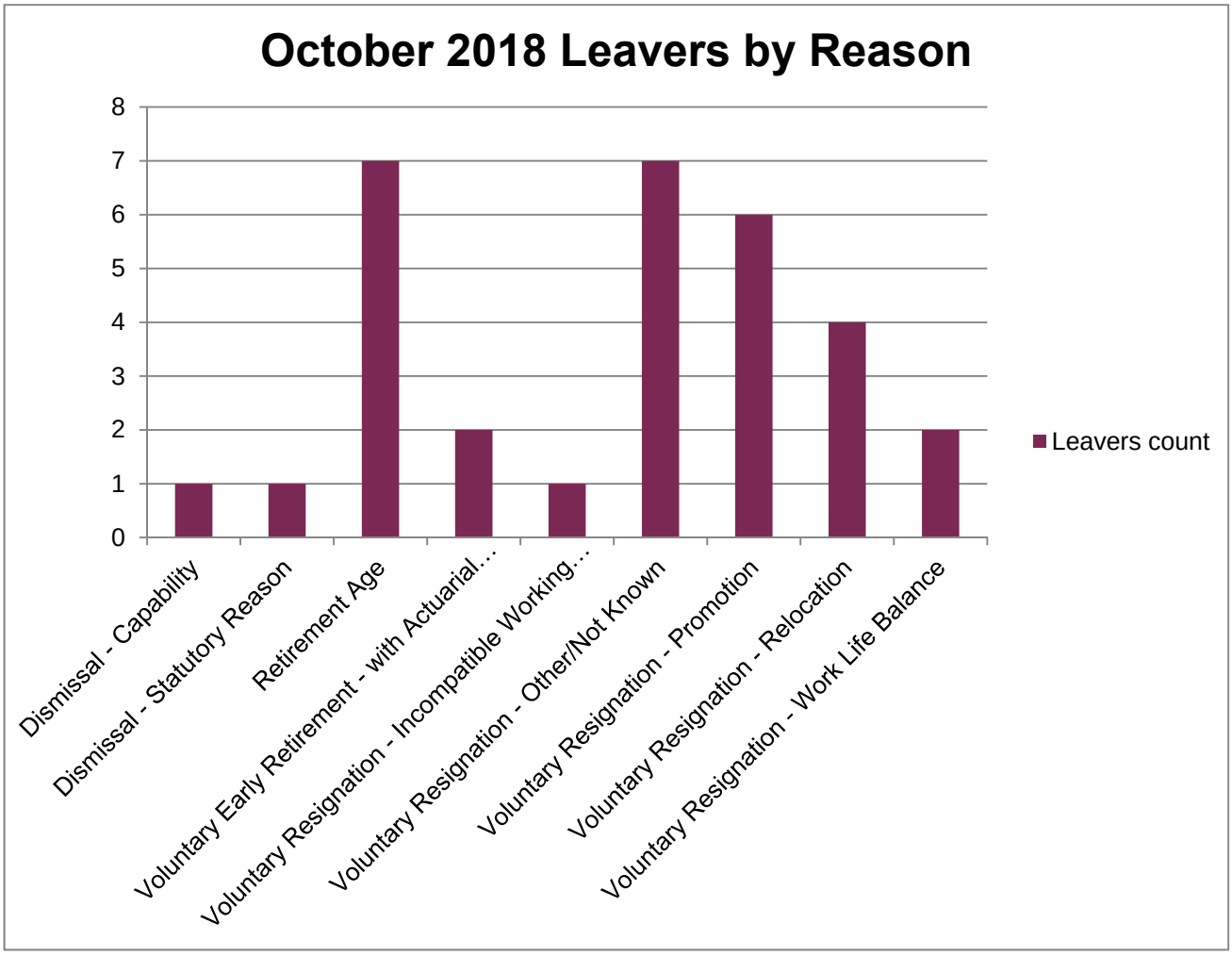
The one avoidable pressure ulcer investigation conclued that clinical judgement and the result of the pressure screening tool would have determined that pressure relieving equipment was needed. Since pressure relieving equipment has been in place thepressure ulcer has healed which is indicative that it would have prevented the initial damage had it of been in situ.

Appendix 2: Retention background data

In October 2018 there were 31 leavers across the Trust. Their distribution by Business Unit, staff group and reason for leaving is set out below:

Business Unit	October 18 Leavers
Adult Business unit	13
Children's Business Unit	6
Corporate / Operations	3
Specialist Business Unit	9
Grand Total	**31**

Staff Group	October 18 Leavers
Clinical Services and Scientific/medical	5
Administrative and Clerical	9
Allied Health Professionals	3
Nursing and Midwifery Registered	13
Medical and Dental	1
Grand Total	**31**



Appendix 3 Detailed Financial Data Tables

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	£1.6m	£0.3m	£4.0m	G
Remain with EFL of (£3.708m)			-£3.7m	G
Remain within CRL of £2.039m	£1.0m	-£0.5m	£3.4m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	97%	2%	95%	G
BPPC NHS Invoices Value 95%	99%	4%	95%	G
BPPC Non NHS Invoices Number 95%	96%	1%	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	£1.9m	-5%	£3.0m	R
CIP Savings £1.5m planned non recurrent in year	£0.6m	-	£1.7m	G

Table 2 Income & Expenditure Summary	October Plan WTE	October 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			(81.1)	(80.9)	0.2	(138.9)	(138.7)	0.3	0.3
Other Income			(6.0)	(6.0)	0.0	(10.2)	(10.2)	0.0	(0.0)
Total Income			***(87.1)***	***(86.8)***	***0.3***	***(149.1)***	***(148.8)***	***0.3***	***0.3***
Expenditure									
Pay	2,675.1	2,581.1	62.4	62.0	(0.4)	107.1	106.8	(0.3)	(0.2)
Non pay			21.5	21.7	0.1	36.8	37.3	0.5	0.5
Reserves & Non Recurrent			0.4	(0.0)	(0.4)	0.3	(0.9)	(1.2)	(0.6)
Total Expenditure	***2,675.1***	***2,581.1***	***84.3***	***83.7***	***(0.6)***	***144.1***	***143.1***	***(1.0)***	***(0.3)***
EBITDA	**2,675.1**	**2,581.1**	**(2.8)**	**(3.1)**	**(0.4)**	**(5.0)**	**(5.7)**	**(0.7)**	**(0.0)**
Depreciation			1.1	1.1	0.0	1.9	2.0	0.0	0.0
Public Dividend Capital			0.4	0.4	(0.0)	0.7	0.8	0.1	0.0
Profit/Loss on Asset Disp			0.0	0.1	0.1	0.0	0.1	0.1	0.1
Interest Received			(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)
Retained Net Surplus	**2,675.1**	**2,581.1**	**(1.3)**	**(1.6)**	**(0.3)**	**(2.5)**	**(3.0)**	**(0.5)**	**(0.0)**
	Variance =	**(94.0)**							

Table 3 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	YTD Actuals £k
Directly employed staff	7,886	7,829	7,898	8,247	8,688	8,344	8,340	57,233
Seconded staff costs	88	51	109	86	83	12	72	501
Bank staff	176	218	224	45	163	166	138	1,129
Agency staff	438	417	549	394	462	507	386	3,153
Total Pay Costs	**8,588**	**8,515**	**8,781**	**8,772**	**9,396**	**9,029**	**8,936**	**62,017**

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	471	474	3	7	
Clinical Supplies & Services	5,928	5,620	(307)	(273)	
General Supplies & Services	3,010	2,916	(94)	(73)	
Establishment Expenses	3,904	3,833	(71)	(82)	
Premises	7,272	7,403	132	193	
Other non pay	963	1,432	468	366	
Total Non Pay Costs	**21,548**	**21,679**	**130**	**137**	**505**

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	408	408	0	700	700	0	0%
Admin Review	146	146	0	250	250	0	0%
Corporate Support	175	175	0	300	300	0	0%
Procurement	105	10	(95)	180	10	(170)	-94%
Non Pay Inflation	257	257	0	440	440	0	0%
CQUIN	264	264	0	452	452	0	0%
Contribution to overheads / fixed costs	485	485	0	831	831	0	0%
Release of Reserves	44	44	0	75	75	0	0%
IT Kit	175	175	0	300	300	0	0%
Discretionary spending	292	292	0	500	500	0	0%
Decommissioning cost reduction	117	117	0	700	700	0	0%
Total Efficiency Savings Delivery	**2,466**	**2,371**	**(95)**	**4,728**	**4,558**	**(170)**	**-4%**

Table 6 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.3	0.3	(0.1)	0.7	0.7	0.0
Equipment/IT	0.0	0.4	0.4	0.5	0.5	0.0
Electronic Patient Records	0.2	0.2	(0.0)	0.5	0.5	0.0
CAMHS Tier 4	0.0	0.2	0.2	1.5	1.5	0.0
Public WiFi				0.1	0.1	0.0
Totals	**0.5**	**1.0**	**0.5**	**3.4**	**3.4**	**0.0**

Table 7 Statement of Financial Position	Plan 31/10/2018 £m	Actual 31/10/2018 £m	Variance 31/10/2018 £m	*Opening 01/04/18 £m*	Planned Outturn 31/03/19 £m	Forecast Outturn 31/03/19 £m	Forecast Variance 31/03/19 £m
Property, Plant and Equipment	28.7	29.1	0.4	*29.3*	30.7	30.7	0.1
Intangible Assets	0.0	0.0	(0.0)	*0.1*	0.0	0.0	0.0
Total Non Current Assets	**28.8**	**29.1**	**0.4**	*29.4*	**30.7**	**30.8**	**0.1**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	7.0	7.5	0.5	*8.8*	7.9	8.9	1.0
Cash and Cash Equivalents	26.3	25.2	(1.1)	*23.2*	27.3	27.3	0.1
Total Current Assets	**33.2**	**32.7**	**(0.5)**	*32.1*	**35.2**	**36.2**	**1.1**
TOTAL ASSETS	**62.0**	**61.9**	**(0.1)**	*61.5*	**65.8**	**67.0**	**1.1**
Current Liabilities							
Trade and Other Payables	(12.0)	(10.7)	1.3	*(12.1)*	(13.4)	(12.9)	0.5
Provisions	(0.4)	(0.7)	(0.3)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.4)**	**(11.4)**	**1.0**	*(13.4)*	**(13.8)**	**(13.3)**	**0.5**
Net Current Assets/(Liabilities)	**20.8**	**21.3**	**0.5**	*18.7*	**21.4**	**22.9**	**1.6**
TOTAL ASSETS LESS CURRENT LIABILITIES	**49.6**	**50.4**	**0.9**	*48.0*	**52.1**	**53.7**	**1.6**
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	**49.6**	**50.4**	**0.9**	**48.0**	**52.1**	**53.7**	**1.6**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.1	*0.3*	1.8	1.9	0.1
Retained Earnings Reserve	18.8	19.6	0.8	*17.2*	19.7	21.2	1.5
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	**49.6**	**50.4**	**0.9**	**48.0**	**52.1**	**53.7**	**1.6**

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

Table 9 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	54	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	9.8	1	20%	0.2
Underlying performance	I&E margin	3%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-16%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (73)

Meeting: Trust Board 7 December 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 / Company Secretary	**For assurance**	√
Previously considered by: Senior Management Team (SMT) 21 November 2018	**For information**	

Purpose of the report:

This summary report is part of the governance processes supporting risk management in that it provides the Board with updated information about the effectiveness of the risk management processes and that adequate controls are in place to manage risks.

The summary report provides the Board with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received in October 2018.

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

Main issues for consideration:

This summary report shows changes to the risk register (for risks scoring 15 or above) since October 2018

- Two risks currently scoring 15 or above (extreme)
- No new risks scoring 15 or above
- No deescalated risks, which previously scored 15 or above
- No closed risks, which previously scored 15 or above
- One new risk scoring 12

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

Recommendations

The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

SIGNIFICANT RISKS REPORT

1.0 Introduction

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

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks). This report provides a description of risk movement since the last register report was received by the Board (5 October 2018), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk.

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

1.4 This paper provides a summary of the current Board Assurance Framework (BAF) and an indication of the assurance level that has been determined for each strategic risk.

2.0 Summary of current risks scoring 15 or above

2.1 There are two risks with a current score of 15 (extreme) or above on the Trust risk register as at 8 November 2018. These are as follows:

Risk ID	Risk description	Risk score	Risk movement
Risk 224	Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.	16 (extreme)	⟷
Risk 939	New CAMHS Tier 4 building costs	16 (extreme)	⟷

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

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

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

2.5 There are no closed risks which previously scored 15 (extreme) or above.

3.0 Risks scoring 12 (high)

3.1 There is one new risk scoring 12 reported since October 2018:

Risk 954	Initial risk score **15**	Current risk score **12**	Target risk score **3**

Title: Diabetes Service Waiting Times

As a result of an increase in demand for the diabetes service, there is a risk that the waiting times will exceed 18 weeks. This could lead to the condition of patients who are unstable, or who require insulin, worsening or result in their admission to hospital. This would also put the reputation of the service at risk.

In order to achieve the target score of 3 the service needs to reduce its waiting times by having more staff to meet with the demand, and by identifying efficiencies in its current working practices in order for existing staff to see more patients.

Controls in place are:

- Dietitians asked to work extra hours to put on extra clinics
- Clinical Lead holding extra clinics on an ad hoc basis

Planned actions include:

- Business manager exploring potential additional commissioner funding
- Exploring the use of agency staff
- Plan to commence group consultations
- Assistance from LTHT/ external specialist to look at potential efficiencies and carry out the requirements of the action plan

4.0 Risks escalated to a score of 12 (high)

4.1 No risks have been escalated to a score of 12 since October 2018

5.0 Risks deescalated from a score of 12 (high)

5.1 No risks have been deescalated from a score of 12 since October 2018

6.0 Closed risks previously scoring 12

6.1 No risks have been closed, which previously scored 12

7.0 Risks with an out of date review date

7.1 Risk owners are asked to update their risks where a review date had passed. If risks review dates remain outstanding, further reminders are sent and any risks remaining out of date by more than a month are escalated to the relevant director for intervention.

8.0 Board Assurance Framework Summary

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

8.2 Definitions:

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

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

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

8.5 The BAF summary **(appendix 1)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board, in line with the risk assurance levels described in **appendix 2** (BAF risk assurance levels). Where adjustments have been made to the level of assurance, an explanation is provided.

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

Positive assurance movement

- BAF risk 1.3 (maintaining and continuing to improve service quality,) has moved further into reasonable. Progress being made with the Quality Improvement action plan, the assurance received from the Clinical Excellence Group internal audit report, and the Safeguarding Team and Infection Prevention and Control annual reports all provided Quality Committee with reasonable assurance.
- BAF risk 2.1 (achieving internal projects) has moved further into reasonable. The Change Board report to Business Committee included the EPR project which provided substantial assurance and the E-rostering project which provided reasonable assurance.
- BAF risks 3.1 (suitable and sufficient staff capacity and capability), 3.3 (engage with and involve staff) and 3.4 (invest in developing managerial and leadership capability) have all moved further into reasonable as the outline of revised Workforce Strategy provided reasonable assurance to Business Committee.
- BAF risk 3.2 (address the scale of sickness absence) Business Committee was provided with reasonable assurance of the good practice leading to improved attendance in some areas of the organisation.

Negative assurance movement

- No negative movement has taken place during this reporting period.

8.7 The attached BAF summary reflects the amended assurance levels.

9.0 Recommendation

9.1 The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

Appendix One: Board Assurance Framework summary

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score				Current Level of Assurance (denoted by ◆).					
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	12				◆		Clinical Outcomes Programme received limited assurance at Quality Committee	
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships.	SL	QC	2	4	8				◆			
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	SL	QC	2	3	6				◆		QIP action plan progress, CEG internal audit report, Safeguarding Team, Infection Prevention and Control annual report all receved reasonable assurance at Quality Committee	→
	RISK 1.4 If the Trust does not achieve external and internal quality priorities and targets then this may cause damage to reputation and loss of income.	SL	QC	3	2	6				◆			
Provide sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	2	3	6				◆		Within the Change Board report to Business Committee, EPR received substantial assurance and E-rostering received reasonable assurance.	→
	RISK 2.2 If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	3	3	9				◆			
	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				◆		Productivity Group update received reasonable assurance at Business Committee	
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12				◆			
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8				◆			

Recruit, develop and retain the staff we need now and for the future	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	AH	BC	4	4	16						Outline of revised Workforce Strategy received reasonable assurance at Business Committee.	→
	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						Performance Brief information on sickness absence provided Business Committee with reasonable assurance, recognising the good practice leading to improved attendance in some areas.	→
	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 received reasonable assurance from WRES action plan and outline of revised Workforce Strategy	→
	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						Outline of revised Workforce Strategy received reasonable assurance at Business Committee.	→
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ex STP) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC	3	3	9							
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	3	4	12							
	RISK 4.3 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage.	SL	QC	3	3	9						Friends and family test received reasonable assurance at Quality Committee	
	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 Two: Glossary- BAF risk assurance levels

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (74)

Meeting: Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title Telling the Neighbourhood Team Activity Story	**For approval**	
Responsible director Executive Director of Operations	**For assurance**	✓
Previously considered by Business Committee – 24 October 2018	**For information**	

Purpose of the report

This paper explains how the reduction in face to face activity in Neighbourhood Team is a consequence of the transformational change in the service.

The case study included as the appendix demonstrates how the changes have impacted on practice and the reporting of activity

Main issues for consideration

This explanation of the changes is now accepted by commissioners and work on a revised and realistic contractual profile was signed off at the Contract Management Board on 27 November 2018

The Board is recommended to:

- The Board is asked to receive the narrative explaining the reduction in face to face activity in the Neighbourhood Teams

TELLING THE NEIGHBOURHOOD TEAM ACTIVITY STORY

1. Purpose of the Report

1.1 This paper explains how the reduction in face to face activity in Neighbourhood Team is a consequence of the transformational change in the service.

1.2 The case study included as the appendix demonstrates how the changes have impacted on practice and the reporting of activity

2. Background

2.1 In 2011 Leeds Community Healthcare NHS Trust (LCH) embarked on a programme of work to transform the services provided within the then district nursing, intermediate care (ICT), community matrons, domiciliary physiotherapy, social work and associated support services. This resulted in the development of thirteen integrated neighbourhood teams covering the Leeds footprint.

2.2 The aims of the programme were influenced by what patients had told us – that their experience was not joined up and they were tired of repeating their story. They felt that too many people were involved in their care and they wanted to relate to a small team of clinicians who knew them well. Our staff told us that they were not using their clinical skills to the optimum and their roles would be more rewarding if they could ensure continuity of care for their patients. Our approach to integrate the teams was supported by system leaders and commissioners.

3. The Transformation Programme

3.1 The transformation of the service entailed:

- Integrating staff from the different community based teams into 13 neighbourhood teams
- Routing all referrals through a single point of urgent referral to ensure that all referrals are appropriate and patients are directed to the correct service (thus reducing the number of “inappropriate” referrals)
- Introducing a single, comprehensive assessment process
- Ensuring all staff had the necessary clinical skills to meet patient need (eg District Nurses and Senior Nurses in Intermediate Care did not have a common skill set at the point of integration which led to unnecessary multiple visits)
- Introducing new ways of working to ensure the right clinician see the right patient every time (through new allocation processes)
- Developing an essential visits list so there is clear guidance when and how often patients must be seen
- Ensuring all patients are regularly reviewed and when appropriate discharged from the caseload
- Implementing an electronic patient record so all care staff had access to a contemporaneous record
- Encouraging patients (or their family members) to self-care including the recent appointment of self-management advisers into the teams
- Implementing daily handovers and safety huddles to give assurance on safety

4. How did this affect activity recording?

4.1 At the start of the project activity was captured and reported by each professional group – this reporting was consolidated in April 2016. Since that time there has been a steady reduction in the number of face to face contacts

4.2 When considering the changes introduced through the programme, a reduction in face to face contacts could have been anticipated but was not but should have been highlighted to commissioners at the time.

4.3 During this same period the average contact time increased by 2.29 minutes (6.6%) meaning total patient facing time has reduced by approximately 146 hours per week. This has allowed the teams to introduce daily handovers, safety huddles, caseload reviews and other quality assurance processes.

Time Period	Average Weekly Face To Face Contacts	Average Contact Duration (mins)	Total Time (mins)	Total Time (hours)
FY 2016/2017	15,516	34.88	541,198	9,020
FY 2017/2018	14,324	37.17	532,423	8,874

5 Conclusion

5.1 The multiple changes that occurred over the extended period clearly resulted in improved quality of care (increased continuity, care provided by most appropriate and skilled clinician, regular caseload reviews)

5.2 It is challenging to attribute specific reduction in face to face activity to any single element of the transformation programme

5.3 The information we have suggests that patients are being visited less frequently but the contacts are longer and meet individuals' needs more appropriately.

5.4 Commissioners now understand this story and have agreed a revised and realistic contractual profile. This was signed off at Contract Management Board on 27 November 2018

6 Recommendations for Board

- The Board is asked to receive the narrative explaining the reduction in face to face activity in the Neighbourhood Teams

Appendix I – case study

- Let us take a moment to review Mrs Stockdale's* care experience over the past three years. Like many people on the Neighbourhood Team caseload, Mrs Stockdale is a frail older person with a range of needs. She is an insulin dependent diabetic. In addition she has some wound care needs. She lives with her husband who is showing early signs of dementia

- In 2015 Mrs Stockdale may have received three separate assessments: a district nursing assessment, an ICT assessment and a Community Matron assessment. Each team would have completed a separate assessment and care plan

- In April 2018, Mrs Stockdale was referred into a Neighbourhood Team. She was triaged by a senior clinician and referred to a nurse who visited her to undertake a comprehensive holistic assessment. This was a single contact and assessment, based on a proactive personalised approach.

- Following assessment, Mrs Stockdale was allocated to a named clinician, who regularly brought her case for discussion to the multi-professional caseload management meeting. As part of that discussion her wound care needs were identified and then discussed with the Wound Prevention and Management Service. The team used the agreed Clinical Care Framework for wound care to support care planning. Because everything is recorded electronically on EPR, the WPAMS team was able to access information easily about Mrs Stockdale. The social worker involved in the case management meeting was also alerted to concerns about Mrs Stockdale's husband and could then follow that up.

- In May 2018, as part of a daily handover meeting it was suggested that Mrs Stockdale might be suitable for a self-management approach to help her manage her diabetes. Over a three month period Mrs Stockdale received support from a self-management advisor. For the first three weeks she received the same frequency of contacts – but longer contacts of about an hour to help Mrs Stockdale self-manage (including insulin support, health coaching and behavioural change techniques). Gradually the duration of those contacts reduced as Mrs Stockdale's confidence grew.

- Three months later Mrs Stockdale was reviewed at a caseload cluster review meeting. The team discussed her patient activation (outcome) measures which had gone up as a result of her increased confidence and engagement in managing her diabetes and so it was agreed the self-management advisor could discharge Mrs Stockdale from her caseload. She continued to be case managed by her named clinician, although the number of interventions required has reduced.

*Mrs Stockdale is a pseudonym

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (75)

Meeting Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title Serious Incidents Summary Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident & Risk Assurance Manager	**For assurance**	√
Previously considered by: N/A	**For information**	

Purpose of the report

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

Main issues for consideration

A total of twenty one Serious Incidents were reported and verified in July through to September 2018

Seven of the SI's in this reporting period related to pressure ulcers and four to serious falls. There has been a diverse range of SI Categories in the quarter which is a change from previous quarters, with a total of nine different types of SI's reported to commissioners.

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

Recommendations

The Board is recommended to:

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

Serious Incident Summary Report

1.0 Purpose of this report

1.1 The purpose of this report is to provide the Trust Board with an overview of Serious Incidents (SI's) managed within LCH in the period 01 July – 30 September 2018.

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

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

2.0 Background

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

2.2 SIs should be reported on StEIS within two working days of the incident being confirmed as a Serious Incident. They are allocated to the relevant commissioner via the StEIS report.

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

2.4 A monthly summary of SIs and any exceptions is included within the monthly Clinical Governance Exception report.. This is submitted to the Quality Committee.

3.0 New Serious Incidents in Quarter 2

3.1 Twenty one SI's were reported to the commissioners via STEIS between July and September 2018.

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

Quarter 2 2018/19	Jul 2018	Aug 2018	Sep 2018	Total
Pressure ulcer - Category 3	3	1	0	4
Pressure ulcer - Unstageable	2	1	0	3
Slips, trips, falls and collisions	1	1	2	4
Confidentiality of Information	2	0	0	2
Unexpected Death	2	1	0	3
Patient's case notes or records	1	1	0	2
Possible delay or failure to Monitor	1	1	0	2
Treatment, procedure - failure	0	0	1	1
Total	12	6	3	21

The three unexpected death SI's relates to;

I. Patient died in hospital following breakdown of wound site in the community and developed necrotising fasciitis – investigations yet to be concluded.
II. Unexpected death of a Mother under the care of the Infant mental health service
III. Unexpected death of a patient previously discharged from IAPT service

4.0 Completed Investigations

4.1 Fourteen SI's were signed off by the Director of Nursing or her deputy in quarter 2. All were signed off before the commissioners due date.

4.2 Of the fourteen reports, two were sent directly to the CCG for review, the remaining twelve related to category 3 and unstageable pressure ulcers and a quarterly thematic report and review is sent to commissioners
There were no category 4 pressure ulcers closed in quarter two.

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

Ref	Type	Status	Root Cause(s)
50597	Failure to act on adverse symptoms	Avoidable	It was unclear from the GP referral if the GP wanted acute or community opinion The triage did not follow the triage process correctly and use available resources appropriately. Appropriate treatment was delayed
50357	Patient fall resulting in a complex pelvic	Avoidable	Missed opportunities by the neighbourhood team. Lying/standing blood pressure was not completed, this is important as it could have

	fracture		identified a postural drop which may have contributed to the patient's unsteady balance. No apparent consideration of referral to the therapy team for exercises/rehabilitation which may have addressed unsteady gait. Also it was identified that the patient was identified as being at risk of osteoporosis and not on any bone protection medication at the time, this was never raised with the patients GP.

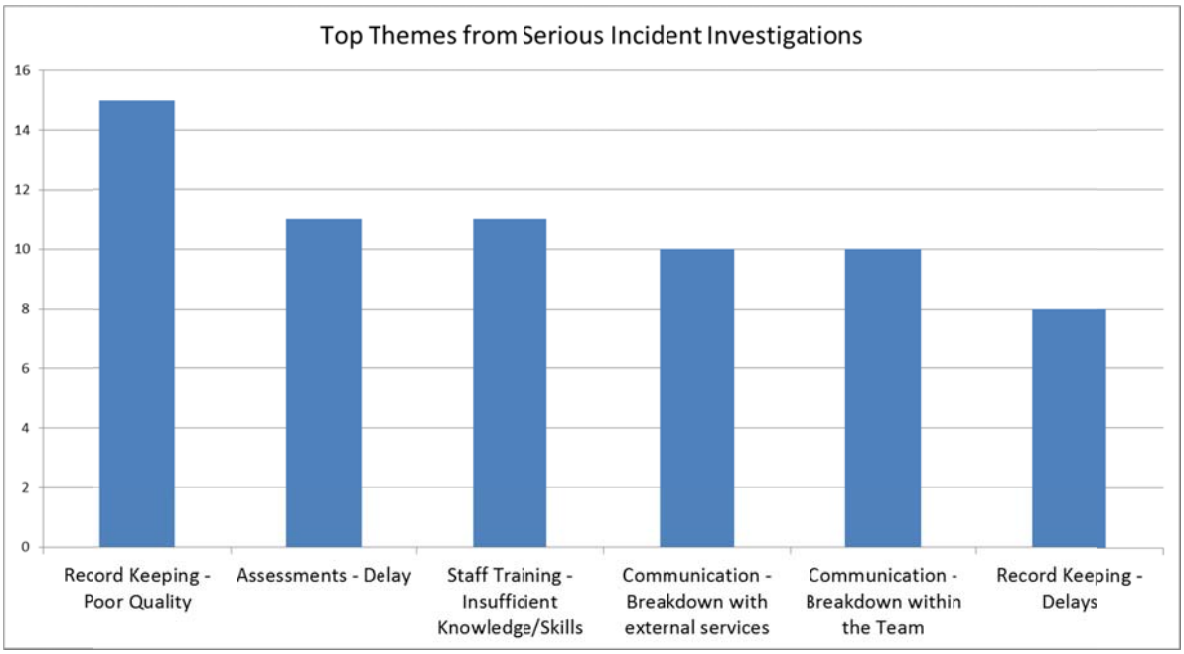
4.3 The themes and learning from the closed investigations have been extracted and included in section 5.0.

4.4 Of the fourteen SI records closed in the quarter, four were found to be avoidable (the two records above, one category 3 pressure ulcer and one unstageable pressure ulcer). The remaining ten were all unavoidable. However there were themes and learning points identified in the majority of incidents investigated.

5.0 Outcomes and Themes

5.1 Themes emerging from all the SI investigation reports completed in July to September identify themes around documentation and record keeping in particular.

5.2 A review of highest reported themes over the rolling year shows that the themes seen in the quarter are reflected in the 12 month data.



5.3 All SIs that have been subject to the serious incident process have both themes and local action plans developed regardless of whether or not the incident is deemed avoidable.

All SI reports require an action plan to be developed alongside completion of the investigation. Action plans are reviewed at a review panel to ensure they are SMART and fully address the recommendations. The action plans, when completed aim to reduce the risk of both the incident reoccurring and a reduction in the associated recurrent themes.

6.0 CCG response

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

6.2 Partnership work continues between LCH and the CCG to cross reference all open SI's to ensure consistent records are held and that all completed investigations are closed on the StEIS database

7.0 Inquests

7.1 Two potential inquests were registered with LCH as an interested party in quarter 2

7.2 One inquest was held and closed in the quarter with no recommendations for the organisation.

	Synopsis	Inquest Date	Outcome	Recommendations
1	Death of a previous patient of CAMHS found hanging	*19/07/2018*	Suicide	There were no coroner recommendations for LCH

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

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

Meeting: Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title – Patient Experience Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Complaints, Claims and Patient Experience Manager	**For assurance**	✓
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

This report provides the Trust Board with the agreed six monthly update of the themes of patient experience within Leeds Community Healthcare NHS Trust (LCH) for the financial year.
The report incorporates the information required for the annual complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). The information used in the report has been taken from complaints, concerns and the Friends and Family Test.

MAIN ISSUES FOR CONSIDERATION

The report provides a thematic review of complaints, concerns, and feedback via the Friends and Family Test for 2017/18. It compares the data with previous years and where relevant, national data. It later analyses identified themes in greater detail and triangulates information where possible to identify commonalities across all sources of intelligence.

Clinical Judgement/Poor Treatment, Appointments, Attitude, Communication and Access/Availability are the top 5 themes of complaint and concerns for the second year running. These themes are generally in keeping with what has been the national picture for complaints for more than five years.

Friends and Family Test (FFT) intelligence has previously been described as generally unreflective of the themes identified primarily because FFT feedback is mostly positive with few true negative comments being received through this source. Where possible the FFT data has been linked to themes with the other patient feedback although it is recognised that the number of overall responses to FFT is low hence the use and significance of FFT intelligence is limited for this type of analysis.

RECOMMENDATIONS

Trust Board is requested to:

- Receive this report
- Note the updated information and stability of ongoing themes.
- Approve the proposal that the report is presented in this format for the final time.

Patient Experience Report

1. INTRODUCTION

The purpose of this report is to provide the Trust Board with the agreed six monthly update of the themes of patient experience within Leeds Community Healthcare NHS Trust (LCH) for the current financial year.

The report incorporates the information required for the annual complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009). The information used in the report has been taken from complaints, concerns and the Friends and Family Test.

2. BACKGROUND

2.1 It was previously agreed that the Trust Board would receive a six-monthly report on the experience and feedback from patients and their carers'. The report was to include detailed consideration of complaints and patient experience data and would, where possible, include triangulation of themes across the different areas of activity and comparisons to the nationally reported data.

Following discussion at the Patient Safety, Experience and Governance Group (PSEGG), the report was to be shared with the Trust Board, which has corporate responsibility for the monitoring of quality of care. Within LCH, the Chief Executive delegates responsibility for the management of patient experience and incident management to the Executive Director of Nursing.

2.2 The Clinical Governance Team (CGT) is an arm of the Quality and Professional Development Department within the portfolio of responsibility of the Executive Director of Nursing and Quality. The CGT is responsible for providing overarching services for the organisation and includes:

- Quality and safety of patient care
- Meeting statutory/regulatory requirements
- Supporting services in all fields of governance
- The organisations reputation with external and internal stakeholders

Concerns and Complaints, Incidents/Serious Incidents and the Friends and Family Test (FFT) are managed alongside other governance priorities within this structure.

2.3 An annual complaints report is prepared in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This report contributes to those requirements and draws on additional available sources of feedback to gain a more complete picture of the quality of our services.

2.4 A performance summary of patient experience is provided on a monthly basis via the performance exception report and a fuller analysis via the quarterly PSEGG report, and Clinical Governance report.

3 LCH PATIENT FEEDBACK

3.1 The Numbers

3.1.1 For the purposes of clarity throughout the paper, LCH collects patient experience feedback in two different systems. Complaints, concerns, enquiries and compliments are collected / recorded within the Datix® system held by the Trust. The Friends and Family Test (FFT) and the comments provided with it are collected via an external system provided by Membership Engagement Services (MES).

3.1.2 From 1 April – 30 September 2018, LCH received 76 complaints which were managed under the 2009 regulations. To date the Trust has received 175 concerns and a total of 101 enquiries – 47 regarding LCH services and 54 about other NHS or local services. The number of concerns recorded is a marked increase and exceeds the number recorded for the previous year.

3.1.3 Subjects and sub-subjects are linked to complaints and concerns; for the 251 pieces of feedback considered for this element of the report, 292 subjects and sub-subjects were recorded.

3.1.4 The Trust acknowledged and responded to all received complaints within the statutory timeframes (3 and 180 working days respectively). Of the complaints closed to date, 52% were not upheld; 35% were partially upheld and 13% were fully upheld. LCH figures are lower than the nationally released figures (September 2018) of approximately 60-65% being either partially or fully upheld. A dip in performance has seen only 36% of complaints received, being responded to within the LCH target timeframe of 40 working days or less. This is discussed further in section 5.4.

3.1.5 So far this year, In addition to the new complaints received, the Trust received requests to consider re-opening 9 complaints, 7 of which were originally received in previous reporting periods. Although the Trust has not been notified of any referrals made to the Parliamentary and Health Services Ombudsman, the Complaints Manager is aware of one case which has been rejected by the PHSO. The family involved has been referred back to the Trust. There are currently no LCH complaints under review or investigation by the PHSO.

3.1.6 A further 8 complaints were received, of which 4 were withdrawn by the respective complainants and 4 were withdrawn by the Trust, 2 due to finding on review they did not relate to the Trust, 1 complainant did not respond to correspondence or contact to confirm the complaint content and areas to review and 1 patient had died before the investigation could take place and was therefore withdrawn. The withdrawn complaints are not included in the figures noted in 4.1.2. Those re-opened by the Trust were counted when originally received and responded to and are also excluded.

3.1.7 To the end of September 2018, Trust services had also received 744 compliments. 83% of compliments received were given by patients or carers. More information on compliments can be found in Appendix 1.

3.1.8 Feedback on the previous report focussed on a perceived lack of action regarding the drop in recorded compliments. The acknowledged, ongoing decline in the number of compliments recorded via Datix® has been highlighted previously. It is noted that the decrease has been recognised as being offset by the positive comments received via the

Friends and Family Test and that many patients are choosing to give all feedback via the FFT rather than sending compliments separately.

3.1.9 So far 8998 responses to the FFT have been received (6.55% response rate); with 96.2% of respondents saying they would recommend LCH services. This represents an increase in both figures compared to the same period last year. People responding to the FFT have to date provided 8947 comments about their experiences.

3.1.10 To put the feedback figures in context, the Trust made over 760,000 patient contacts in the first half of the year which is broken down by business unit below:

Business Unit	Number of patient contacts
Adult	378,414
Children's	165,519
Specialist	219,766
Total	763,699

Overall, the Trust received 3 complaints or concerns for every 10,000 patient contacts; this is a small increase on the overall figure from last year which was 2.5 complaints or concerns for every 10,000 patient contacts.

3.2 Overarching themes

3.2.1 This section provides an overview of the categorisation of issues raised to date. The relatively low numbers of different types of feedback the Trust receives makes it difficult to complete thematic review over a short period of time. As demonstrated below, the top five categories for complaints have remained consistent for over three years.

3.2.2 Subjects of the same theme are colour coded in the table below.

COMPLAINTS				
	Nationally 2016/17	**Nationally 2017/18**	**LCH 2016/17**	**LCH 2017/18**
1	Communication	Communication	Clinical Judgement / Poor Treatment	Clinical judgement / Poor treatment
2	Patient Care including Nutrition and Hydration	Patient Care including Nutrition and Hydration	Attitude, conduct, cultural and dignity issues	Appointments
3	Values and Behaviours (Staff)	Values and Behaviours (Staff)	Appointments	Attitude, conduct, cultural and dignity issues including Staff attitude and communication
4	Appointments including delays and cancellations	Appointments including delays and cancellations	Communication	Communication
5	Other	Other	Access and availability	Access and availability

3.2.3 The top five subjects within complaints for the first six months of this year are identical to the last two years. At the end of September 2018 the subjects ranked in the following order:

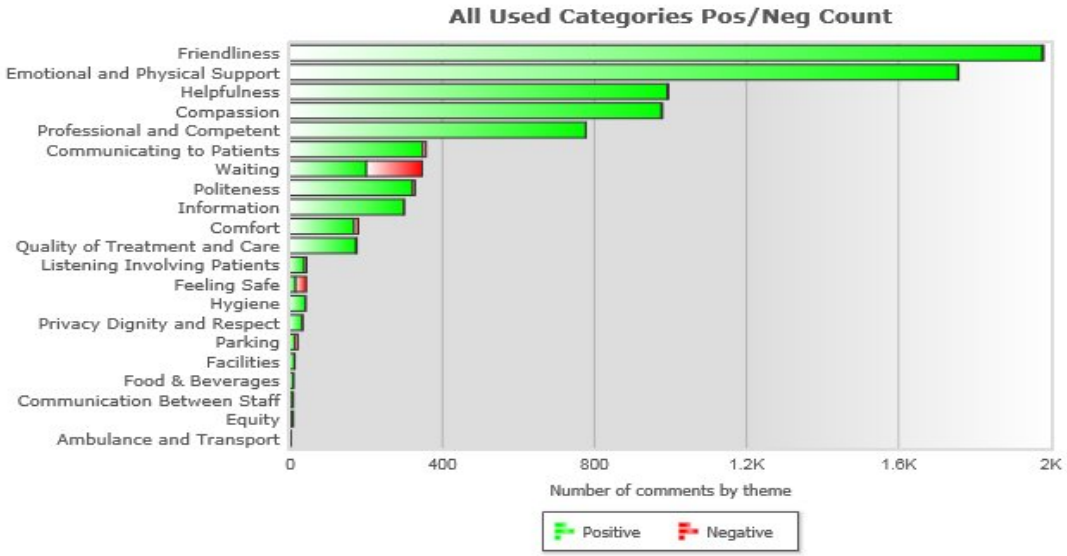
1. Appointment issues
2. Clinical Judgement / Poor Treatment
3. Access and availability
4. Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)
5. Communication issues with the patient

3.2.4 The table below shows the LCH subjects for concerns for the past two years and the first six months of 2018 have remained consistent. This demonstrates the consistency of the issues being raised by patients; it is also noted that over the years the subjects are the same as those raised within complaints.

CONCERNS			
	LCH 2016/17	**LCH 2017/18**	**LCH Apr-Sept 2018**
1	Appointments	Appointments	Appointments
2	Communication issues with the patient	Clinical judgement/ Treatment	Clinical judgement/ Treatment
3	Clinical judgement/ Treatment	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues
4	Attitude, conduct, cultural and dignity issues	Communication issues with the patient	Access and availability
5	Access and availability	Access and availability	Communication issues with the patient

3.3 Friends and Family Test

3.3.1 The FFT results demonstrate an overall positive response to the FFT question with 96.2% of community service users and 96.36% of in-patient user saying they would recommend LCH services. The chart below highlights the overwhelmingly positive nature of the 8947 comments received so far this year.



3.3.2 These comments are provided from 8998 FFT surveys, a response rate that is slightly higher than the same time last year. It has been agreed that the Trust would not apply a blanket target for response rates this year; instead, individual services are expected to achieve a 3% increase on their individual response rates from last year.

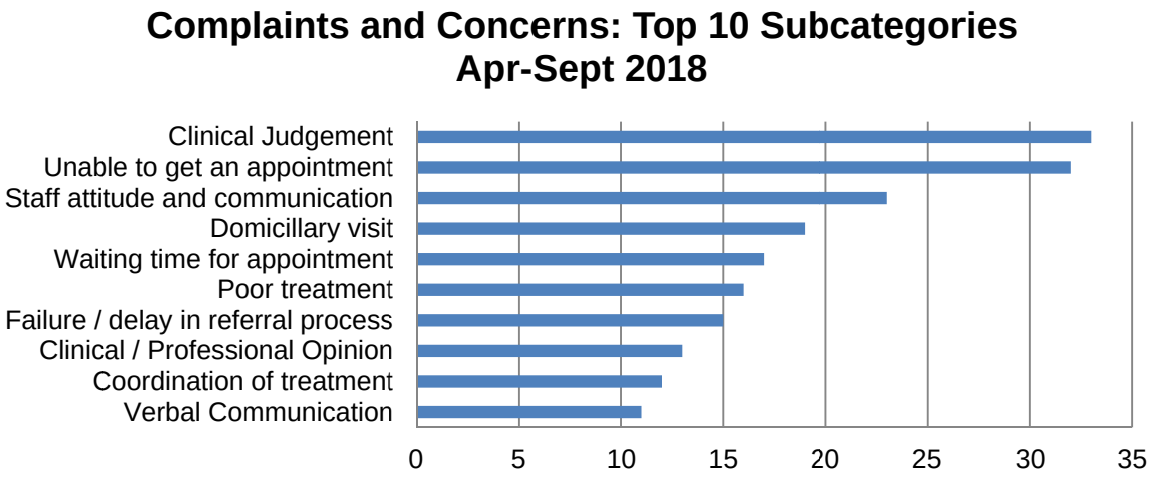
3.3.3 Negative comment responses are primarily recorded under the themes of Waiting, Communicating to patients, Comfort, Parking and Feeling Safe which mirrors the results of the previous report.

3.3.4 The following word cloud provides examples of the words used in the comments received via the FFT in the first six months of the year. It should be noted that "rob" is a member of staff who has been mentioned a number of times by patients. (Normally staff members are referred to by their initials to prevent this from happening). The remaining negative (red) words have been checked and primarily represent a negative word used in a positive sentence e.g. I was worried but you helped to calm me or The thought of the treatment scared me but the staff are amazing.

4.4 Complaint & Concern Sub-Subjects

4.4.1 Sub-subjects lie below the main subject of complaints within the Trust's Complaint and Concern database (C&C). They offer the opportunity for the user to select a more specific representation of the patient or carer's main issue.

4.4.2 The chart below represents the top ten C&C subcategories for the year to date:



4.4.3 This level of categorisation can deepen understanding of the core issues of C&C. The options presently available do not provide significant additional insight beyond the higher level category selected.

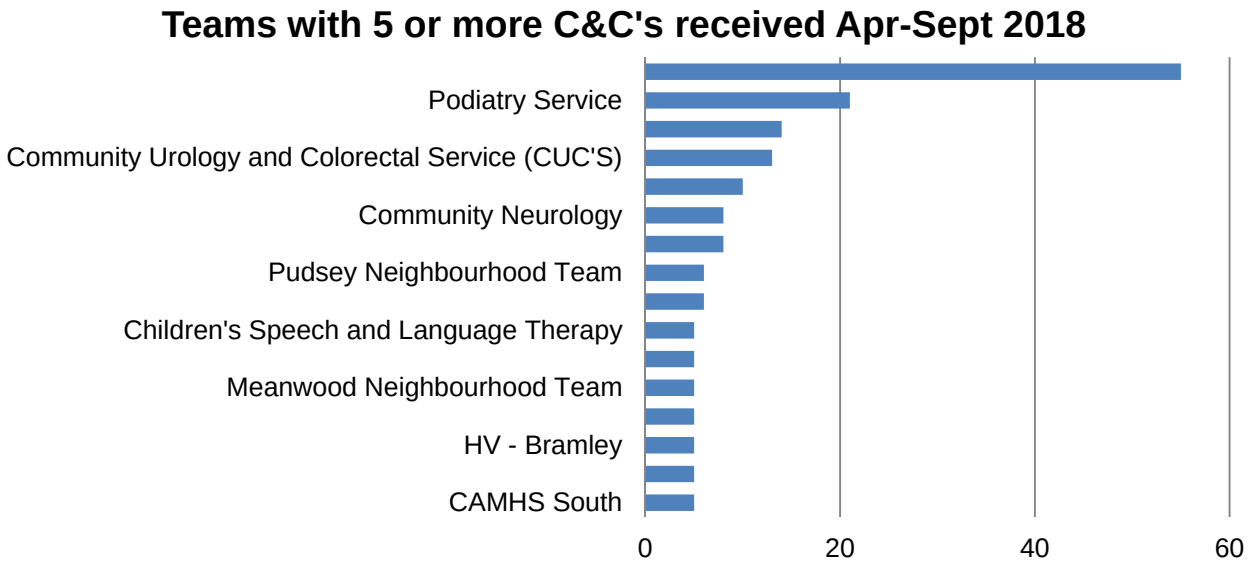
4.4.4 As noted in previous reports, a full review of the Datix® Feedback module including subject categorisation used is planned as part of a larger programme of work around the complaints process and systems.

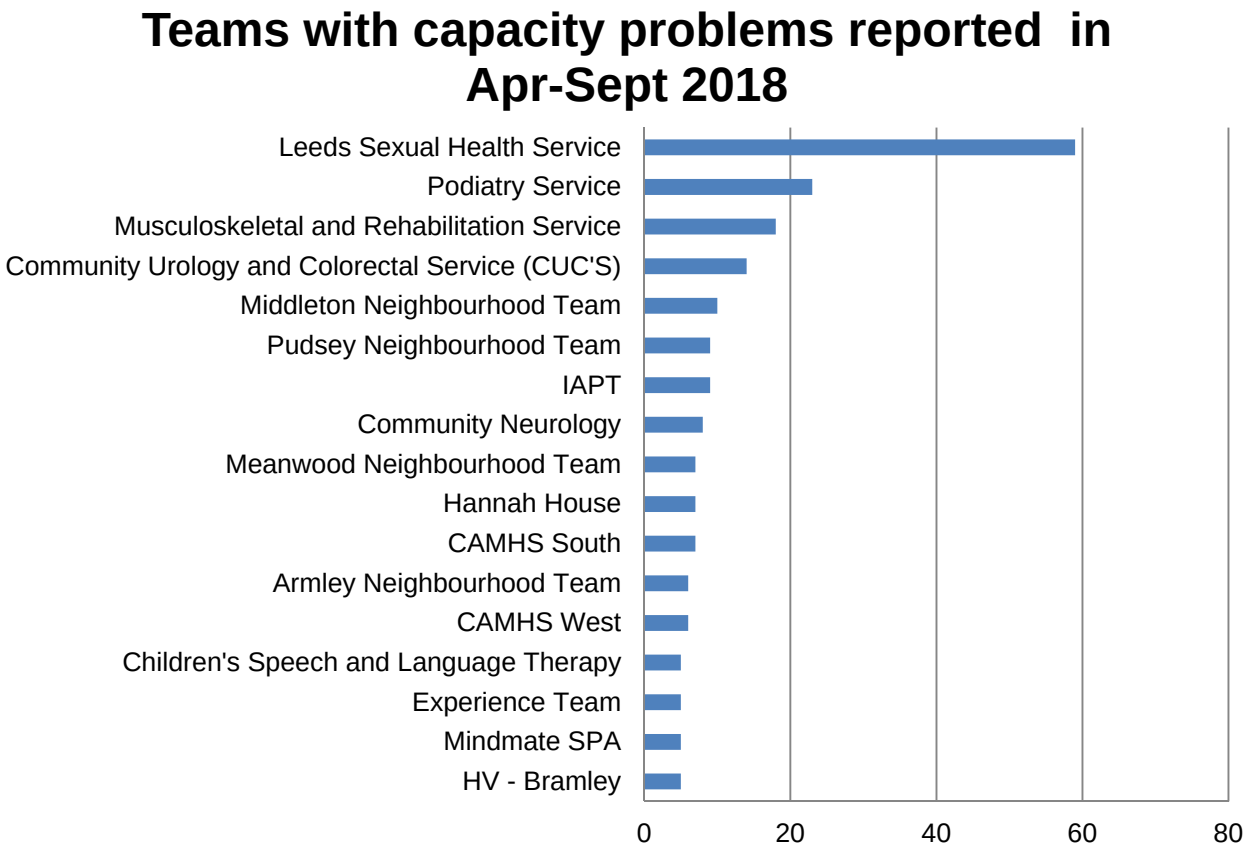
4.5 Teams with highest number of C&Cs

4.5.1 In the reporting period, the Trust has completed 763,699 patient contacts. The table below details how the contacts were split across the business units and the ratio of complaints per 10,000 contacts:

Business Unit	Number of contacts	Total Complaints and Concerns received	Ratio
Adult	378,414	58	1.53
Children's	165,519	59	3.56
Specialist	219,766	126	5.73

4.5.2 The two charts below illustrate the teams with five or more concerns or complaints received and the teams with *capacity problems within the reporting period:





* Capacity problems include capacity and demand problems, staffing, recruitment and retention, levels of sickness – all which are affecting the team's capacity

4.5.3 As identified in previous reports, the teams with the most C&Cs are areas with high numbers of patient contacts (e.g. Leeds Sexual Health Service). They also represent either services where patients receive care for a chronic condition that may be difficult to manage (e.g. Podiatry services) or those where there is a high level of demand for the service (e.g. Community Urology and Colorectal Service (CUC'S).

4.5.4 In total, 56 teams across all business units have received a complaint or concern. There are no unexpected clusters identified within the reporting period.

5.0 OTHER UPDATES

5.1 Internal Audit

In the first half of the year an Internal Audit has been completed with regard to the complaints process. We were rated as providing reasonable assurance regarding the processes in place for the identification, reporting and management of complaints, including how lessons learned are dealt with, communicated and disseminated across the Trust.

The audit highlighted issues that were already known to the Patient Experience and Clinical Governance Teams and as such were being considered for action. Following the audit, the suggested actions are being incorporated into a bigger plan of work, with changes to be introduced and tested over the next four months.

Changes include updates to the management of actions identified during investigations; the re-introduction of Complaints training for front line staff; the re-introduction of Patient Experience sessions in the Corporate Induction; updates to the Feedback module in Datix® and where possible, improved alignment between processes such as incidents and serious incidents. In addition to these changes, formally risk assessing complaints will also be trialled and assessed for impact by the end of the year.

5.2 Patient Experience (Complaints) Policy

The Patient Experience (Complaints) policy was originally intended to be updated before the end of 2017-18. Due to a great deal of interest from front line staff, the process of updating the policy was delayed due to a longer than expected consultation period.
The updated policy was ratified in May 2018 and a further update applied in September 2018.

LCH is part of a citywide complaints managers group, chaired by Healthwatch. The group is currently working on plans for a consistent, citywide approach to dealing with persistent and/or abusive complainants. Should this or the plans relating to the internal audit lead to further changes to the policy; the required process will be followed and staff informed.

5.3 Patient Experience (Complaints) Training

It is recognised that training in dealing with patient feedback and complaints in particular has not been provided for a significant period of time.

Training on complaints management for front line staff was reintroduced as of May 2018. Due to the significant staff involvement with the policy and process update, it was agreed that the training could be re-focussed away from process. The training now includes awareness of the complainants perspective and the benefits of dealing with them positively. Small and large group sessions, and one to one training have been provided to trial the new format; it has been found to be most effective in larger groups. Excellent feedback has been received for the new format.

To date individual uptake via ESR is low but increasing; group sessions booked for specific services are also being utilised. Work to increase visibility and uptake of the training is being considered as this training is beneficial and necessary.

5.4 Performance – Closed Complaint Timeframes

The first six months of the year have been challenging from a response timeframe perspective. As the chart below demonstrates, the Trust performance has dipped with only 36% of the responses to the 64 original complaints closed in the reported period being sent in the LCH target timeframe of 40 working days or less.

Response time	
40 days or less	23
41 - 60 days	23
61 - 90 day	15
91 - 180 days	3
181 days or more	0

A review of the cases has shown that the Trust is fully compliant with the NHS Complaints legislation. Where required, extensions to timeframes are negotiated with complainants. In some instances the extended response time is due to either the complexity of the issues involved or the difficulties experienced in arranging meetings; these issues are again always discussed with complainants.

The review has highlighted that a number of the complaints in this period were delayed due to staffing availability at various levels. These issues meant that either the investigation, the drafting of the response or the review and quality assurance process of the response was delayed or extended beyond the expected timeframes.

As noted in the Internal Audit update, work on the Complaints Process is being discussed and planned. In addition to introducing the elements highlighted by the audit, the longer term goals are to increase the amount of feedback, including complaints, received by the Trust and to have processes in place that ensure all staff and services are clear how to manage and respond to all feedback correctly and in line with the Trust process.

6. ACTIONS AND LEARNING TO IMPROVE SERVICES

6.1 Following the recent internal Complaints audit, the Patient Experience team has now implemented a new step in the process of sharing learning across the Trust using the lessons learnt template. This will align the process with learning from incidents with a collective aim to ensure that the Trust is a 'learning organisation.'

The actions and learning on the new process will be provided in the annual report. The PSEGG meeting is currently being reviewed to include focus on learning from patient experience from services and the Trust.

7. RECOMMENDATIONS

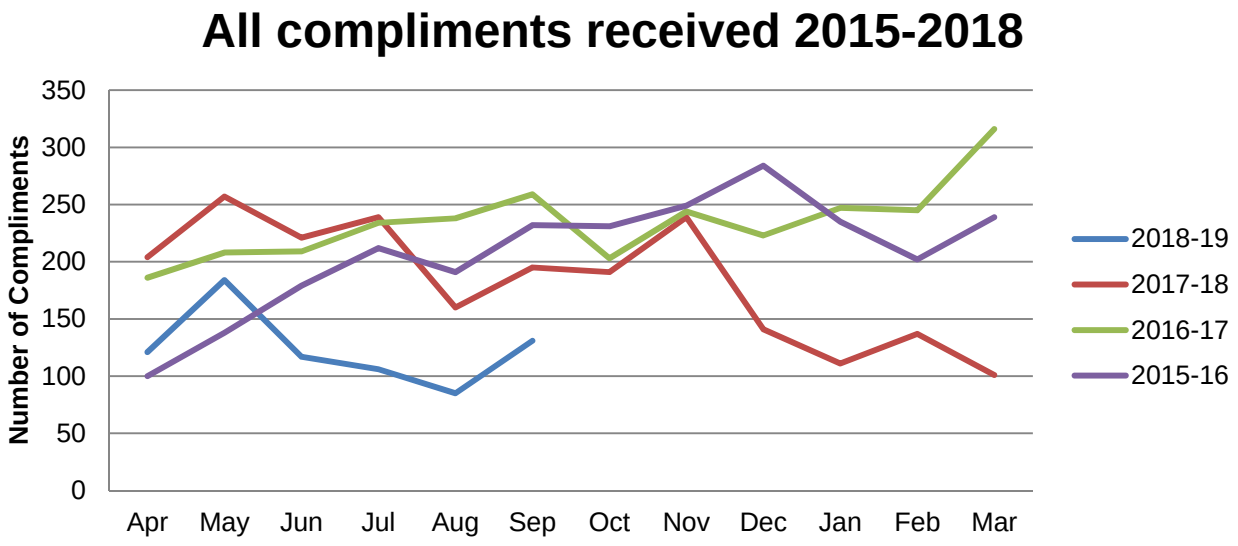
7.1 Trust Board is requested to:

- Receive this report
- Note the updated information and stability of ongoing themes.
- Approve the proposal that the report is presented in this format for the final time.

Appendix 1: Compliments received by LCH services

The charts below provide further detail about the compliments received by LCH services and reported via Datix® from 2015 to September 2018.

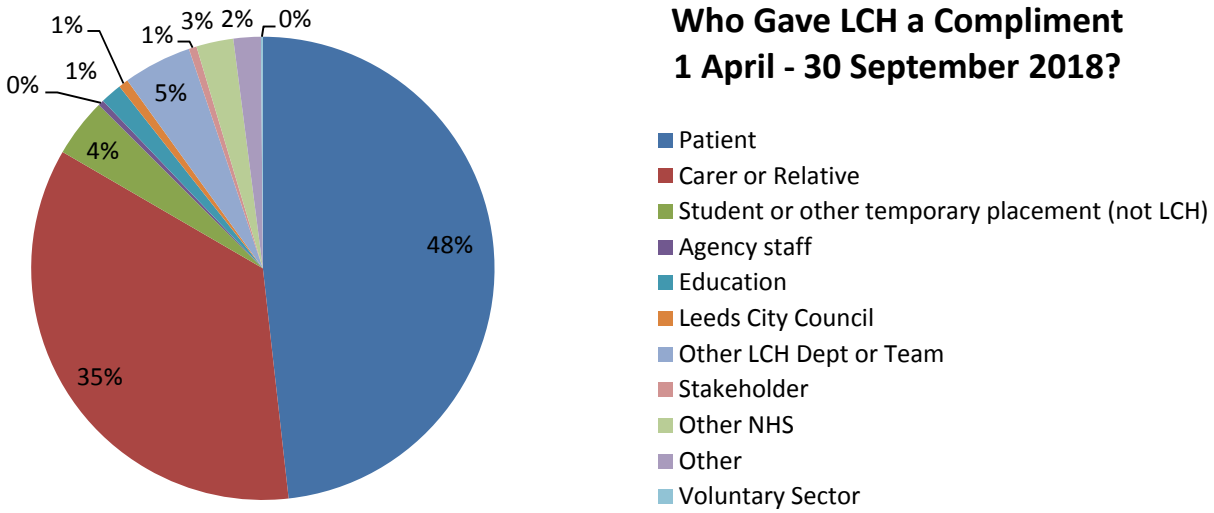
a) The number of compliments received by LCH:



b) Compliments received and reported via Datix® by each Business Unit in the last 18 months

Compliment (or positive comment)		
Business Unit	**2017-18**	**Apr-Sept 2018**
Adult Services	522	304
Children's Services	942	231
Specialist Services	571	190
Operational Support Services	36	11
Corporate & HQ functions	90	4
No Data	35	4
Total	**2196**	**744**

c) A breakdown of who provided the compliments LCH received in the first six months of the year.



d) Examples of compliments received:

Adult Services

"7 Weeks of immaculate care
I would like to thank every person who cared for me over the last seven weeks - I think you are a wonderful team who assessed my situation immediately and acted appropriately. LCH should be proud that they have introduced this package, in my situation with emphysema, crush fractures & actual fracture of spine & being on oxygen 24/7 as well as pitted oedema in my legs it must have seemed a daunting task which was tackled thoughtfully and well. I can't praise you enough; there isn't room here to say more than Thank you all from my heart."

"You may remember that when you came over to see me for my review, you suggested that I should be able physically to go and see my parents for their sixtieth wedding anniversary. We did this, using wheelchair cabs, a portable ramp and excellent work by my assistants. My parents were delighted to see me after so long; we haven't met in about eighteen months. I doubt if I would have done this without your gentle encouragement, so this is a quick line to thank you very much."

Children's Services

"Just writing to tell you how thankful I am for your love when I needed it most. I know that anyone who steps over the threshold and onto your ward will no doubt be embraced by you all. Thank you to each and every one of you."

"When with a recently bereaved family mum expressed her heartfelt thanks for the care provided to her child at home by the Children's Continuing Care Team. She wanted staff to know how much it meant to them as a family and her daughter that familiar staff were able to care for her whilst she was still at home."

"My problems were taken seriously and the methods provided to deal with them were extremely helpful. It was very helpful and has helped me deal with my struggles and feel like a happier person. There have been many positive changes in me from this service."

Specialist Services

"I just wanted to say a huge thank you to you!
Without sounding too dramatic, you have helped me turn my life around and I can't be grateful enough!! I know it is your job but I have had therapy before over the years and never gotten anywhere. I have seen such a difference in myself and literally it is down to your guidance!!"

"I have just completed a Cardiac Rehabilitation Class at Armley Sport Centre and I would like to congratulate you on this wonderful team. They all showed such kindness and dedication and made my attendance so happy and very much worthwhile. Thank you so much for these lovely professionals."

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (77)

Meeting: Trust Board Report 7 December 2018	**Category of paper**	
Report title: Freedom To Speak Up Guardian Report	**For approval**	
Responsible director: Chief Executive **Report author:** Freedom To Speak Up Guardian	**For assurance**	✓
Previously considered by N/A	**For information**	

Purpose of the paper

This paper provides an overview of the Freedom To Speak Up Guardian work, basic activity data and the future direction on this work stream. The report covers the period from August to December 2018.

Main issues for consideration

This report addresses matters relating to working in the Freedom to Speak Up role: the work, its spread and its links to other areas of work in the Trust.

Recommendation

The Board is recommended to:

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

Freedom To Speak Up Guardian Report

1.0 Introduction

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

2.0 Background

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

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

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

3.0 Current position

3.1 The Freedom To Speak Up Guardian role is working well in the Trust and receives strong support from the chief executive, the Board and the wider organisation. A clear form of work has been established which aligns with the well-led aspect of the CQC and LCH's work.

3.2 Communication of the role across the Trust and a positive relationship with Staff-side is in place. Regular supervision meetings and co-learning with the Freedom To Speak Up Guardian from Locala are in place. A peer review with Locala of each other's Freedom Guardian service is planned for late January.

3.3 Work on the Speaking Up Strategy is continuing with the company secretary. The Trust performing well on the three assurance measures it uses: national reporting, spread and local comparison. The Trust is reporting nationally on a quarterly basis, covering all four Trust business units / seeing staff from across all occupations and reaching, in terms of local comparison, significant numbers of staff. The LCH Freedom To Speak Up Guardian has been asked to have the same role in the GP Confederation. This has been agreed in LCH and this work has started.

4.0 Activity data

4.1 The table below shows the volume and type of activity with which the Freedom To Speak Up Guardian has been engaged between August and December 2018. The table also indicates the nature of the issues raised with the Freedom To Speak Up Guardian.

Business Unit	Method of contact	Numbers of staff	Issue
Adults	Phone, emails, texts	2	Culture, leadership, process
Children's	Emails and face to face	3	CCTV use in patients homes, culture and wellbeing of staff
Corporate	Face to face and email	6	Culture, leadership, behaviours and process
Specialist	Emails	1	uncertainty of service .location in future.

4.2 12 staff members have met directly and worked with the Freedom To Speak Up Guardian. This doesn't include work with whole teams. This whole team work has been recently with a team in the Specialist Business Unit and concluded in September 2018. A new team approach is planned to start in late December with a team in the Adults Business Unit. This work is always at the invite and agreement of managers. There has been a sharing of learning from the role in the wider organisation. An example is staff sharing their experiences around process via the Freedom Guardian. Three staff members have raised this. This has been shared with the Directors of HR / Workforce and the Head of ODI to inform the work on people before process and the new leadership offer. It has also linked into conversations on just culture.

5.0 Themes

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

- ***Uncertainty of where a service is to be located.*** There are ongoing discussions on this issue and the staff member is aware of this.
- ***Process.*** A sense that in our processes there is not a strong enough focus on the wellbeing of the staff involved. There is, at times, a reported lack of pastoral support for staff involved in formal processes.
- ***Leadership and culture in teams and services.*** A sense that our agreed values and behaviours are not always lived out visibly in certain teams. Contrary behaviours and language are reported. This is usually connected to comments about staff leaving or planning to leave.

- ***CCTV.*** Staff raised questions about how modern technology is used to film them and where their rights are in these experiences. This raises how our staff will encounter and work in the digital age in which we live.

6.0 Conclusions

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

- The Freedom To Speak Up Guardian role has had a positive impact with strong support from the Trust.
- The role illustrates the centrality of workplace culture. It validates the Trust's commitment to a workforce strategy and a person-centred vision
- The work reflects the importance of safe spaces, empathic listening and inclusion of the staff voice in the organisation – it offers an actualisation of the values of LCH for its staff and services.
- We are starting to work more across our city and regionally with this role. Citywide, with the GP Confed and general practice. Regionally, by collaboration with the regional network of Freedom To Speak Up Guardians.
- The role links well with the other Trust mechanisms we have for staff to share concerns. This embodies our vision that speaking up is a practice that we seek to share widely so it emerges as a culture.

7.1 Recommendation

7.1 The Board is recommended to:

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (78)

Meeting Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title Guardian of Safe Working Hours Report	**For approval**	
Responsible director Executive Medical Director **Report author** Guardian of Safe Working Hours	**For assurance**	✓
Previously considered by Quality Committee 26 November 2018	**For information**	

Purpose of the report

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

Main issues for consideration

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

Recommendations

Trust Board is recommended to:

- Continue to promote interface between GSWH and trainees
- Support HR to continue to maintain accurate database of medical trainees

Guardian of Safe Working Hours Report

1.0 Introduction

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

2.0 Background

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

3.0 Report of Guardian of Safe Working Hours

3.1 There are 24 Junior Doctors and Dentists employed throughout the Trust (in different specialities) as detailed in the table below. Doctors and Dentists are mostly employed through honorary contracts.

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

3.2 Quarterly overview

Vacancies		There is 1 vacancy in the CAMHS Specialty Trainee (ST) establishment. LCH produce and populate an ST 2nd on call rota in CAMHS.					
Rota Gaps (number of nights uncovered)		August		September		October	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	14	n/a	16	n/a	14
	Internal Cover	n/a	0	n/a		n/a	0
	External cover	n/a	14	n/a	16	n/a	14
	Unfilled	n/a	0	n/a	0	n/a	0
Exception reports (ER)		0	1	0	0	0	0
		1 report from CAMHS ST. Relating to impact on training from unfilled consultant vacancy. Resolved to satisfaction at the time					
Fines		None.					
Patient Safety Issues		None					
Junior Doctor Forum		11th October 2018					

3.3 Rota gaps

The CAMHS ST rota is not fully recruited to. There is 1 FTE post unfilled. This will increase to 2 by the end of November.

External locums have been sourced directly by the Trust to populate the CAMHS 2nd on call rota. There has been a reduction in the numbers of locums used this quarter. The CAMHS Clinical Lead and HR are developing CAMHS second on call locum bank.

3.4 Implementing the role of GSWH

3.4.1 Feedback from trainees

The Guardian attended the HEE Monitoring the Learning and Educational Environment meeting on the 5th September 2018. LCH is one of the best performing trusts in the region, with trainees reporting high levels of satisfaction with their training experience.

JDF was attended by all CAMHS core trainees. No other specialities attended despite email invitation. CAMHS trainees continue to report high workload linked particularly to high volume of in hours emergency presentations. However, no exception reports have been submitted. Encouraged to discuss with GSWH if they are uncertain of whether they should submit reports and reassured that they are encouraged through their contract to submit reports.

Development of urgent and emergency/crisis team in CAMHS will significantly reduce these pressures.

3.4.2 Challenges

Engagement

CAMHS trainees appear engaged. However, engagement with other specialties continues to pose a challenge.

For trainees other than paediatric trainees, this is likely to indicate an absence of concerns.

Although paediatric trainees have previously reported concerns in relation to their acute trust on-call duties, there have been no exception reports submitted in the last two quarters.

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

Administrative support

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

4.0 Impact

4.1 *Quality*

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

5.0 Recommendations

5.1 Trust Board is recommended to:

- Continue to promote interface between GSWH and trainees
- Support HR to continue to maintain accurate database of medical trainees

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (79)

Meeting Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title Health Education England '2018 Education & Training Self-Assessment Report (SAR)	**For approval**	✓
Responsible director – Dr Ruth Burnett **Report author** – Leanne Wilson	**For assurance**	
Previously considered by N/A	**For information**	

Purpose of the report

In line with their National Quality Framework Health Education England (HEE) require the Trust to complete an annual 'Education & Training Self-Assessment Report' (SAR) as the placement provider for trainees in all professional groups.

HEE required the Trust to map the work with trainees and any supporting policies to the HEE and GMC domains.

Main issues for consideration

The 'Education & Training Self-Assessment Report' covers the period of 1 April 2017 to 31 March 2018 and includes information and activity relating to 'Multi-professional', 'Postgraduate Medical' and 'Undergraduate Medical' trainees.

This paper provides assurance to the Board of the current position regarding provision for trainees associated with the Trust.

Please note the successes of good practice highlighted in each area; and that the challenges shown are known and are being dealt with locally.

Recommendations
The Board/Committee is recommended to:

- Accept the 2017/18 'Education & Training Self-Assessment Report' as the current LCH position.
- Approve the report for release to Health Education England.

2018 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 1 August 2017 to 31 July 2018

Deadline for submission to HEE: 14 December 2018

Trust's name:	**Leeds Community Healthcare NHS Trust**
Value of contract / funding with HEE:	1. Total initial 18/19 LDA value *(including undergraduate)*: £1,251,294.37 2. Total for salaries for doctors in training in 18/19: £269,730.00 3. Total estimated Medical placement tariff in 18/19: £141,708.00 4. Total estimated Non-medical placement tariff in 18/19: £288,865.20
Trust Chief Executive's name:	**Thea Stein**
Director(s) of Education's name: **(or equivalent, please state job title):**	**Dr Charles Stanley**
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	**Dr Ruth Burnett – Executive Medical Director**
Report compiled by (responsible for completion of):	**Dr Charles Stanley and Leanne Wilson**
Report signed off by:	**Dr Ruth Burnett**
Date signed off:	**26th November 2018**
Board Approval: **1. Approved by / on behalf of the Trust Board: (date / details)** **2. Date seen at or scheduled for Board meeting**	**Public Trust Board** **7th December 2018**

Contents

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: https://hee.nhs.uk/our-work/quality
For medical education the SAR is also aligned to the GMC Standards:
http://www.gmc-uk.org/eduation/index.asp

Trust's response (max of 500 words)

1. Learning environment and culture – The Trust focus is on education placement design that embeds students in multi-disciplinary teams that allow multi-professional feedback. Practice areas are audited to ensure high quality placements. A placement introduction booklet is provided for students containing information regarding all the potential clinics and learning environments they might attend together with the related learning outcomes. Students reported they found these helpful in a variety of placements.

2. Educational governance and leadership – The Trust has clear policies in place that safeguard both trainees and patients. Training is developed in line with relevant regulator standards, and educational audits are completed every two years. All trainees are closely supervised by named HEE accredited trainers and those trainers have time protected within their job plan. The Trust has a named Associate Director of Student Support and Training to provide oversight and leadership around educational governance across the range of placements and learning opportunities for students provided.

3. Supporting and empowering learners – All students are assigned a Practice Educator or Mentor whilst on placement. Educators receive regular updates from the relevant Higher Education Institutes. Feedback is sought from all students on the quality of their placement.

4. Supporting and empowering educators – Trainers are supported in educating students to the highest possible standard, by having protected time within their job plan. All trainers are mandated to attend HEYH training to update their educational requirements, they are also required to complete the education section of their trust annual appraisal and then reflect in their annual CPD.

5. Delivering Curricula and assessments – Trainers are supported to fully appreciate and understand the curricula in which the trainee needs to achieve competency and implement those curricula with the use of relevant work based assessments. Learners gain exposure to multi-disciplinary teams providing insight into innovative health care delivery in a community setting as an alternative to a hospital setting; whilst receiving quality educational and pastoral support.

6. Developing a sustainable workforce – The curriculum and learning placements are regularly reviewed to ensure students develop the skills knowledge and behaviours to meet the changing needs of patients and the service. Leeds Community Healthcare staff attend University open days to promote the wide spectrum of services that the trust delivers. The trust has a robust preceptorship programme in place. A Community Pathway is in place for third year nursing students that wish to pursue a career in a community setting.

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
1. The successful development of high quality educational placements and training opportunities that are specifically focused on affording undergraduates and postgraduates exposure to innovative heath care delivery in the community as an alternative to hospital based care as documented by student and trainee feedback.	Developing & Implementing curricula and assessments (Domain 5)	Standards S5.1 & S5.2
2.A focus on educational placement design that affords learners of all professional disciplines timely access to educational and pastoral support through the embedding of learners in multi-disciplinary teams that allow multi-professional feedback and perspective taking as standard leading to both improved learning outcomes and the development of more rounded clinicians as documented by student and trainee feedback.	Learning Environment & Culture and Supporting Learners (Domains 1 & 3)	Standards S1.1 & S1.2 Standard S3.1
3.A focus on supporting the trainers to educate students and trainees to the highest standards and affording them protected dedicated time to do so within the (trainer) Trust appraisal and job planning process as documented by feedback from trainers.	Supporting Educators (Domain 4)	Standards S4.1 & S4.2

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
1. Service pressures, most especially seasonal workload pressures, have the potential to disrupt the education of students and trainees by reducing their trainer accessibility and availability.	Supporting Learners & Supporting Educators	Standards S 3.1 S4.1 & S4.2
2. A focus on estate management and, in particular, increasing the efficiency of estate usage has the potential to disrupt the education of students and trainees who require reasonable access to accommodation, desk space and meeting rooms.	Learning Environment and Culture	Standard S 1.2
3. A lack of the financial resources to support an expansion of innovative community placements for medical and non-medical trainees with the specific aim of providing 'out of hospital' community care for patients who are currently reliant on 'hospital care'.	Learning Environment and Culture & Developing and Implementing Curricula and Assessments	Standards S 1.1, 1.2, 5.1 & 5.2

1.4. Strategic Workforce Plan

Does your organisation have a strategic workforce plan (delete as appropriate)?

~~Yes~~	No – We have an 'Operational Plan'

Who within your organisation is responsible?

Name and job title	Jenny Allen and Laura Smith – Directors of Workforce

Section 2: Exception Reporting against HEE Quality Domains

2.1. Multi-professional

2.1.1. Organisation overview linked to the HEE Quality Domains

Please report, by exception, where your organisation does not meet the HEE Quality Framework within the reporting period for the groups listed in the guidance notes. In addition, please provide an overall narrative along with some organisational / departmental / unit examples which support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

HEE Domain 1 Learning Environment and Culture *For additional guidance refer to HEE Quality Framework, page 10*
HEE priority for 2018 reporting in this domain is: • *A focus on workplace behaviours and strategies for resolution of issues of concern*
Trust's response: Students are placed in practice areas which must be audited prior to their use, the audit looks at all aspects of care and the quality of education provided. Only placements that meet the criteria are utilised. All staff complete equality and diversity training and this would cover students as well as patients, service users and public. Student's feedback on their evaluations that they do feel valued and treated fairly, and with dignity and respect. Where appropriate and possible, students are invited to be involved in Quality Improvement (QI), improving evidence based practice, and research and innovation. Evaluations suggest that students learn from their experiences with service users, and they value this opportunity. Students have access to space within the Trust Estate and can access library services, most students have access to IT depending upon length of placement and service requirement. All students have the opportunity to work alongside and with staff from other disciplines.
HEE Domain 2 Educational Governance and Leadership *For additional guidance see HEE Quality Framework, page 11 -12*
HEE is keen to understand new models of learning in practice and the impact this is having on your organisation. Please include within your response: • *Have you increased capacity for learners in your organisation?* • *Have you increased your numbers of supervisors/mentors?*
HEE priority for 2018 reporting in this domain is: • *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)* • *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.* • *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*
Trust's response:

All training provided is developed in line with the relevant regulators standards, when standards fall below those set by the regulator HEI's have their own disciplinary mechanisms, which LCH staff may be required to contribute to.

Educational audits are completed every two years, to measure the quality and opportunity of the leaning environment, which is set against regulatory requirements.

Students when in practice placements; wherever possible have the opportunity to work with and learn from staff from multi-professional teams.

Education and training opportunities are based on principles of equality and diversity at LCH.

Where incidents of patient safety occur involving students, staff will contact the Clinical Education Team and the relevant HEI, we would also complete the Datix patient safety software. Where there are performance issues with learners staff would contact the Clinical Education Team for advice and the Clinical Team will be supported in their decision making process. The HEI would also be contacted and the staff would support both the student and the Mentor/Practice Educator.

HEE Domain 3 Supporting and Empowering Learners

For additional guidance refer to HEE Quality Framework, page 13-14

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

Trust's response:

All students are allocated a Practice Educator or Mentor whilst on Practice Placement; staff can also seek support from their own personal tutors from within their HEI.

Students are supported with their practice assessment documents. Where students struggle to complete staff will work with the student to increase the opportunity to practice. Where the student is unable to meet a standard, feedback will be offered in written and verbal format, this will be carried through to the next placement and the HEI will be contacted.

Students are required to evaluate their placement experiences. Feedback from students suggests that they do feel that they are valued members of the team when on placement.

All students have an induction at the start of their Practice Placement. Most teams offer and induction book to orientate the students to the local area. The PPQA website also offers descriptions about the area and what to expect when on placement with the team.

Students get the opportunity to work alongside other disciplines and to follow the care pathway for the patient that they are working with within the service that they are placed.

HEE Domain 4 Supporting and Empowering Educators

For additional guidance refer to HEE Quality Framework, page 15

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

Trust's response:

As required practice educators or mentors attend the relevant HEI courses prior to taking on their roles and

also attend updates.

Educators receive regular updates from HEI staff to inform them of curricula changes. Some staff are invited to get involved in curricula planning or to speak to students about their specialities.

All LCH staff do receive annual appraisals and nursing staff who are registered mentors also are required to complete a triennial review document.

All practice educators and mentors are supported in their role with time being given to attend updates.

HEE Domain 5 Delivering Curricula and Assessments

For additional guidance refer to HEE Quality Framework, page 16

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

Trust's response:

Staff are invited to be part of curriculum planning at local HEI's.

Staff feedback during educational audits if there are changes to their service remit, thereby ensuring that students are placed in the most appropriate area for the training.

Practice educators and mentors seek feedback from patients and service users on their interactions with students. Nursing students are encouraged to seek a written testimony from patients and service users.

HEE Domain 6 Developing a Sustainable Workforce

For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

Trust's response:

Where HEI's identify a student who requires additional practice hours in order to meet practice requirements, LCH will endeavour to offer additional placement opportunities.

LCH staff attend university open days to promote their multiple services. Nurses in their second year have the opportunity to opt onto a community pathway for their entire third year therefore widening exposure to community nursing and increasing the likelihood of them securing a role in the community.

LCH staff attend universities to speak with students about their clinical specialities and they discuss the change in needs of patients and services.

LCH has a robust preceptorship programme for newly qualified staff, the programme is one year and staff work in their own teams but are supported by the Clinical Education Team; and have regular meetings with their cohort throughout the year.

2.1.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2).

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
The neighbourhood teams offer a Community Pathway for third year nursing students that are interested in pursuing a role in community nursing.	This promotes community nursing opportunities to students that are about to qualify.	6	6.2

2.1.3. Challenges or important issues that HEE should be aware of.

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
LCH recognises that staffing resource issues can negatively impact on capacity for student placements, for example if a member of the team is on long term sick, reducing the staffing numbers from 3 to 2, this would reduce the capacity for students by a third.	3	3.2

2.2. Postgraduate Medical

2.2.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for postgraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC theme 1 Learning Environment and Culture *For additional guidance refer to* http://www.gmc-uk.org/education/index.asp
HEE priority for 2018 reporting in this domain is: *A focus on workplace behaviours and strategies for resolution of issues of concern*
Trust's response: Leeds Community Healthcare Trust are committed to providing post-graduate medical trainee placements that are both safe for the trainee and for the patients. All trainees are closely supervised by named HEE accredited trainers. The Trust has in place clear policies that safeguard both trainees and patients. Trainers carefully scrutinise the complexity of cases and allocate commiserate with the trainees' levels of competence. Leeds Community Healthcare Trust supports the highest level of clinical supervision though the Trust

Supervision Policy and HEE Trainee Supervision Policy guidelines. Trainees are supported to report any issue of concern in respect of patient safety / wellbeing & specific training concerns through generic Trust risk profiling & reporting guidelines as well as through the Trust Medical Education line management structure (up to and including the Trust Medical Education lead and the Trust Executive Medical Director). Learning from untoward events and, if evident, related problematic systems of care is based on a careful investigation and feedback to trainees and trainers.

A particular strength of the Trust is its longstanding interest in, and expertise with respect to, multi-disciplinary care though fullest possible integration of the trainee into multidisciplinary teams operating in community settings. The experience of both trainees and trainers in Leeds Community Health Care Trust placements is audited by the Trust on a regular basis. Where trainee concerns have been raised historically through HEYH quality assurance visits to the Trust and made subject to conditions, those conditions have been formally addressed to the satisfaction of the HEYH and signed off by the nominated Associate Postgraduate Dean. The 2018 GMC National Training Survey data documents 'across the board' positive feedback from both trainees and trainers in Leeds Community Health Care Trust placements. The feedback from the recent HEYH 'Monitoring the Learning Environment' meeting on 05.09.18 was that Leeds Community Health Care Trust placements (based on trainee feedback) outperformed all other Trusts in the region.

GMC theme 2 Educational Governance and Leadership

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE. Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

Trust's response:

Leeds Community Healthcare Trust is committed to supporting the training of trainers to HEE standards and affording Trainers the appropriate amount of time to both supervise and educate their trainees. Each group of trainees and linked trainers in the various community specialities supported by the Trust: Child & Adolescent Psychiatry, Community Paediatrics, Community Old Age Medicine, Community Sexual Health - have designated lead trainers with timely access to the Trust Lead for Medical Education and, if required, the Executive Medical Director. Learning from Serious Incidents and 'near-miss' untoward events and, if evident, related problematic systems of care is an integral part of the Trust's investigatory processes. All serious untoward incidents are reported as a matter of written policy to the Trust Lead for Medical Education as well as the Executive Medical Director in addition to automatic disclosure of the same by way of exception reporting to Health Education Yorkshire & Humber authorities.

All trainees have access to dedicated pastoral support when exposed to traumatic incidents of any sort in the work place. The Trust Lead for Medical Education and the lead trainers liaise closely with the Trust Guardian of Safe Working Hours in respect of all trainee concerns about their training with exception reporting of all problems (including being required to work excessive hours) relating to the trainee working environment. The Guardian of Safe Working Hours and the Associate Director of Medical Education meet quarterly with HR, trainer and trainee representatives to discuss and minute specific issues arising from the trainee's working environment including breaches of safe working hours. The Associate Director of Medical Education receives copies of all exception reports authored by the Guardian who reports directly to the Executive Medical Director and the Trust board. The 2018 GMC National Training Survey data documents 'across the board' positive feedback from both trainees and trainers in Leeds Community Health Care Trust placements. The feedback from the recent HEYH 'Monitoring the Learning Environment' meeting on

05.09.18 was that Leeds Community Health Care Trust placements (based on trainee feedback) outperformed all other Trusts in the region.

GMC theme 3 Supporting Learners

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

Trust's response:

The Trust's Serious Incident & Serious Incident Policy mandates that the Executive Medical Director and the Associate Medical Director for Medical Education are informed when any undergraduate or postgraduate medical trainee is involved in a Serious Incident. Initial and, if required, ongoing support for undergraduate or postgraduate medical trainees involved in a Serious Incident is provided by the nominated trainer for the trainee in conjunction with Service and Directorate management and clinical leads. The Trust's Serious Incident & Serious Incident Policy mandates that all parties and stakeholders be informed of the learning (and specific actions) required of service and wider Trust employees with a specific focus on learning for improved patient safety.

The Trust provides support for all learners required to provide statements for the Coroners Court and attend Coroners hearings. In respect of medical trainees the nominated trainer would in the first instance support the trainee in providing a statement for the Court with additional supervision from the Service and Directorate clinical leads who have a specific focus on patient safety. The trainee and the clinical leads would expect to accompany a learner to the Coroner's Court. Trust legal advice is sought and all Trust employees attending the Court legally briefed. All Trust employees, including learners, are offered a 'debriefing' session or sessions either individually or as a group, depending on the issues highlighted by the Coronial process. The Trust's Serious Incident & Serious Incident Policy specifies the Duty of Candour responsibilities for clinicians involved in patient safety incidents and all learners (guided by their trainers) are supported to transparently communicate issues of concern to patients and their families in a timely manner.

GMC theme 4 Supporting Educators

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

Trust's response:

All trainers are mandated to attend Health Education Yorkshire and Humber training to update their educational requirements for postgraduate training and retain their regional status as trainers as mandated by Health Education England and the GMC. All trainers are required to complete the Education section of their Trust Annual Appraisal and document, and then reflect, on their annual CPD as educators as well as on any impediments that might interfere with their roles as trainers. Concerns raised by trainers are directed in the first instance to the Associate Medical Director for Medical Education and, if necessary, the Guardian of Safe Working Hours. Concerns are escalated to the Executive Medical Director and Trust Senior Management if issues cannot be straightforwardly resolved. The Trust affords trainers 'ring fenced' time in their annually revised job plans to fulfil their roles as trainers. The costs of supporting Undergraduate and Postgraduate training posts (including the trainer's time, the time of other clinicians, administration time etc.) are accurately recorded by the Trust to evidence appropriate allocation of financial resources from HEE.

GMC theme 5 Developing and implementing curricula and assessments *For additional guidance refer to http://www.gmc-uk.org/education/index.asp*
HEE priority for 2018 reporting in this domain is: • *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*
Trust's response All trainers are supported to fully appreciate and understand the curricula in which the trainee needs to achieve competency and implement those curricula with the use of the relevant work based assessments. Any impediments to training trainees, be they (Trust) organisational problems or wider systemic pressures, are communicated to the Associate Medical Director for Medical Education. Concerns are escalated to the Executive Medical Director and Trust Senior Management if issues cannot be straightforwardly resolved. Pressures, seasonal or otherwise, are a fact of life in the modern NHS and the Trust seeks to support the trainers to train trainees to manage these pressures without detriment to themselves or their patients. The Trust is well placed as a community organisation to innovate in respect of multidisciplinary ways of working that avoid hospital admission / episodes of inpatient care with a specific focus on looking at safe alternative to hospital care.
HEE Theme 6 Developing a sustainable workforce *For additional guidance refer to HEE Quality Framework, page 17*
HEE priority for 2018 reporting in this domain is: • *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.* • *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.* • *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*
Trust's response Historically, and indeed currently, trainee placements have not been compromised by fluctuating capacity in the Trust medical workforce. Placements are monitored in respect of their viability and trainers assigned from out with the placement if necessary on a case-by-case basis in order to ensure a seamless training experience. Intelligence from internal Trust and national surveys in addition to exemption reports are monitored to determine if a placement is or is not at risk. No loss of training approval in respect of Leeds Community Health Care Trust educational placements has occurred in the last five years. The Trust, through its overarching workforce plan and individual services more specifically, proactively identify future gaps in the workforce and encourage trainees of all professional disciplines to consider Leeds Community Health Care Trust posts on their qualification, providing targeted support and mentorship to support the trainee make the transition to substantive service employee. A significant proportion of the current Leeds Community Health Care Trust workforce have historically been trained in Leeds Community Health Care educational placements.

2.2.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)

The successful development of high quality educational placements and training opportunities that are specifically focused on affording undergraduates and postgraduates exposure to innovative heath care delivery in the community as an alternative to hospital based care as documented by student and trainee feedback.	The Trust considers its unique skill set to be in the training future doctors to innovate in the provision of care to patients that avoids / shortens avoidable hospital admissions	Developing & Implementing curricula and assessments (Domain 5)	Standards S5.1 & S5.2
A focus on educational placement design that affords learners of all professional disciplines timely access to educational and pastoral support through the embedding of learners in multi-disciplinary teams that allow multi-professional feedback and perspective taking as standard leading to both improved learning outcomes and the development of more rounded clinicians as documented by student and trainee feedback.	The Trust considers its unique skill set to be in the training future doctors to work as members of multi-professional teams in order to understand the complexities of medical support to, and leadership within, multi-disciplinary teams.	Learning Environment & Culture and Supporting Learners (Domains 1 & 3)	Standards S1.1 & S1.2 Standard S3.1
A focus on supporting the trainers to educate students and trainees to the highest standards and affording them protected dedicated time to do so within the (trainer) Trust appraisal and job planning process as documented by feedback from trainers.	The Trust understands that trainers have to be afforded 'ring fenced' time to train trainees and be supported by the Trust to develop and maintain their skills as educators and trainers	Learning Environment and Culture & Developing and Implementing Curricula and Assessments	Standards S 1.1, 1.2, 5.1 & 5.2

2.2.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Service pressures, most especially seasonal workload pressures, have the potential to disrupt the education of students and trainees by reducing their trainer accessibility and availability. Educational placements are closely monitored and periodically audited to identify any untoward disruption in their quality.	Supporting Learners & Supporting Educators	Standards S 3.1 S4.1 & S4.2
A 'working hours' challenge in respect of a specific group of postgraduate trainees in Community Paediatrics whose 'on call' commitments reduce by up to 60% training opportunities that would	Learning Environment & Culture	Standard S 1.2

otherwise be available to them during the working day. Trainees are strongly encouraged and supported to report disruption to their training by way of exception reports to the Guardian of Safe Working Hours, their trainers, Training Programme Director and the Associate Medical Director for Medical Education but are unwilling to do so because of a wish to complete their training competencies as expeditiously as possible.	and Supporting Learners (Domains 1 & 3)	
A lack of the financial resources to support an expansion of innovative community placements for medical and non-medical trainees with the specific aim of providing 'out of hospital' community care for patients who are currently reliant on 'hospital care'.	Learning Environment and Culture & Developing and Implementing Curricula and Assessments	Standards S 1.1, 1.2, 5.1 & 5.2
A focus on estate management and, in particular, increasing the efficiency of estate usage has the potential to disrupt the education of students and trainees who require reasonable access to accommodation, desk space and meeting rooms. Educational placements are closely monitored and periodically audited to identify any untoward disruption in their quality.	Learning Environment and Culture	Standard S 1.2

2.2.4. Medical faculty roles, organisation and accountability

If there have been any changes to your organisation's educational governance structures within the reporting period please detail this here, otherwise please state 'no changes'.
If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

Trust's response:

Medical Director
Medical Education Manager
Director of Medical Education
Associate Director of Teaching and Student Support
Director of Nursing
Deputy Director of Nursing
Operational Manager
Clinical Education Team
Administrator for Education and Training

2.2.5. Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

Questions	Trust's answer

Number of SASG doctors within the trust	7
Total SASG funding received	**£** 0
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	Yes
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	Development needs are identified through individual consultation with each of the doctors. The scheme where money was allocated no longer applies. Money is reimbursed by the allocated process from YHEE.
SASG nominated lead within the trust	Dr Melanie Epstein

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)	To be reimbursed to Trust for Named doctor training for SAS Dr to take on Lead role. To be reimbursed to Trust for FMERSA training completed to date. This is applied for through bursary process.
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered)	No bespoke training arranged this year due to insufficient demand with reduced numbers of SAS doctors, and active professional development to date. I provide email notification to SAS doctors regarding SAS training events arranged around the region to which the SAS Leads have agreed free access for all.
3. Payment for SAS tutors/leads sessions	£6000 payment to LCH for SAS Lead time from YHEE.
4. Administrative costs to support SAS tutors	N/A
5. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)	N/A

2.3. Undergraduate Medical

2.3.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for undergraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC standard theme 1 – Learning Environment and Culture
▪ Students were provided with sufficient opportunities to meet learning outcomes ▪ Students received sufficient feedback to track and direct their learning ▪ Students were satisfied with the overall organisation of the placement ▪ Students were satisfied with the overall quality of the Stage ▪ Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need) ▪ The overall quality of the teaching was of a consistently high standard
All trainers receive regular updated information regarding the undergraduate curriculum and learning outcomes. 983% of students in the Leeds Integrated Sexual Health Placements agreed or strongly agreed that the placement gave them the opportunity to achieve the expected outcomes. This specific question is not one of those asked for the other placements so we do not have comparative quantitative data. A placement introduction booklet is provided for students containing information regarding all the potential clinics and learning environments they might attend together with the related learning outcomes. Students reported they found these helpful in a variety of placements. Student feedback was that between 70-75% of students agreed or strongly agreed that they benefitted from the time in the community paediatric clinic, the GP placement, and that they found their child psychiatry teaching useful. The feedback regarding the nursery placement and the community paediatric discussion group was less positive and these have been modified for the next year to address this. Students were generally satisfied with the organisation of their placements. There were a small number of reported instances where placements did not seem to be expecting students despite having been provided with information, or where a small group of students were asked to attend the incorrect spoke clinic. These issues were all addressed and have resolved subsequent to the time of initial reporting. Generally students attended clinics or sessions where clinicians were already present to run clinics or planned sessions. Where students attended specifically for example for the paediatric discussion groups, the clinical teachers were punctual and reliable.

GMC standard theme 2 – Educational Governance and Leadership
▪ Trust systems are in place to detect and investigate patient harm involving or as a result of student activity ▪ Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students ▪ Clinicians / teachers are appraised against their teaching
All staff are regularly updated regarding the process to use the Clinical Placement Tool to report serious concerns around a specific student or student activity. Information regarding who to contact directly is also provided. Where incidents of patient safety occur involving students we would also implement our LCH procedures

and complete the Datix patient safety software.

All LCH staff have annual Security Awareness to ensure they are always up to date around governance and safety issues. Staff also receive regular updates around the process of obtaining and documenting including around informed consent. Informed consent is obtained from patients and their families when they may encounter students.

All doctors undergo annual appraisal including educational appraisal. All doctors are required to provide information for their appraisal relating to the Academy of Medical Education domains, including an item of annual educational Continuing Professional Development. All nursing staff are required to undergo revalidation to maintain registration and will provide evidence of their teaching and training as part of this within the appraisal system. All LCH staff undergo annual appraisal.

The Trust has a named Associate Director of Student Support and Training to provide oversight and leadership around educational governance across the range of placements and learning opportunities for students provided.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

Students are provided with details of a range of staff to contact for guidance and support outside of teaching. This includes the Associate Director of Student Support and Training. This information is available on Medex and in the pre-placement information provided.

All staff are reminded regularly regarding the Clinical Placement Reporting Tool so that positive as well the raising of concerns can be provided to support students.

Teaching generally takes place in clinical areas, or meeting rooms within Health Centres where clinical services are provided.

Students are provided with pre-placement and course information packs and booklets including information about additional on-line or other resources to support their learning.

Students have mobile phones as provided by the University, and have access to IT facilities as required within their placement. Students can also access library services with the associated resources and IT>

The community placements are designed to link to the relevant curriculum, and learning goals. The teaching and clinical placements are set up meet the required objectives, but there are some areas where the students may need to take more initiatives to make the most of the learning opportunities provided.

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

All medical teachers and trainers have time in their job plans for teaching and training and supervision. Regular updates are provided to staff about the teaching and training Continuing Professional Development opportunities available through LIME.

All clinicians and teachers are supported in their role through the appraisal system and have opportunities to take study leave for educational training and updates as required.

We have a process whereby clinicians and teachers can receive the title of honorary lecturer at the University if they meet specific criteria for their contribution to teaching and medical education.

All educators are encouraged to complete the GMC Trainer survey.

Educators are supported by the Associate Director for Student Support and Training.

GMC standard theme 5 – Developing and implementing curricula and assessments

- The Trust has processes to ensure those undertaking summative assessments are appropriately trained
- The Trust has a system in place to provide educational supervision
- The Trust has an executive or non-executive director at board level responsible for supporting training programmes

Placements are designed to ensure that learners obtain a balance between accessing and providing educational and training opportunities whilst also providing services that focus is on patient and service user needs.

LCH are committed to improving our training placements and implementing innovation. For example we have significantly modified the community paediatric week for the forthcoming year to improve the student experience and learning opportunities.

All staff involved in summative assessments undergo appropriate training at the outset. We have a group of staff who regularly support the assessment and examination process. Staff are encouraged to receive training in order to be involved in future.
Staff receive regular updates to inform them of updates to the curriculum. Staff are also invited to become involved in curriculum planning.
The oversight of the register of trainers is maintained by the Associate Director for Student Support and Training.

HEE Theme 6 Developing a sustainable workforce

For additional guidance refer to HEE Quality Framework, page 17

The curriculum and learning placements are regularly reviewed to ensure learners will develop the skills, knowledge and behaviours to meet the changing needs of patients and service.

As a Community Trust, we are committed to providing students with a learning experience that provides opportunities for multi-disciplinary learning, and learning about providing care for patients and families in their communities and homes, and across wider health and care partners.

We seek to engage students with learning about a range of career opportunities that they may not have previously considered, and to contribute to our long-term development of a sustainable workforce.

We actively seek feedback from students to help improve our services and to support placement innovation.

2.3.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
As with postgraduate training, the Trust undergraduate educational placements and training opportunities are specifically focused on affording undergraduates exposure as early as possible in their careers to innovative heath care delivery in the community as an alternative to hospital based care.	Medical educators have a duty to train undergraduates to address future demographic and monetary pressures on the NHS that can only be addressed by a radical shift away from hospital care towards innovative care in the community.	Developing & Implementing curricula and assessments (Domain 5)	Standards S5.1 & S5.2
As with postgraduate training, the Trust focus is on educational placement design that embeds undergraduates in multi-disciplinary teams that allow multi-professional feedback and perspective taking as standard leading to both improved learning outcomes and the development of more rounded clinicians commencing as early as possible in their careers.	Medical educators have a duty to train undergraduates to work closely with and value other professional disciplines early in their careers as possible with a specific focus on the inclusive style of medical leadership required for modern multidisciplinary working practices.	Learning Environment & Culture and Supporting Learners (Domains 1 & 3)	Standards S1.1 & S1.2 Standard S3.1
As with postgraduate training, the focus on supporting the trainers to educate undergraduates to the highest standards by affording trainers protected dedicated time to do so utilising the (trainer) Trust appraisal and job planning process to do so.	Trainers can only educate undergraduates to a high standard if they are afforded the time to do so.	Supporting Educators (Domain 4)	Standards S4.1 & S4.2

2.3.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
As with postgraduate training, service pressures, most especially seasonal workload pressures, have the potential to disrupt the education of undergraduates by reducing their trainer accessibility and availability.	Supporting Learners & Supporting Educators	Standards S 3.1 S4.1 & S4.2
As with postgraduate training, a focus on estate management and, in particular, increasing the efficiency of estate usage has the potential to disrupt the education of undergraduates who require reasonable access to accommodation, desk space and meeting rooms.	Learning Environment and Culture	Standard S 1.2
As with postgraduate training, **A lack of the financial resources to support an expansion of innovative community placements for medical and non-medical trainees with the specific aim of providing 'out of hospital' community care for patients who are currently reliant on 'hospital care'.	Learning Environment and Culture & Developing and Implementing Curricula and Assessments	Standards S 1.1, 1.2, 5.1 & 5.2

2.4. Academic Training

Please describe how your organisation supports academic learners, including Integrated Academic Training Programmes e.g. NIHR, clearly highlighting any challenges or good practice items.

Trust's response

Leeds Community Health Care Trust has limited capacity to support the development of clinical academic trainees other than afford them clinical placements in collaboration with colleagues working in Teaching Hospital Trusts that take a primary role in supporting their development as researchers and lecturers. Trainees undertaking joint clinical and academic training are fully supported by their trainers to pursue their joint vocation in Trust training placements with time 'ring fenced' for academic development. A number of Trust trainers have Honorary Senior Lecturer status with the University of Leeds and are actively supported by the Trust to apply and maintain that status through access to relevant educational courses and training. There is only one trainer (in Musculo-skeletal Medicine) in the Trust that has shared clinical and academic responsibilities. A number of trainers are active researchers and are actively supported by the Trust to engage in research projects in collaboration with lead researchers out with the Trust.

Section 3: Reference List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework.

This section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.
Please list key policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.
Please advise which domains and standards are being supported the policy.
Please note, we do not require copies of documents. Please do not embed documents or insert links. If required the quality team will request a copy by exception.
Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

Description of supporting information	**HEE/GMC Domain(s)**	**HEE/GMC Standard(s)**	**Please advise if document referenced in the SAR e.g.** *SAR, section 1.4 and 2.1.1*
Acceptable Standards of Behaviour	HEE Domain 1 Learning environment and culture HEE Domain 2 Education governance and leadership GMC Theme 1: Learning environment and culture	1.1, 1.2 2.4 S1.1	N/A
Appraisal Policy and Procedure	HEE Domain 4 Supporting and empowering educators GMC Theme 4: Supporting educators	4.3 S4.1, S4.2	N/A
Disciplinary Policy	HEE Domain 2 Education governance and leadership GMC Theme 2: Educational governance and leadership	2.5 S2.2	N/A
Freedom to speak up Policy	GMC Theme 1:	S1.1	N/A

	Learning environment and culture HEE Domain 1 Learning environment and culture HEE Domain 2 Education governance and leadership GMC Theme 2 Education governance and leadership	 1.1 2.2 S2.2	
Incident and serious incident management policy	HEE Domain 2 Education governance and leadership GMC Theme 2 Education governance and leadership	2.5 S2.2	N/A
Induction Policy	HEE Domain 3 Supporting and empowering learners	3.4	N/A
Information Governance Policy	GMC Theme 1: Learning environment and culture	S1.1, S1.2	N/A
Information Handling Policy	GMC Theme 1: Learning environment and culture	S1.1, S1.2	N/A
Managing Concerns and Performance Policy	HEE Domain 2 Education governance and leadership GMC Theme 2 Education governance and leadership	2.5 S2.2	N/A
Managing Stress in the workplace	GMC Theme 3:	S3.1	N/A

	Supporting learners		
Patient Experience, Dealing with compliments, concerns and complaints	HEE Domain 2 Education governance and leadership GMC Theme 2 Education governance and leadership	2.5 S2.2	N/A
Personal and Professional Development	HEE Domain 1 Learning environment and culture HEE Domain 2 Quality Standards HEE Domain 3 Supporting and empowering learners HEE Domain 6 Developing a sustainable workforce	1.1, 1.3, 1.4, 1.5 & 1.6 2.2, 2.3 & 2.4 3.1, 3.2 6.2, 6.3	N/A
Safeguarding Children Policy	HEE Domain 1 Learning environment and culture GMC Theme 1: Learning environment and culture GMC Theme 2 Education governance and leadership	1.1 S1.1, S1.2 S2.2	N/A
Working Time Regulations Policy	HEE Domain 6 Developing a sustainable workforce GMC Theme 1: Learning	6.1 S1.1, S1.2	N/A

	environment and culture GMC Theme 3: Supporting learners	 S3.1	

Section 4: 17/18 and 18/19 LDA Funding

		Total paid in 17/18	Estimated 18/19 funding
Total paid to the trust in 17/18:		£1,398,603.81	n/a
Total initial 18/19 LDA value *(including undergraduate)*:		n/a	£1,251,294.37
Total for salaries for doctors in training:		£269,736.00	£269,730.00
Tariff for placement activity			
Postgraduate Medical	Tariff *(as per DoH guidance* £12,152 + MFF)*	£141,215.00	£141,708.00
	Contribution to basic salary costs *(as per DoH Annex A*)*	£269,736.00	£ 269,730.00
	Total	**£410,951.00**	**£411,438.00**
Total Non-medical placement tariff: *(as per DoH guidance* £3,112 + MFF)*		£288,864.00	£288,865.20

**2017-18 Education & training placement tariffs: Tariff guidance and prices from 1st April 2017*

A placement in England that attracts a tariff payment must meet each of the criteria in line with the DoH guidance*. Please provide details of how you utilised your 17/18 placement tariff within the financial year April 17 to March 18 to support learners and educators.
Please note figures entered below should reconcile to the 17/18 tariff figures shown in the table above. Please provide details of expenditure and associated costs.

	Trust's Response
Postgraduate Medical Placement Tariff *The E&T placement tariffs cover funding for all direct costs involved in delivering E&T by the provider, for example (please see DoH guidance page 6):* *Direct staff teaching time within a clinical placement* *Teaching and student facilities, including access to library services* *Administration costs* *Infrastructure costs*	£141,708.00
Non-Medical Placement Tariff *As above*	**Overall Summary:** **Pay costs:** Management of training provision 20,749 Training facilitators and direct teaching 191,138 Admin Costs 21,196 **Total Pay 233,083** **Non Pay costs:** Training Equipment 41,211

	Stationery	1,653	
	Travel	5,932	
	General course/training costs	5,705	
	Phone costs - Mobile and fixed	1,027	
	Other	253	
	Total Non Pay		**55,781**
	Grand Total		**288,864**
Additional Funding *Please confirm how any additional money has been spent.*	N/A – No additional funding received		

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	There is a lead for patient safety for each area. Nursing trainees - Steph Lawrence – Interim Director for Nursing Allied Health Professional trainees – Nikki Stubbs - Interim Professional Lead for Nursing Medical trainees – Charles Stanley – Education Lead
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	Introduction of safety huddles where staff with identified risk of falls or pressure ulcers are identified and highlighted so all team is aware. Introduction of quality boards across all clinical services - identifies in a very visual way for the team the quality of services across key indicators including number of harms, appraisal rates, compliance with stat/mand training, patient feedback. In our inpatient services these boards are visible to the public and service users so that can see the quality of the service Focussed work on reducing falls and pressure ulcers has led to a reduction in incidents in both areas. Work has included review of the investigation process and review meetings where incidents are presented by the clinical team involved to explore contributory factors and learning in more detail. Clinical staff are encouraged to attend to observe and feedback is they find this a valuable learning experience and take back learning to their teams and to apply to their own practice.
3. In which areas would you like support from HEE? E.g. educational events,	Students are provided with training locally by the Clinical Governance Team, with packages including

funding, specific areas of training for example quality improvement?	Datix incident reporting, handling complaints and clinical audit reporting. However the portfolio for clinical audit training is quite small in comparison to acute trusts, do HEE provide National Audit Training? It would also be good to know how patient safety looks in a larger health economy.

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	Julia Spencer and Karen Hemingway, Resuscitation Officers and Clinical Educators. Julia.spencer1@nhs.net k.hemingway@nhs.net We have some resources available such as manikins etc. but little planning time due to our diaries being full. Julia Spencer is a member of ASPiH and is in the process of obtaining accreditation.
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	The Clinical Education team maintains an inventory of the equipment that they have but are unaware of other equipment that is available within the Trust itself.
3. How many simulation specific trained facilities does the trust have?	2
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Simulation has recently been introduced to the Community dental teams and simulation based courses run such as ILS, PILS, AIM which is bookable for staff via ESR
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical governance, patient safety, incident reviews?	Not at the present time but this is something we will look to work towards for the future

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? Eg job-planned time, resources etc.	Leeds Community Healthcare does not have a Lead for Human Factors; aspects of this are carried out by a number of teams across the organisation.
2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	People – Training is carried out by the Organisational Development Team, who work with individuals, teams and the organisation as a whole to provide training and coaching. Environments – The Estates and Facilities teams ensure that Leeds Community Healthcare NHS Trust occupies and delivers services from buildings that are a clean, safe, secure and suitable environment.

	Equipment and technology – Leeds Community Healthcare NHS Trust have a central IT team that provide necessary IT equipment, IT/simulation Leads Tasks and processes will be decided locally by the service. Organisation – HR and Workforce work to support staff and managers through change management, disciplinary, grievance and capability issues that arise within our Trust. They develop and deliver HR policies and strategies to support the Trust in achieving best practice and all aspects of people management. Ergonomics – Need for ergonomic equipment is identified at a local/service level and assessments are carried out by occupational Health. The Occupational Health Team specialise in the relationship between work and health. They provide advice to individuals and managers on work related health problems and health problems that can effect work. Research – The Research Team ensures that Research undertaken by the organisation meets ethical and regulatory standards. Their aim is to increase the amount of research the trust is involved in by: • Supporting existing research activity • Engaging and supporting new teams to become involved in research • Developing links with local universities and other external organisations
3. For the training delivered in the reporting period please also consider and describe the following: The audience to which HF training is being delivered, including details of multi-professional staff. Frequency of training, or whether ad hoc events. Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned time to deliver HF training. What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	HF training is not delivered within the trust. Information on the relevant teams will be discussed at induction and disseminated locally within the service.

Section 6: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:

- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	Richard Worlock - Equality & Diversity Manager
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the trust, demonstrating that you value diversity as an organisation?	At the very start of the Corporate induction day, the CEO welcomes all new staff and talks in depth about the Trusts Vision, Values and Behaviours; Vision *We provide the best possible care to every community that we serve* Values • *We are open and honest and do what we say we will* • *We treat everyone as an individual* • *We are continuously listening, learning and improving* *Behaviours (How we work)* • *Caring for our patients* • *Making the best decisions* • *Leading by example* • *Caring for one another* • *Adapting to change and delivering improvements* • *Working together* • *Finding solutions*
2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to: • Ensure trust reporting mechanisms and	All learners are staff members and as such are were invited to provide personal equality data as part of the application process on the NHS Jobs web portal. All

data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	learners, prior to attending any learning event are asked for their access requirements and/or if any reasonable adjustments are needed in the venue. All learning venues have been subject to an Equality Analysis and reasonable adjustments have been made. All Trust policies are reviewed on a regular basis during which an Equality Analysis is carried out.
3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	The Trust has identified through the NHS staff survey that both BME and staff with a disability have a lesser experience in Trust compared to white staff with no disability. Through staff engagement, specifically at BAME and disability staff meetings views and concerns are heard and responded to. The Trust has in place a Workplace Race Equality Standards action plan to improve the experiences of BME staff and improve representation of BME staff in post at all levels of the Trust. The Trust currently offers coaching to all staff and will be implementing a reverse mentoring programme specifically for BME staff. The Trust has a 2 year equality objective in place to implement the forthcoming Workplace Disability Equality Standard due to be released in March 2019
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?	As part of the Corporate Induction for all Trust staff the EDI lead delivers a session which includes; • Equality Act 2010 – a context • The Public Sector Equality Duty • The Equality Act – “protected characteristics” • Bullying and Harassment • Reasonable adjustment process • Health Inequalities
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	During regular 121 meetings and annual appraisal educators are encouraged to reflect on their performance and experiences, identified development/support is met through coaching and development sessions. The EDI lead provides advice and guidance when requested.

Section 7: Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf) namely:

   "To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:

   - Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
   - Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England."

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

Trust's response

The library team provide a services to all staff, no matter what their role or grade, including students on placement and bank staff.

The library team provide a current awareness service, literature searching and enquiry service, and access to electronic and print resources. They also provide a range of training courses covering literature searching, finding information and critical appraisal of the literature.

The service answers queries of both a managerial and clinical nature. The current awareness service covers topics such as management, leadership, governance, medicines management, HR, workforce planning as well as clinical topics. The library team provide resources for both clinical and managerial topics via the www.leedslibraries.nhs.uk website.

The majority of Leeds Community Healthcare NHS Trust staff are geographically spread throughout the city of Leeds, and Custody Suite staff are spread further afield across Yorkshire and Humberside. As such, the majority of interactions with the library team are done by email, phone or through web forms. Books are posted out to users, either at their work address, or home address if that is more appropriate. To remove any potential barrier to accessing the service, there is no requirement to physically visit the library space to utilise any elements of the service provided.

The librarian's access specialist training provided by the Health Care Libraries Unit, YOHHLNet etc, and are involved in evidence mobilisation activities within the Trust. One example of this is the creation and maintenance of the Innovation and Research Hub, which highlights and shares lessons learned from innovation projects.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.

- Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
- If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

Trust's response

£133,029 – of which £19,425 is income generated by Service Level Agreements, and the rest (£113,604) is fully funded by the organisation

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

Trust's response

The library are fully embedded in the work of the trust, including active membership of the Innovation and Research Council, Clinical and Corporate Policies Group, Clinical Effectiveness Group, Health and Wellbeing Group (Quality improvement project), Learning and Development Group and Clinical Procurement Group.

The library team respond to a high number of literature searches each year, many directly affecting service development within the Trust. Work done by Dominic Gilroy, HEE's NHS LKS Development Manager - Yorkshire & the Humber highlighted that for 2016/17, the LCH library team were 4th highest (out of 18 Yorkshire and Humber NHS library services) for the number of searches completed. For a relatively small Trust, this demonstrates a fantastic use of this high value part of the library service offer. When the figures are shown by WTE Band 5 (i.e qualified librarian), LCH comes 3rd out of 18 library services.

The Library Service Manager has recently done a talk for the Senior Management Team (during Health Information Week), and also to the Board (as part of the Digital Strategy refresh work delivered by the Assistant Director of Business Intelligence, Systems and IT) to highlight how the Library Service maximises the use of the digital resources at its disposal to support good practice.

The LCH library team maintains partnership working with the other NHS libraries and Public Health Resource Centre in Leeds, despite the demise of joint funding many years ago. The most visible output of this partnership work is the www.leedslibraries.nhs.uk website, which includes the shared catalogue and joint programme of information skills training. The joint work is managed via bi-monthly Leeds Library & Information Services Project Team meetings, with oversight from a Partnership Group, which includes membership from universities, mHabitat, public libraries, Department of Health and the Health Care Libraries Unit North, as well as the Leeds NHS libraries and Public Health Resource Centre.

The Library Services Manager led a successful pan Leeds bid to the HEE Education Research and Innovation Committee, to develop a collection of Personal Stories resources, highlighting the impact of illness on individuals and their families. Partners in the bid included public libraries and universities, as well as the other NHS Trust in Leeds and Public Health Resources Centre. More information about this can be found at https://www.leedslibraries.nhs.uk/resources/personal-stories/

The library team have also been developing and extending their health and wellbeing collection, including the Reading Agency Books on Prescription series, mood boosting books, and also books

on health and wellbeing in general. More information can be found at https://www.leedslibraries.nhs.uk/resources/health-wellbeing/

Finally, as part of initiatives for Health Information Week and World Mental Health Day, the library team have been working with external and third sector partners such as HealthWatch, social prescribing organisations in Leeds, mHabitat, Forum Central etc. This joint approach was recognised and commended by the Health Information Week team and also demonstrates the ideals of partnership working which underpin the Leeds Health and Wellbeing Plan.

4. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).
   If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

Trust's response

n/a – score for 2017/18 was 97%

Section 8: Additional Information

8.1 Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Serious Incidents and Never Events

Questions	Trust's Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	The Trust's Serious Incident & Serious Incident Policy mandates that the Executive Medical Director and the Associate Medical Director for Medical Education are informed when any undergraduate or postgraduate medical trainee are involved in a Serious Incident. Similar arrangements pertain with respect to non-medical professionals **.
What support systems exist to support learners? How are these systems monitored?	Initial and, if required, ongoing support for undergraduate or postgraduate medical trainees are involved in a Serious Incident is provided by the nominated trainer for the trainee in conjunction with the accommodating Service and Directorate management and clinical leads. Similar arrangements pertain with respect to non-medical professionals **.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	Trainees involved in a serious incident are encouraged and supported by their nominated trainer and the clinical lead for the service to reflect on their involvement in the incident and to record their experiences in an anonymised manner following advice set out in the recent GMC guidance on reflective practice. Similar arrangements pertain with respect to non-medical professionals **.
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees? the HEIs supporting learners?	When a medical trainee is involved in a serious incident the Training Programme Director is informed in a timely manner by the nominated trainer and the Associate Medical Director for Medical Education - as is the Health Education Yorkshire & Humber Liaison Dean for the Trust and, if necessary, the Speciality Postgraduate Dean.
How many patient safety incidents have you reported to NHSI.	None – N/A
How many serious incidents impacting on trainees' revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?	One serious incident in the last four years had the potential to impact on a trainee's validation. The trainee however left Specialty training of their own volition / sought alternative SAS grade employment in another area of the country. There was liaison between the involved Trusts and the GMC in respect of the incident and patient safety.
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	The Trust's Serious Incident & Serious Incident Policy mandates that all parties and stakeholders be informed of the learning (and specific actions) required of service and wider Trust employees with a specific focus on learning for improved patient safety in respect of all learners.

Coroners Hearings

Questions	Trust's Response
What support is available for learners who are required to provide statements and/or attend	The Trust provides support for all learners required to provide statements for the Coroners Court and attend

Coroners hearings?	Coroners hearings. In respect of medical trainees the nominated trainer would in the first instance support the trainee providing a statement for the Court with additional inputs from the Service and Directorate clinical leads who have a specific focus on patient safety. The trainee and the clinical leads would expect to accompany a learner to the Coroner's Court. Trust legal advice would be sought and all Trust employees attending the Court would be legally briefed. All employees including learners would be offered a 'debriefing' session or sessions – individually or as a group depending on the issues highlighted by the Coronial process.
How is your organisation involving learners in responding to Duty of Candour responsibilities?	The Trust's Serious Incident & Serious Incident Policy specifies the Duty of Candour responsibilities for clinicians involved in patient safety incidents and all learners (guided by their trainers) are supported to transparently communicate issues of concern to patients and their families in a timely manner.

Guardians of Safe Working

Questions	**Trust's Response**
10. Please describe the interrelationship between the GOSW and the Director of Education?	The Guardian of Safe Working Hours and the Associate Director of Medical Education meet quarterly with HR, trainer and trainee representatives (in the course of a minuted meeting) to discuss specific issues arising from the trainee's working environment including breaches of safe working hours. The Associate Director of Medical Education receives copies of all exception reports authored by the Guardian who reports directly to the Executive Medical Director and the Trust board.
11. Please provide a summary of the exception reports you have received within the reporting period, number, type and time to resolve.	To date, all issues of concern raised by trainees and documented by the Guardian of Safe Working Hours have been resolved in a timely manner with the exception of the longstanding restrictions (up to a 60% reduction of training opportunities) on postgraduate Community Paediatric Training of the 'out of hours' Paediatrics and Neonatology rotas rostered by the Trust responsible for General Paediatrics and Neonatology care. Trainees are extremely reluctant to exception report despite Trust support to do so. The issue remains unresolved despite direct communication between the Associate Medical Director for Medical Education, Guardian of Safe Working Hours and the Training Programme Director with Health Education Yorkshire and Humber.

8.2. Educational Opportunities during winter pressures

Please describe how your organisation Maintains curriculum delivery opportunities during winter pressures

Questions	Trust's response
1a) Please describe how winter pressures in 2017/18 affected your ability to deliver training to all learners within your organisation? 1b) Please detail the specific areas, placements and programmes which were adversely affected by last winter's pressures.	Winter pressures in 2017/18 offered challenges to student placement capacity. This was predominantly across the Adult Business Unit and impacted the Adult Nursing Programmes at our local HEI's.
2. Please describe what strategies you used to protect training for all learners across their whole placement with your organisation in 2017/18 e.g. moving educational sessions to times of less pressure, ring-fencing specific clinics, lists etc for training	LCH managed to meet capacity requirements by moving students between different teams and different services, and discussing with the placement unit at our local HEI. Some students were swapped with students on in-patient placements.
3. Please describe what plans you are putting in place to mitigate the effects of winter service pressures on training in 2018/19.	Through discussion with the Universities and practice placement areas, we are aware of current capacity in the lead up to winter and we are trying to pre-empt large numbers of students being placed.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (81)

Meeting Board 7 December 2018	**Category of paper**	
Report title Well-Led Framework Update	**For approval**	
Responsible director Chief Executive **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by SMT 28 November 2018	**For information**	

Purpose of the report

This report provides an update to the Board on progress in developing our Well-Led Framework self-assessment and action plan.

Main issues for consideration

In October 2018 the Board reviewed the draft Well-Led Framework self-assessment to challenge the views gathered at this point, to add to the assessment and to reflect on the process to date and agree on the emerging issues for the draft development plan. It was agreed that in December 2018 the Board would receive the final version of the self-assessment and action plan for approval.

The self-assessment and action plan however will now be submitted to Board in January 2019 to allow the findings from the peer review led by Cambridgeshire Community Services NHS Trust which took place 26-27 November 2018, and the peer review of Freedom to Speak Up being undertaken by Locala to be fully reflected in our self- assessment and action plan

To date the senior managers across the Trust, Staff side, 50 Voices, staff groups, medical and dental leads have all been involved in considering the key KLOEs within the Well-Led framework and therefore feeding in to the overall assessment.

Whilst taking longer this is giving richness and depth to our self-assessment which we feel is welcome and gives us a much clearer, 360^0 view of where we are and the focus for our work going forward.

Outline of the action plan to date:

A picture is emerging of an overall assessment of Good and we are testing rigorously against possible areas where we could be considered Outstanding.

Being Good does not however, of course, mitigate against the need for continuing work and energy to improve and develop across all areas of the Trust and we of course strive to be outstanding across all areas of inspection.

The areas which have been identified so far for further work and focus are:

Our people:

- Increasing focus on talent management and succession
- Enhancing our leadership and management development offer for middle managers
- Further development of our health and well-being offer

- Increasing our work on Equality and Diversity with particular focus on race equality supporting people with disability and our support to people with mental health issues
- Reviewing training and development to ensure alignment to organisational objectives as well as provision and senior oversight of role specific and statutory and mandatory training

Quality improvement

- Continuing to consolidating and embedding our Quality Improvement approach across all areas of the Trust and grow the great work already undwerway

Quality

- Developing and assuring ourselves of our approach to and learning from clinical audit and spread across the trust
- Ensuring that our patient involvement work is framed by an up to date and new strategy and the work is refreshed. There is some outstanding work but this needs to be spread across the whole Trust
- Developing our approach for reducing unwarranted variation
- Continuing to develop our work on outcomes across all service areas

Governance and strategy

- Clarifying partnership governance for increasingly complex partnerships
- Developing further our key staffs understanding of our strategic direction – they are clear on vision, values and behaviours and demonstrating link to overall strategy
- Ensuring clear auditable trails on escalations from front line to Board demonstrating this clarity of process. It happens but is it always simple to follow the trail and paperwork.
- Ensuring further focus on using data as information for triangulation across service areas
- Continue to strengthen the work already underway to clearly link Board discussions with the BAF risks and the strategic direction of the Trust

Finance

- Ensure clarity of CIP process development and review and its interphase with Quality impact is made more visible

Recommendations

The Board is recommended to:

- note the reason for not submitting the self-assessment and action plan to December 2018 Board
- consider whether it is assured that the approach to preparing for the CQC Well-Led Framework review is satisfactory
- note the development of the areas of focus for the action plan

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 82

Meeting: Trust Board 7 December 2018	**Category of paper** *(please tick)*	
Report title: Equality and Diversity Annual Report	**For approval**	
Responsible director: Director of Workforce **Report author:** Assistant Director of Workforce, and Equality and Diversity Facilitator	**For assurance**	√
Previously considered by: SMT	**For information**	

PURPOSE OF THE REPORT

This report outlines progress made over the last 12 months in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED)

MAIN ISSUES FOR CONSIDERATION

The Trust Board is asked to note the progress made over the last 12 months around the wider equality and diversity agenda and to note the next steps as outlined in the attached action plans.

RECOMMENDATIONS

The Trust Board is recommended to:

- Recognise that we are meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract in part, as we recognise that there are areas for improvement, as evidenced from the NHS staff survey results.
  .
- To note that the trust position around equality and diversity reflects the national picture across the wider NHS and be assured of the comprehensive plans and resources that have been put into place to advance equality of opportunity.

- The Board is recommended to continue to be actively involved with and promoting the equality and diversity agenda, recognising that this is a long term cultural change we are embarking upon.

Equality and Diversity Annual Report

1.0 Purpose of this report

1.1 This report outlines progress made over the last 12 months in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED), *That in the exercise of their functions, organisations have due regard to the need to:*

- *Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.*
- *Advance equality of opportunity between people who share a protected characteristic and those who do not.*
- *Foster good relations between people who share a protected characteristic and those who do not.*

Due regard for advancing equality involves:

- *Removing or minimising disadvantages suffered by people due to their protected characteristics.*
- *Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.*
- *Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.*

1.2 To demonstrate compliance with the NHS standard contract through the adoption of the NHS Equality Delivery System2 (EDS2) and Workplace Race Equality Standard (WRES) to assist the Trust in meeting the PSED.

2.0 Background

2.1 At the December 2015 Trust Board meeting, in order to meet statutory and contractual reporting requirements, it was agreed that an annual update would be provided at the December formal Board meeting and would contain progress on the NHS Equality Delivery System2 (EDS2) and equality objectives. This process enables the sharing of the ratified equality annual report with Commissioners as part of scheduled contract monitoring arrangements, and meets the requirement of the Equality Act Public Sector Equality Duty (PSED) to share progress with the public on the 31 January 2019.

2.2 In our commitment to meet our duty, in-depth analysis has been undertaken around the NHS staff survey 2017 results comparing “BAME” results compared to “White” comparators. One of the areas from the national results and that is also reflected within the Trust, is the steady decline in staff believing that their organisation provides equal opportunities for career progression or promotion. The full results of the staff survey were shared with the BAME staff network and feedback sought on how to

better understand the results. This has been fed into the WRES action plan (further detail below), which includes the development and launch of a BAME talent management pipeline and to promote and facilitate the take up of non- mandatory training and development opportunities for BAME staff.

3.0 Current position

3.1 EDS2

3.1.2 The NHS standard contract requires the Trust to utilise the NHS EDS2 framework. EDS2 is designed to help NHS organisations improve the services they provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS. It is based on four goals, with 18 specific outcomes.

The EDS2 goals are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels

3.1.3 The Trust's current NHS EDS2 overall performance rating is *Achieving.*

3.1.4 Appendix A contains the current grading for all of the EDS2 goals and outcomes.

3.2 Race

3.2.1 The Workforce Race Equality Standard (WRES) was introduced to enable employees from black and minority ethnic backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. A comprehensive Workforce Race Equality Standard (WRES) Action Plan, Appendix B, was ratified by the Trust Board in September 2018, containing deliverable actions to improve the overall Trust WRES performance.

3.2.2 Since August 2018 WRES metric 1, *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* has been reported to the Business Committee as part of the monthly Trust performance report.

		Aug	Sep	Oct
WRES indicator 1 - *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*	% of BME staff in the overall workforce	10.13%	9.69%	9.77%
	% of BME staff in Bands 8-9, VSM	3.13%	3.16%	3.19%

3.2.3 The Trust's BAME staff network has been established for 12 months, which works to Formal terms of reference and appointments made to key roles within the network. The network has 43 members and during this time has;

- Engaged with the estates team to develop a suitable space for use as a multi-faith/contemplation room within Stockdale House.
- Developed a network logo and intranet page to further promote the network and increase engagement from staff within the Trust.
- Network staff who have committed to playing an active part in the Trust 'Reverse Mentoring' programme.

3.2.4 The Trust has provided resource to the BAME staff network to provide facility time for the Chair to carry out the duties of the appointment.

3.2.5 The BAME staff network chair was nominated and has been shortlisted by National Centre for Diversity for 'Employee of the Year' 2019 award for their commitment and contribution to the Trust's staff network and will attend the presentation event in London, on the 17th January 2019.

3.2.6 The Trust has appointed a BME project officer who has a key role in the delivery of the WRES action plan. Some of the key areas include the creation and implementation of sustainable process to enable diverse recruitment and selection panels to take place, support the development of a cultural competence (Race) awareness programme and to lead on the Reverse Mentoring Programme.

3.3 Disability

3.3.1 Disability Confident Scheme– (Equality Objective) is a YouGov scheme that is designed to help organisations recruit and retain disabled people and people with health conditions, for their skills and talent. The scheme consists of 3 levels:

- Disability Confident - committed
- Disability Confident – employer
- Disability Confident – leader

3.3.2 The trust is currently ranking Level 2 (Employer); the attached Staff Disability action at Appendix C outlines the actions and associated timescales to reach Level 3 (Leader) accreditation.

3.3.3 Once the Workforce Disability Equality Standard (WDES) is published in Q3 2018/19, it will enable the Trust to compare the experiences of disabled and non-disabled staff. It will support positive change for existing staff, and enable a more inclusive environment for people with a disability working in the Trust.

3.3.4 In anticipation of the WDES metrics, and informed by the Disability Confident framework, SMT approved the Staff Disability Action Plan 2018-2020 (Appendix C), which is designed to provide support to employees and prospective employees with disabilities,

3.3.5 Additional support has been provided to deliver the Trust Staff Disability Action plan. A project officer role has been finalised and recruitment will take place in Quarter 3/4 20018/19.

3.4 Inclusive Top 50 UK employers

3.4.1 From over 1000 entries, the Trust is now named with leading private and public sector employers such as Touchstone, West Midlands Fire Service, Sky, BT and Cheshire Constabulary, as one of the nation's most inclusive organisations in The Inclusive Top 50 UK Employers List. This recognises the outstanding efforts of organisations that have begun their journey to attracting and retaining a truly diverse workforce, achieving equality, diversity and inclusion at its purest form.

3.5 NHS Employers Diversity & Inclusion Partners Programme

3.5.1 This is the second occasion that the Trust has been part of this national programme, the aim of the partners programme is to enhance the ability of the Trusts leaders to think more strategically about diversity and inclusion issues, and to use learning in practical applications within the workplace.

3.6 Stonewall Diversity Champions

3.6.1 The Trust became Stonewall Diversity Champions in 2012 and continues to utilise the Stonewall Workplace Equality Index (WEI) as a framework to support the creation of an inclusive organisation.

3.6.2 As part of a Task & Finish group, mandated by Leeds Health and Wellbeing Board the Trust is currently working with Leeds CC and other Leeds NHS organisations to address issues identified in Stonewalls report *Unhealthy Attitudes*.

3.6.3 The *Unhealthy Attitudes* Task & Finish group will report to the Leeds Health & Wellbeing Board meeting in Q4 2018/19.

4.0 Risk and assurance

4.1 Risk - The key risk in failing to deliver the equality objectives is the potential for legal challenge if the Trust failed to meet its duties under equality legislation or if knowingly or unknowingly allowed discrimination to occur. The equality objectives are consistent with the Trusts risk tolerance with an aim to reduce to a minimum level.

4.2 Legal/Regulatory - The equality objectives and work streams detailed within this paper, will meet the legal requirements of the Equality Act 2010, Human Rights Act 1998 and CQC regulatory requirements.

5.0 Next steps

5.1 NHS EDS2

5.1.1 Following consultation with NHS England and voluntary/community partners, the Leeds NHS EDS2 assessment panel has agreed the following assessment timetable;

- EDS2 Goal 1 - Better health outcomes for all Q3 2018/19
- EDS2 Goal 2 - Improved patient access and experience Q3 2019/20
- EDS2 Goal 3 & 4 – Empowered, engaged and well-supported staff/ Inclusive leadership at all levels Q3 2020/21

5.1.2 NHS England is currently reviewing EDS2, findings of which will be published in 2019/20 and any changes implemented in 2020/21.

5.2 **WRES**

5.2.1 The actions for the next 12 months identified in the WRES action plan (Appendix B) have been resourced and will be delivered.

5.2.2 Updates of progress of the WRES action plan will be reported to the Business Committee.

5.2.3 Trust WRES metrics data will be captured on 31 March 2019 and submitted to NHS England in June 2019.

5.3 WDES

5.3.1 NHS England provided a schedule for the sharing of metrics, reporting requirements and action planning for WDES, which has informed the Trust Disability Action Plan, Appendix C refers.

5.3.2 The Trust Disability Action plan will be reviewed following the release, by NHS England, of the WDES metrics and reporting requirements.

5.4 Inclusive Top 50 Employers

5.4.1 Analysis of the Trusts 2018 submission will be conducted to formulate an Inclusion Improvement plan for the Trusts 2019 submission.

5.5 NHS Employers Diversity & Inclusion Partners Programme

5.5.1 The Workforce Directors have committed resource to allow high level attendance at the remaining two programme meetings. Following this there will be a period of consolidation of learning from this programme

5.6 **Stonewall Diversity Champions**

5.6.1 The Trust will commit resource to continue for a further 12 months as Stonewall Diversity Champions.

5.6.2 The Trust's Stonewall Workplace Equality Index will be submitted in September 2020.

6.0 Recommendations

6.1 The Trust Board is recommended to:

- Recognise that we are meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract in part, as we recognise that there are areas for improvement, as evidenced from the NHS staff survey results.

.

- To note that the trust position around equality and diversity reflects the national picture across the wider NHS and be assured of the comprehensive plans and resources that have been put into place to advance equality of opportunity.

- The Board is recommended to continue to be actively involved with and promoting the equality and diversity agenda, recognising that this is a long term cultural change we are embarking upon.

Appendix A – NHS EDS2

Goal 1 – Better health outcomes for all		Assessment
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	**Achieving**
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	**Achieving**
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	**Achieving**
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	**Achieving**
1.5	Screening, vaccinations and other health promotion services reach and benefit all local communities	**Excelling**

GOAL 2 – Improved patient access and experience		**Assessment**
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	**Excelling**
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	**Excelling**
2.3	People report positive experiences of the NHS	**Achieving**
2.4	People's complaints about services are handled respectfully and efficiently	**Achieving**

GOAL 3 – Empowered, engaged and well-supported staff		Assessment
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	**Achieving**
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	**Achieving**
3.3	Training and development opportunities are taken up and positively evaluated by all staff	**Achieving**
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	**Achieving**
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	**Achieving**
3.6	Staff report positive experiences of their membership of the workforce	**Achieving**

GOAL 4 – Inclusive leadership at all levels		Assessment
4.1	Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	**Achieving**
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	**Achieving**
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	**Achieving**

Appendix B

Workforce Race Equality Standrard (WRES) over-arching 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 hey 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	OD/ 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	Implement a BAME Talent Management strategy	OD/Lead and Asst. Director of Workforce	An increase in BAME staff employed in Senior and Board level roles	1,2,7,9	28.6.19
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 Work force	The probability of BAME applicants being shortlisted and selected for posts is comparable to that of White applicants	1,2,7,9	28.6.19
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	OD/Lead and Asst.Director of Workforce	Provide robust data to inform the WRES action planning	4	31.12.19
8	Research and design a Cultural Competence (Race) awareness programme	OD/ 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	29.3.19

Appendix C

Staff Disability action plan 2018 - 2020			
Action	*Lead*	*Board Lead*	*Delivery date*
Carry out Root Cause Analysis of cases regarding disability	Clinical Lead CBU	Exec Director of Operations	Q3 18/19
Publish the WDES metrics and guidance (expected end of Dec 2018)	NHS England	N/A	Q3 18/19
Legal training update for HR team, focused on disability and protected characteristics	Asst. Director of Workforce	Director of Workforce	Q3 18/19
Link with key stakeholders, including TU partners/JNCF and specialist agencies, for feedback, access to learning resources and input to this action plan	Asst. Director of Workforce	Director of Workforce	Q3 18/19
Conduct a baseline audit against the Disability Confident Leaders accreditation criteria	E&D Manager	Director of Workforce	Q3 18/19
Develop resource request for Disability Project Officer responsible for raising awareness, providing support to & monitor reasonable adjustments and advising on access to work	Asst. Director of Workforce	Director of Workforce	Q3 18/19
Include the duty to make “reasonable adjustment” in the Corporate Induction E&D session	E&D Manager	Director of Workforce	Q3 18/19
Introduce biannual (every 2 years) Equality & Diversity online training to Statutory & Mandatory training programme for all staff	E&D Manager	Director of Workforce	Q4 18/19
Informed by the base line audit create a Disability Confident Leaders accreditation delivery plan	E&D Manager	Director of Workforce	Q4 18/19
Review data and reporting arrangements	E&D Manager	Director of Workforce	Q4 18/19

against the WDES metrics			
Introduce Disability classroom sessions for managers as part of management training offer	E&D Manager	Director of Workforce	Q1 19/20
Online WDES reporting form published	NHS England	N/A	Q1 19/20
Upload WDES data run on the date specified in the WDES guidance	Workforce Information Manager	Director of Workforce	Q1 19/20
Develop a high level WDES action plan on initial findings to share with SMT	E&D Manager	Director of Workforce	Q1 19/20
WDES reports published based on data from the 2018/19 financial year	NHS England	Director of Workforce	Q2 19/20
Disability Confident Leaders self-assessment validation	E&D Manager	Director of Workforce	Q2 19/20
Review and refine the WDES action plan (if appropriate), after publication of NHS England report for all Trusts. For discussion at SMT	E&D Manager	Director of Workforce	Q3 19/20
Publish the national WDES annual report	NHS England	N/A	Q1 20/21

*Trust Board Champion – TBC

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (83)

Trust Board public workplan 2018-19
Version 12 9 November 2018

Topic	Frequency	Lead officer	3 August 2018	7 September 2018 Extraordinary	5 October 2018	7 December 2018	1 February 2019	5 April 2019	24 May 2019
Preliminary business									
Minutes of previous meeting	every meeting	CS	X		X	X	X	X	X
Action log	every meeting	CS	X		X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X		X	X	X	X	X
Patient story	every meeting	EDN	X (End of life care)		X	X	X	X	X
Quality and delivery									
Chief Executive's report	every meeting	CE	X		X	X	X	X	X
Performance Brief	every meeting	EDFR	X		X	X	X	X	X
Perfomance Brief: annual report	Annual	EDFR							X
Care Quality Commission inspection reports	as required	EMD							
Quality account	annual	EDN							X
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 summary 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 Guardian report	2 x year	CE	X Annual report			X			
Guardian for safe working hours report	4 x year	EMD	X			X	X		X Annual report
Strategy and planning									
Operational plan including financial plan	2 x year	EDFR			X				X End of year report
Service strategy	as required	EDFR							
Quality strategy	annual	EDN					X		
Professional strategy	annual	EDN				X verbal report			
Workforce Strategy (formerly Organisational Development strategy 2017-19)	2 x year	DW	X Deferred from May		X		X		X?
Research and development strategy	annual	EMD	X						
Governance									
Medical Director's report: doctors' revalidation	annual	EMD	X						
Nurse revalidation	annual	EDN	X						
Well-led framework	as required	CS	X CEs report			X Action plan			
Annual report	annual	EDFR							X
Annual accounts	annual	EDFR							X
Letter of representation	annual	EDFR							X
Audit opinion	annual	EDFR							X
Audit Committee annual report	annual	CS							X
Standing orders/standing financial instructions review	annual	CS							X
Annual governance statement	annual	CS						X	
Going concern statement (part of corporate governance update)	annual	EDFR						X	
NHS provider licence compliance	annual	CS							X
Committee terms of reference review	annual	CS							X
Board and sub-committee effectiveness	annual	CS							X
Register of sealings	annual	CS							X
Declarations of interest/fit and proper persons test (part of corporate governance update)	annual	CS						X	
Significant risks and risk assurance report	every meeting	CS	X		X	X	X	X	X
Corporate governance update	as required	CS							
Reports									
Equality and diversity report	annual	EDN				X			
Safeguarding annual report	annual	EDN			X				
Infection prevention control annual report	annual	EDN			X				
Emergency preparedness annual report	annual	EDO			X				
Additional items									
West Yorkshire Mental Health Services Collaborative	as required	CE	X Verbal						
Leeds Health and Care Academy - Partner Board briefing	as required	CE	X						
Leeds Providers Integrated Care Collaborative - Committees in Common	as required	CE			X (MOU APPROVAL)				
Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common	as required	CE			X (MOU APPROVAL)				
CAMHS Tier 4 - Building	as required	EDFR	X Verbal						
Health Education Engl;and self-assessment return	as required					X			
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 (84ai)

Quality Committee
Monday 24 September 2018
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Thea Stein	Chief Executive
	Ruth Burnett	Interim Medical Director
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Elaine Goodwin	Clinical Lead for Specialist Services
	Diane Allison	Company Secretary
	Julie Mountain	Clinical Head of Service for Adult Services
	Nikki Stubbs	Interim Professional Lead for Nursing
	Helen Rowland	Interim Clinical Lead for Children's Services
	Suzanne Slater	Clinical Governance Manager
	Debbie Reilley	Head of Service for Safeguarding
Observing	Roohi Collins	Aspiring NEDs programme delegate
	Helen Knight	Clinical Lead for Adult Community Speech Therapy
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Neil Franklin	Trust Chair
	Marcia Perry	Executive Director of Nursing
	Caroline McNamara	Clinical Lead for Adult Services
	Debbie Myers	Deputy Director of Nursing

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (38a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed the members. The group introduced themselves. Apologies were received from Neil Franklin, Marcia Perry, Caroline McNamara and Debbie Myers.	
2018-19 (38b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (38c)	**Minutes of meeting held on 23 July 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2018-19 (38d)	**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 action was completed. 2017-18 (79b) Director of Nursing report: confirmation that appraisals and statutory mandatory training has been planned outwith of winter months 2018/19 The action was addressed in the Director of Nursing report. The action was completed. 2017-18 (79b) Director of Nursing report: CQC/HMIP report on young Offenders' Institute The action was completed. 2018-19 (15) (i) Board Assurance Framework 2018-19: Patient engagement strategy The action was completed. 2018-19 (29c) Minutes of meeting held on 25 June 2018 It was confirmed that the action was addressed in the Director of Nursing report. The action was completed. 2018-19 (32a) Director of Nursing quality and safety report The action was completed. 2018-19 (32b) Quality improvement priorities position The Company Secretary advised that the information she had received was the majority of staff (all based at Little Woodhouse Hall) had completed their training and the remaining staff member would have received their training by October 2018. The timescale was revised to October 2018. 2018-19 (32c) Guardian for safe working hours (GSWH) The Interim Medical Director advised the Committee that a Human Resources Advisor was now in post to support the GSWH. The action was completed. 2018-19 (32e) Medical Director revalidation report The action was completed. 2018-19 (33a) Clinical Audit Programme 2017-18 update It was agreed that the Clinical Effectiveness Group in October 2018 would review how the Trust uses information from the national clinical audits and would feed this back to the Committee. The Chair stated that he wanted to see the learning from audits systematised into the annual audits programme and report. **Action: Head of Medicines Management to discuss how the Trust uses information from the national clinical audits at the Clinical Effectiveness Group in October 2018, and feed back to the Committee in November 2018** 2018-19 (33c) Research and Development Strategy update The Head of Medicines Management stated that she had discussed with the Head of Research and Development how the Trust should maximise contact with academic partners and the issue of uncertainty around finances. It was noted that the Research and Development Strategy implementation plan would be discussed as an agenda item at the Committee in November 2018. The action was completed.	**Head of Medicines Management**

Service Spotlight: Adult Business Unit		
2018-19 (39)	**Community Falls Team** The Executive Director of Operations introduced Jo Brayshaw, Clinical Falls Specialist/Team Leader and Debbie Lowe, Operational Lead. The Committee introduced themselves. The Clinical Falls Specialist/Team Leader gave an overview of the Community Falls Team including current staffing, key quality indicator data, patient engagement and feedback, challenges and service priorities. The presentation is summarised in the key points below: The Clinical Falls Specialist/Team Leader stated the Community Falls Team had maintained service provision and patient satisfaction during the time of reduced staffing and increasing referrals and caseload. It was noted that the service had secured Improved Better Care Funding to provide 8 week group falls education programmes that have continued to show positive outcomes and feedback following on from the previous pilot programmes. It was noted that following the Quality Challenge visit in September 2017, the overall rating was good with three areas receiving an outstanding rating. The Clinical Falls Specialist/Team Leader advised the Committee of the different ways patient feedback was obtained. The current challenges facing the service were: • An increasing number of referrals and complexity of these – subsequent increase in waiting times and the time required to appropriately triage these referrals. • The current staffing model does not include non-registered staff in the team which impacts on waiting times for new patient assessments, as registered staff have a proportion of time taken up with non-registered visits. • Pace of development of integration with the Leeds Teaching Hospitals NHS Trust (LTHT) Falls Clinic. • The increasing complexity in relation to falls and assessments and interventions required, increasing the patient face to face and non-face to face time required. • Current service capacity is impacting on ability to support patients to sustain positive objective outcomes following discharge from the service. • New registered staff into the service in recent months and associated induction time required has impacted on service patient facing activity. The Clinical Falls Specialist/Team Leader advised the Committee of the current service priorities which were: • To explore opportunities for additional capacity for Band 4 Therapy TIs, • Develop a pathway of integration with the LTHT Falls Clinic, and explore potential for Falls Clinics in the community, • Secure senior management support for ongoing funding to continue to run the community group falls education programmes • To find opportunities for working more closely across the city on the frailty agenda. A Non-Executive Director (TD) asked for more information regarding outcome measures. The Clinical Falls Specialist/Team Leader advised the Committee that	

	the service continued to show good outcomes and detailed the improvements in the last quarter. The Non-Executive Director (TD) asked how the details were clinically significant and the Clinical Falls Specialist/Team Leader explained how the outcomes were assessed. In response to a question on NICE guidance compliance it was confirmed that the NICE guidance was mapped to the assessment process. A Non-Executive Director (TD) asked if there was anything the Committee could do to help with the future challenges identified in the presentation. It was agreed that the Chief Executive and the Executive Director of Operations would support the service with the integration with LTHT. **Action: Chief Executive and Executive Director of Operations to offer support to the Community Falls Team with the integration work with LTHT. To report back to Committee November 2018.** It was confirmed that the Interim Medical Director was also involved in the LTHT and primary care integration. The Executive Director of Operations asked about the pathway between reablement and the Falls service. The Clinical Falls Specialist/Team Leader confirmed that reablement patients are referred through neighbourhood teams and GPs. The Clinical Falls Specialist/Team Leader clarified the referrals process. The Executive Director of Operations suggested that a fast track referral process be considered from the reablement service. The Executive Director of Operations asked about the waiting lists and risk assessments of patients. The Clinical Falls Specialist/Team Leader stated that although it was not an urgent service, all referred patients were at a high risk of falls and it was a challenge to prioritise referrals. At the moment, the quality of information received in the referral was used to prioritise patients. It was suggested that a tool to enable the service to prioritise patients could be used to manage risk. It was agreed that the Chief Executive and the Executive Director of Operations would discuss the quality of referrals as part of the integration work with LTHT. The Committee Chair thanked the Clinical Falls Specialist/Team Leader for the presentation and confirmed that any feedback could be made through the management team.	**Chief Executive / Executive Director of Operations**
Key issues		
2018-19 (40a)	**Hannah House** **Item 40a –** (Please see private minutes)	
(40b)	**CQC/HMIP Young Offenders' Institute (YOI) inspection report** The Clinical Lead for Specialist Services provided an update of the report following the HMIP unannounced inspection of Wetherby YOI and Keppel Unit in March 2018. Of the ten good practice notes made in the report, five were in relation to healthcare provision and related to governance access, feedback, health promotion and physical and mental health support during transition periods. The service had previously received an improvement notice, however the inspectors now recognised that improvements had been made and positive action	

	taken to comply with regulation. The improvement notice has now been withdrawn. The challenges of providing healthcare in the secure environment contributed to three recommendations from the previous inspection not being achieved which related to prison officers undertaking mental health training. The Committee was advised that a training package was developed, however, access to the prison officers to provide the training was restricted. Other concerns previously raised included nurses not being called to all incidents relating to use of force or restraint by prison staff, and healthcare appointments were sometimes being compromised because of the prison regime. The Clinical Lead for Specialist Services advised that surprise had been expressed that there was no current health needs analysis (HNA) in place and stated that the YOI team would welcome advice from the Committee on this matter. The Interim Medical Director suggested that there should be a thorough review of what is currently relevant, rather than completing a HNA in name only. The Executive Director of Operations stated that although the overall inspection showed improvement, the operational focus on security had been prioritised over healthcare. The Committee Chair asked whether there is discussion about healthcare at the Operational Board. The Clinical Lead for Specialist Services confirmed that the Head of Healthcare at the YOI attends the Board on the Trust's behalf. It was agreed that the issue of mental health awareness training for officers would be raised at the Regional Provider Forum. **Action: Interim Medical Director to ensure the issue of mental health awareness training is raised at the Regional Provider Forum.** **Action: Executive Director of Operations to discuss with Prison Governor the challenges of completing the actions that are jointly owned.** The Committee Chair committed to writing to the healthcare team to commend them on the positive report. **Action: Clinical Lead for Specialist Services to draft a letter of congratulations to the team, for the Committee Chair to sign, on behalf of the Committee.**	**Interim Medical Director** **Executive Director of Operations** **Executive Director of Operations** **Clinical Lead for Specialist Services**
(40c)	**Outcome Measures approach** 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 had 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 be presented at its meeting in November 2018, to 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. The Committee Chair suggested the programme plan should be planned on three levels: the NHS Outcome Framework at an organisational level, a service level, and an individual level. **Action: a further Outcome Measures paper to be presented at November 2018 Committee meeting, with a more defined and shorter term plan (two to three years) as well as the systems and process.** **Outcome: Assurance level for this item was limited**	**Interim Medical Director**
(40d)	**Patient engagement** The Clinical Governance Manager presented the paper which included the work already completed and next steps. It was acknowledged that services are doing more to engage with patients and carers; however the Trust cannot currently collectively evidence this. It was noted that the role of Patient Experience and Engagement Officer needed to be recruited to substantively, and work was underway to achieve this. The previous post holder, who had completed a lot of work on the bronze, silver and gold standards for engagement, had moved roles. Concerns were expressed about the currently advertised banding for the Patient Experience and Engagement Officer, which is Band 5, as it was thought that a more senior role was required in order to provide strategic direction. The Head of Medicines Management advised the Committee that evidence of patient and public engagement was one of the Key Lines of Enquiry in the CQC Well-led Framework. In response to a question about volunteers the Chief Executive confirmed that this was on the agenda to be discussed by the Senior Management Team (SMT). A Non-Executive Director (TD) reminded the Committee that a key theme from members of the public at the recent annual general meeting was the lack of coordination between services and organisations in the City. The Chief Executive said she would take the issue of how views and experiences of the wider health system can captured for discussion at a Committees in Common meeting with the GP Confederation. The Chair stated that assurance regarding progress would need to be given at this Committee and it was noted that a Board workshop on patient engagement would be taking place. It was agreed that patient engagement would also be a workshop topic for the Committee in 2019. **Action: Company Secretary to schedule a patient engagement workshop for Quality Committee in early 2019.**	**Company Secretary**
Quality governance and safety		
2018-19 (41a)	**Director of Nursing quality and safety report** The Clinical Governance Manager presented the report and it was noted that there were no exceptions to report. The Committee discussed the possible reasons for the decrease in the number of incidents, which included staff being less likely to report incidents when they are very busy with other tasks. The Chair asked about changes to the Nursing and Midwifery Council (NMC) standards and the report that was expected. The Clinical Governance Manager confirmed that work was still ongoing and was on track. A Non-Executive Director (TD) queried the Friends and Family test (FFT) data relating to inpatient services. The Clinical Lead for Specialist Services agreed	

	to investigate the figures for Specialist Service inpatients. **Action: Clinical Lead for Specialist Services to investigate the FFT figures for inpatients.** In response to a query about safeguarding training compliance figures, the Executive Director of Operations advised the Committee that the Trust was in the process of changing from the old to the new compliance requirements. The Chief Executive advised that the process of transition had been challenging, but was confident that the figures would improve. **Clinical Leads' quality reports** *Adult services:* • The increased city-wide service pressures in the summer months had impacted on the delivery of the leadership team's plan to prioritise staff training, appraisals and clinical supervision. The service is on track to deliver the plan by the end of the year • Daily safety huddles have been rolled out to Middleton, Kippax and Holt Park • The Leadership Team have moved some resource to support the volume of internal and city-wide pilots. *Specialist services:* • Work is underway in the Community Stroke Team on integration with Acute and Community Rehabilitation services • Waiting times in the Diabetes services have increased. Risks have been mitigated and business cases are being written • There are capacity issues in IAPT. IAPT is due to be tendered in November 2018 and new service specifications may address the issues with waiting lists • The Respiratory Virtual Ward will be led by LTHT • Many SBU services reported inaccurate information on ESR in August 2018 , making staff training and appraisals difficult to manage **(to pick up in matters arising October 2018)** *Children's services:* • 0-19 service has been awarded the UNICEF Baby friendly gold award • A lot of great work had carried out on waiting times throughout the Business Unit and new care models were being developed • The successfully awarded 0-19 contract is now in the mobilisation stage. • Key challenges included ensuring all staff were compliant with safeguarding training, high levels of sickness at Hannah House, a backlog of administrative work in the Admin single point of access (SPA), for which there is a recovery plan in place • There had been three pressure ulcers reported by the children's nursing team. These were all due to either discharge from hospital or equipment. The team have worked with LTHT regarding better discharge and equipment, and worked with parents to stress the importance of letting the team know of any concerns they have about their child's skin as soon as possible. **(to pick up in matters arising October 2018)**	**Clinical Lead for Specialist Services**
2018-19 (41b)	**Performance brief and domain report** The Committee reviewed the Performance Brief and the Clinical Governance Manager highlighted the following to note under the Safe and Caring domains: 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. 100% of inpatient respondents recommended care. The percentage of patients recommending community care remains above target. A Non-executive Director (TD) alerted the Committee to a discrepancy relating to reporting whether pressure ulcers were avoidable or unavoidable. The Committee noted that the Effective domain was not reported on in August 2018 as the metrics were reported quarterly. The Head of Medicines Management confirmed that quarter two information will be available in the October 2018 Performance Brief, including reporting on compliance with NICE guidance at the November 2018 Committee meeting. **Outcome: The Committee agreed that the Safe and Caring domain information provided reasonable assurance.**	
2018-19 (41c)	**Risk Register and Board Assurance Framework (BAF)** The Company Secretary introduced the risk register and highlighted that there were two new risks to note, two risks with a higher score, five closed risks and seven deescalated. A typo-graphical error was noted about 'non clinical risks' and the Company Secretary will ensure this is amended for future reports. The Company Secretary advised the Committee that there had been a lot of discussion at SMT and Audit Committee about consistency of risk scores. It had been suggested that two strategic (BAF) risks assigned to the Quality Committee should have their risk scores amended and the Quality Committee was asked to review and agreed the risk scoring. One was BAF risk 1.1 (regarding quality assessment) and it was agreed to decrease the risk score from 16 (extreme) to 12 (high). The second was BAF risk 4.3 (patient and public engagement) and the Committee agreed to raise the risk score to 9 (high). The Committee Chair noted that this reflected the concerns raised about patient engagement earlier in the meeting. The Committee Chair asked whether SMT had sight of closed risks and this was confirmed. A Non-executive Director (TD) asked about the current risk score for Risk 940: The risk of delays to the new CAMHS Tier 4 service model. The Executive Director of Operations confirmed that is was currently the correct level; however she was confident that when the service model was in place, the risk score would be reduced. The Company Secretary drew the Committee's attention to Risk 867: lone working, which had an escalated risk score, due to staff concerns about darker evenings. She advised the Committee that lone-working risks should be actively managed all year round. **Outcome: Two BAF score changes were approved**	
2018-19 (41d)	**Quality Priorities quarterly position** The Committee received a quarter one progress report, presented by the Clinical Governance Manager, 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. A Non-executive Director (TD) asked about the two actions that were not on target, relating to outcome measures. The Chief Executive said she would like to see more narrative in the next report to advise the Committee on any areas of concern and celebration.	

	The Committee were reasonably assured that overall, sufficient work had been completed to date on the quality improvement priorities.	
2018-19 (41e)	**Quality Strategy update** The Interim Professional Lead for Nursing presented the Quality Strategy quarter two position. The key points to note were that work with partners and commissioners was ongoing to improve access to the IAPT service, there was significant involvement in work to improve patient flow, there had been a review of ABU skills across registered and non-registered nursing staff groups, and associate and apprenticeship opportunities had been identified in admin and an options appraisal paper was in development for SMT to scope the feasibility in clinical services. The Committee Chair requested further narrative in future updates, to include the strategy objectives, the improvements that should be seen, how these can be evidenced, and what the benefit would be for patients. **Outcome: the Committee noted the content of the Quality Strategy update**	
(41f)	**Always Events update** The Interim Professional Lead for Nursing presented a report on Always Events. It was noted that this was the first time the Committee had received this report. The Interim Professional Lead for Nursing briefed the Committee on the progress made with implementing the Always Framework over the previous six months. She advised that she was linking in with the Organisational Development team to incorporate Always Events into improvement methodology. She also said she was planning to attend an awareness day organised by the Community Urology and Colorectal Service (CUCS) for patients to share ideas about what they expect to always happen in provision of quality of care and a good experience. The Committee Chair requested that Always Events should be brought forward as a key issue for discussion at the November 2018 meeting. **Action: Further Always Events update required to provide more information at the November 2018 meeting** **Outcome: the Committee noted the content of the Always Events update**	**Interim Professional Lead for Nursing**
(41g)	**Professional Strategy update** The Interim Professional Lead for Nursing presented the report which provided the Committee with an update on the progress on actions relating to the Professional Strategy for Clinical Staff (2016-2020) and its implementation. The Interim Professional Lead for Nursing advised the Committee that good progress was being made. To date 433 staff had been trained in the health coaching approach, including 94 in 2018. Over 150 staff have attended motivational interviewing training. The Interim Professional Lead for Nursing said there were good examples of how these approaches are supporting effective case management and these had been identified in recent serious incident reviews. The Committee noted that an 'NHS at 70' conference is planned for 15 October 2018, which will showcase improvements. The Committee Chair commented that the strategy did not include medical and dental staff and to some extent appeared to duplicate the Quality Strategy. He concluded that the Professional Strategy did not include milestones, which were needed to assess success. **Action: Acting Executive Director of Nursing and Interim Executive Medical Director to agree future direction of Professional Strategy and report back to Committee November 2018.**	**Interim Professional Lead for Nursing**

	Outcome: the Committee noted the content of the Professional Strategy update.	
(41h)	**Non- executive director service visits** The Committee received a report on the number of Non-executive Director service visits that had taken place since April 2018. The Committee was advised that there were some reports that remained outstanding. **Outcome: the Committee noted the visits made to services by Non-executive directors**	
Clinical effectiveness		
2018-19 (42a)	**Patient group directions (PGD)** It was confirmed that all PGDs had been through the correct processes prior to being considered by the Committee and were recommended for ratification. **Outcome: The Committee ratified the approved PGDs.**	
2018-19 (42b)	**Internal audit reports: Review of Clinical Effectiveness Group (CEG)** The Committee received the internal auditor's review of the Clinical Effectiveness Group (CEG), a subgroup of the Quality Committee. The Committee had requested the review as part of the Trust's 2018/19 internal audit programme. The CEG had been found to be operating effectively and the auditor concluded that he was satisfied the sub group was able to provide assurance on clinical effectiveness to the Committee. There were two important recommendations relating to 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. **Outcome: The Committee noted that the internal audit review of the Clinical Effectiveness Group had given a reasonable assurance opinion.**	
Annual reports		
2018-19 (43a)	**Safeguarding annual report** The Head of Service for Safeguarding presented the service's annual report. 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 would shape the team's objectives. These themes included maintaining quality standards, responding to CQC recommendations for safeguarding training and competencies, and the development of internal and multi-agency relationships and networks. The Chief Executive advised the Committee of the exemplary support the team provided to the Trust's staff and the high regard the city had for the team. The Committee noted that whilst the Children's safeguarding section was rich in data, the Adult's Safeguarding section did not provide the same level of detail for assurance purposes. The Head of Service for Safeguarding agreed to provide additional detail in future annual reports. The Committee Chair suggested to the Head of Service for Safeguarding that details of the recent CQC inspection should be included in the report to the Trust Board in October 2018 and this was agreed.	**Head of Service for Safeguarding**

	Action: details of the recent CQC inspection should be included in the annual safeguarding report to the Trust Board in October 2018 **Outcome: the Committee concluded that the report provided it with reasonable assurance**	
(43b)	**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 Head of Medicines Management commented that the Trust needed assurance that other organisations, whose buildings the Trust uses, also have processes in place. The Committee commended the IPC team for the quality and breadth of its annual report which provided reasonable assurance and the Committee approved the 2018/19 programme. **Outcome: the Committee concluded that the report provided it with reasonable assurance and approved the IPC Programme for 2018/19**	
Policies, reports and minutes for approval or noting		
2018-19 (44a)	**Clinical Effectiveness Group draft minutes: 16 August 2018** The Committee received the minutes from the Clinical Effectiveness Group on 16 August 2018. It was noted that there is currently limited assurance available at a Trust level to demonstrate how services deliver KLOE 5 *(How are people supported to live healthier lives and, where the service is responsible, how does it improve the health of the population?)*. The Committee learned that a workshop planned for September 2018 had been cancelled due to recent changes in roles and the issue was being progressed.	
2018-19 (44b)	**Mortality Surveillance Group minutes: 07 June 2018** The Committee received the minutes from the Mortality Surveillance Group on 7 June 2018. The Committee noted that a subsequent meeting of the group had taken place in August 2018 and the draft minutes were awaiting approval by the chair of the group.	
2018-19 (44c)	**Patient Safety and Experience Group (PSEG) minutes: 31 July 2018** The Committee received the minutes from the PSEG meeting on 31 July 2018. The Committee noted the number of apologies given for the meeting and the lack of learning actions being recorded.	
2018-19 (44d)	**Safeguarding Children's and Adults Group draft minutes: 23 August 2018** The Committee received the minutes from the Safeguarding Children's and Adults Group meeting on 23 August 2018. It was noted that the CQC review of health services for Looked After Children and Safeguarding in Leeds had been published. It was agreed that the Head of Service for Safeguarding would share the report with the Committee.	**Head of**

	Action: Head of Service for Safeguarding to circulate the CQC Review of Health Services for Looked After Children and Safeguarding in Leeds report to the Committee.	**Service for Safeguarding**
Quality Committee work plan		
2018-19 (45a)	**Items from work plan not on agenda** i. Sub-groups effectiveness review and terms of reference report – to be added to the November 2018 agenda	**Company Secretary**
2018-19 (45b)	**Work plan** The Company Secretary advised that the next Committee meeting would take the form of a workshop.	
2018-19 (46)	**Matters for the Board and other Committees including assurance levels** • Levels of assurance agreed by the Committee as noted in the minutes • Report on Her Majesty's Inspectorate of Prisons unannounced inspection to Wetherby YOI and Kebbel Unit • Hannah House update	
2018-19 (47)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 22 October 2018 Monday 26 November 2018	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (84aii)

Quality Committee
Monday 22 October 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 (from 10.30)	Chief Executive
	Steph Lawrence	Acting Executive Director of Nursing
	Dr Ruth Burnett	Interim Medical Director
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Debbie Myers	Interim Deputy Director of Nursing
	Caroline McNamara	Clinical Lead for Adult Services
	Elaine Goodwin	Clinical Lead for Specialist Services
	Helen Rowland	Clinical Lead for Children's Services
For items 49 and 50 only	Laura Smith	Director of Workforce
	Vanessa Hunt	Assistant General Manager
	Julie Mountain	Clinical Head of Adult Services
	Rose Towers	CAMHS Inpatients Senior Nurse
	Megan Rowland	General Manager – Adult Services
	Sharon Lee	Neighbourhood Team Self-Management Facilitator
	Kezia Prince	Incident and Assurance Manager
	Suzanne Slater	Clinical Governance Manager
	Rachel Ainley	Registered Nurse CBU
	Kirsty Jones	Clinical Pathway Lead
	Fiona Allport	Clinical Pathway Lead
	Rachel Pontefract	Physiotherapist West 2 Neighbourhood Teams Portfolio
Minutes	Diane Allison	Company Secretary
Apologies	None	

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (48a)	**Welcome and Apologies** The Committee Chair welcomed members and attendees and discussed the format of the meeting. No apologies were noted.	
2018-19 (48b)	**Declarations of Interest** There were no declarations of interest received.	
2018-19 (48c)	**Minutes of meeting held on 24 September 2018** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	

2018-19 (48d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. Matters arising: Inaccurate training and appraisal information reported on ESR (SBU report in DON report September 2018). The Clinical Lead for Specialist Services advised the Committee that ESR data had improved this month, and the 'PIP2' (performance portal) was now being used, which appears to have resolved the problem. The Committee was advised that SMT now received a weekly report on statutory/mandatory training in order to sense-check the information. Matters arising: Three pressure ulcers reported in Children's Nursing team (CBU report in DON report September 2018). The Clinical Lead for Children's Services advised these were category 2 and 3 pressure ulcers and were not caused as a result of LCH's care however the investigation identified improvements were needed in discharge communication. The Committee was keen to hear about how lessons would be learned from these incidents and was advised the City-wide pressure ulcer steering group ensured there was better partnership working as well as improved communication and the Transitions Conference, due to be held this week, will demonstrate some of this. <u>2018-19 (26a i) Future work plan (Youth Parliament take-over day)</u> The timescale was amended to April 2019. <u>2018-19 (32a) Director of Nursing quality and safety report</u> The Company Secretary confirmed a spotlight on safeguarding has been added to next year's work plan. The action was completed. <u>2018-19 (32b) Quality Improvement Priorities Position</u> The Clinical Lead for Children's Services will include an update in the Clinical leads' report until the end of December 2018, when it anticipated that all LWH staff members will have received their training. Action completion date to be deferred to December 2018. <u>2018-19 (39) Service Spotlight Community Falls Team integration</u> The Executive Director of Operations confirmed that work is underway to integrate the Community Falls Team with LTHT. The action was completed. <u>2018-19 (40b i and ii) CQC/ HMIP inspection report</u> The Executive Director of Operations and the Interim Executive Medical Director confirmed that the difficulties of implementing jointly owned actions have been raised. The action was completed. <u>2018-19 (40biii) CQC/ HMIP inspection report</u> A letter of congratulations has been sent to the team. The action was completed. <u>2018-19 (40d) Patient engagement workshop</u> The Company secretary confirmed a patient engagement has been added to next year's work plan (for June 2019). The Trust Chair will engage with the new	

	Chair of Health Watch in the meantime. The action was completed. <u>2018-19 (41d) Director of Nursing Report – FFT inpatient figures</u> Clinical Lead for Specialist Services is looking into this, but suspects it may be due to the late input of figures and will report her findings to the Committee in November 2018 Action completion date to be deferred to November 2018. <u>2018-19 (43a) Safeguarding Annual Report – amendment</u> A revised report was presented to Trust Board in October 2018. The action was completed. <u>2018-19 (44d) Safeguarding Children's and Adults Group draft minutes – circulation of CQC review</u> The action was deferred to November 2018.	
Patient Safety Congress		
2018-19 (49)	The Clinical Lead for Adult Services provided an overview of the key themes from the Patient Safety Congress and outlined what the workshop programme would entail. The Committee was advised that 19 members of staff attended this conference, with some sharing places and attending one of the two day event. General feedback from LCH attendees was that the event confirmed to them that most Trusts faced similar challenges, and that they were assured that LCH was doing the right things. Some of the staff who had attended the conference were invited to share their views of the conference with the Committee. Two members of staff described what their first visit to the conference was like. They were impressed by the interactive questions they could be involved in using an app on their phones. They remarked about how poignant and influential individual patient stories were and recognised that the honesty and integrity of Trusts and individual staff members had made a difference to patients who were the victims of serious incidents. One front line member of staff who attended said they felt valued by the Trust, in being allowed to attend the conference, and as they worked in an isolated service, they appreciated the opportunity to network with other Trust colleagues and the wider NHS. Three key themes from the conference were then discussed at the Committee workshop in a 'world café' style of presenting, with a presenter facilitating discussion on a key theme at each of three tables. The first key theme 'What is a Just Culture' which is moving beyond blame and seeing people as the solution, not the problem. It should recognise that staff members involved in incidents be seen as the 'third victim' and should receive support. The Committee heard that this approach was used recently in improvement processes at Merseycare NHS Trust. A comparison to the aviation industry was made to demonstrate how Trusts can learn from other industries safety cultures and how they can improve safety by reducing system variation. In summing up this area of the workshop, the Committee Chair asked how the Trust should outwardly express a just culture, as this would underpin where the	

	Trust wants to be. The Committee debated how improvement in culture could be measured and considered how a shift to a more just culture could be monitored through Quality Committee using existing measures and perhaps introduce some new ones. A copy of the Merseycare NHS Trust article is to be shared as there may be strategies within it that the Trust could adopt. **Action: Company Secretary to share Merseycare article with Committee** Another key theme was 'Deteriorating patients'. The Committee heard about recent developments to the 'NEWS' (National Early Warning Score) tool, which helps to identify when patients are becoming increasingly unwell. This tool has been improved in the new version 'NEWS2' with better templates being used to generate a score, which is being introduced currently into ABU. In addition, the Committee heard about a new version for children, in recognition that children of different ages will have different triggers. The Committee recognised the importance of this tool, particularly as the Trust is now involved in the virtual ward and seeing patients with greater complexities, as well as its uses in earlier identification of sepsis. The third theme was about how the Trust could capture and share the great stuff it is doing. The workshop heard about St George's Hospital NHS Trust who have developed 'Great-ex', a play on their 'Datix' system, but which captures what that Trust describes as 'brilliant stuff' – good practice that it wants to share widely. Examples were given of new ways of working, safety huddles, how St George's offer promotion from within, how it benchmarks against other trusts etc. The workshop discussed how LCH could implement something similar and the workshop was asked to vote on its name - which is to be 'Fabuleeds'. The Chair thanked the attendees for their excellent interactive sessions.	**Company Secretary**
Business unit focus: Adult Services		
2018-19 (50)	The Clinical Lead for Adult Services provided an overview of the Adult Business Unit and the Business Unit representatives introduced themselves to the Committee. The Clinical Lead for Adult Services (ABU) provided the Committee with a word-cloud of feedback words. Caring, Good and Outstanding were the most predominant words. The Committee was also shown the ABU's plans on a page. There was a brief question and answer exercise to ascertain the Committee's knowledge of the services on the number of referrals, contacts, complaints, compliments and incidents. The Clinical Lead for Adult Services explained to the Committee that staff perception of these ratios is worse than in reality. The Committee heard how the commissioners are working with the ABU to become more outcome based. Average time spent with a patient has increased as numbers of contacts has decreased. The neighbourhood teams have monthly meetings to examine quality and to pick up any issues quickly. Quality Boards are routinely used and provide meaningful information on quality indicators. Safety huddles occur at least weekly, and in the case of some teams, are daily. These meetings also discuss team morale and learning from incidents. Safety huddle boards have been developed with support the Improvement Academy.	

	The Clinical Lead for Adult Services described the business unit's approach to recruitment and retention and how supportive roles have been introduced, for example, a secondment post to facilitate the self-management programme to give it traction. Overarching outcome measures have been introduced, as the ABU recognised the importance of understanding the effect of the care its services provide. There is ongoing work to support winter pressures including admission avoidance and discharge support. The Committee heard from the self-management facilitator about the self-management programme, which was described as an exciting piece of work. The self-management facilitator said that the approach needed to ultimately be embedded in how the neighbourhood teams work. The facilitator described the patient activation measure, which assesses how active a patient is in participating in their own healthcare, and is reviewed to see whether the interventions and support make a difference. The Committee heard an impressive patient story from one of the nurses who attended the workshop. She described the patient who has diabetes and has learning difficulties. Other professionals involved in his care were not hopeful that he would be able to manage any of his care, but by getting to know him and by using simple tools, mainly pictorial, the patient is now much more independent in managing his healthcare. The Committee Chair recognised the impact that this positive approach could have on the city as a whole. The Trust Chair commented that Newton Europe had found that there was excessive caution across the healthcare system. The final part of the ABU presentation was on pain assessment in patients with cognitive impairment. The Committee heard about the lack of knowledge and lack of standardised pain management approach to patients with dementia that had led to excellent work being done to improve care in this field. The Committee was advised that pain is undertreated in dementia patients and symptoms can be missed, leading to inappropriate treatment. A flowchart has been developed and a visual scale to try to identify pain through non-verbal means. The Committee recognised that this important and innovative work undertaken by the ABU lends itself to Quality Improvement initiatives and health services research, both of which should be pursued. The Chief Executive commended the ABU for ensuring innovative work is taking place, despite service pressures. The Committee asked about challenges for the ABU. These were: having the capacity for new developments and initiatives, recruitment and retention issues, and leadership capacity and experience, as there are a number of new leaders in post.	
Performance brief and domain reports		
2018-19 (51)	**Performance brief and domain reports** The Committee reviewed the Performance brief document and in particular the safe, caring, effective domains. The Trust Chair brought the Committee's attention to the 9 month wait within the	

	IAPT service for people seeking level 3 interventions. The Trust Chair advised the Committee that he had recently visited this service and his report was in draft. He had found the service to be well-led but was concerned about the waiting times. The Executive Director of Operations explained that there was a recovery plan with actions to address the issues. It was recognised that the commissioning arrangements were not adequate for the demand on the service. The Clinical Lead for Specialist Services advised that the service were developing different ways of working to assess patients more efficiently. A Non-Executive Director (TD) asked for the Committee to have more oversight on this issue and was concerned that data on such waiting times did not appear in the Performance Brief. It was agreed that this concern should be incorporated in the work currently being carried out to improve the Performance Brief. The Committee noted that safe-staffing fill rates have dropped at Hannah House, however it was assured that there has been no impact on patient care. A Non-Executive Director (TD) expressed concern that the FFT (Friends and Family Test) process was not robust. The Acting Executive Director of Nursing advised the Committee that more work was being done on feedback processes. The Committee Chair asked about the incidents of death being reported as patient safety incidents and was advised that these should be investigated through the mortality surveillance process. The Committee Chair requested that a mortality section should be added to the Clinical Governance Report, and a rational should be provided within the narrative. **Action: Narrative section on mortality to be added to the Clinical Governance Report.**	**Acting Executive Director of Nursing**
Quality governance and safety		
2018-19 (52)	**Clinical Governance Report** The Acting Executive Director of Nursing presented the Clinical Governance Report (previously known as the Director of Nursing Report): <u>Children's Business Unit</u> The Committee had discussed the improving situation in the Children's Business Unit with ESR data as part of the matters arising agenda item. The Committee discussed Hannah House eligibility criteria which the commissioners are amending. The Committee remains concerned with the commissioners' decision to bring the upper age limit down to 18 years to be in line other services in the city, particularly since the general pattern of care is moving up to 25 years. <u>Adult Business Unit</u> Within ABU, leadership capacity was a priority, with new leaders being supported through the leadership development programme and time being needed to help them in their new roles. Key challenges were around clinical capacity within the neighbourhood teams, specifically in band 5 nursing roles. A Non-Executive Director asked about how this year's pressures compared to last year. The	

	Executive Director of Operations advised that new roles being recruited to and the situation was constantly under review. Rota management, skills and competency had certainly improved from last year. <u>Specialist Business Unit</u> The Committee discussed the four areas where the SBU identified challenges. These were difficulties retaining staff in Cardiac Services due to pay band issues, increased waiting times in the Diabetes Service – where internal analysis is being carried out to determine the cause of increased waiting times, Dietetics staffing capacity, where there is now an intent to submit a business case for additional staff, and IAPT waiting times, which continue to exceed mandated waiting times. The Clinical Lead for Specialist Services advised the Committee that they were scoping staffing beyond the usual framework, in order to try alleviate the problem. The Committee Chair asked how the Trust compared to other trusts. The Executive Director of Operations said that overall, the vacancy rate benchmarks well – however there were hotspots such as dietetics, which were concerning. The Chief Executive confirmed that staff capacity risks for individual services were on the risk register, with an over-arching strategic risk for staff capacity on the Board Assurance Framework. The Chair thanked the Acting Executive Director of Nursing for the concise report.	
Quality Committee work plan		
2018-19 (53)	The Committee discussed the timings of receipt of papers for Committee meetings, as these were often received the weekend immediately prior to the meeting which did not provide sufficient time to scrutinise the information. The Committee accepted that the Performance Brief and the Clinical Governance Monthly Report have time restrictions as data is not available to be analysed until the second week of the month. Following this, SMT review the performance information prior to it being submitted as a Committee paper. The Committee agreed that it will trial receiving the majority of papers one week prior to the Committee Meeting, with the Performance Brief and the Clinical Governance Monthly Report following.	
2018-19 (54)	**Matters for the Board and other Committees including assurance levels** It was agreed that the Chair would provide an update to the Board at the meeting on 7 December 2018.	
2018-19 (55)	**Any other business** The Executive Director of Operations advised the Committee that she had received initial feedback of the CQC system review of the city. The CQC saw evidence of a well embedded neighbourhood team model and Executive Director of Operations said the teams should be very proud. The full report will be available in due course and will be shared with the Committee.	
	Dates and times of next meetings (09:30 – 12:30) Monday 26 November 2018 Monday 21 January 2019 Monday 18 February 2019	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (84bi)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 26 September 2018 (9.00am – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD)
	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Jenny Allen	Director of Workforce (JA)
	Diane Allison	Company Secretary
	Amanda Wilkinson	Service Manager (for item 37 only)
	Lucy Williams	Consultant in Paediatric Dentistry, Clinical Lead (for item 37)
	Graham Hyde	Head of Business Intelligence (for item 40a only)
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(36)**	The Committee's Chair welcomed everyone to the meeting. **36a - Apologies:** None recorded. **36b - Declarations of Interest:** None recorded. **36c - Minutes of last meeting** The public and private minutes of the meeting dated 25 July 2018 were approved by the Committee. **36d – Matters arising from the minutes and review of actions** *Item 2017/18 (97b) – Draft key performance indicators* This was an action for both the Quality and Business Committee meeting to agree which committee should receive reports on self-management as both were due to receive a report in October 2018. The Chief Executive agreed that it was a quality issue and initiative for the Quality Committee and that consideration should be given for the Business Committee to receive a brief narrative around the performance of the services. The Committee Chair was happy for the Quality Committee to receive a full report in October 2018. **Action closed.** *Item 2018/19 (27d) – Neighbourhood teams activity targets* The Executive Director of Finance & Resources reported that he would not be	

	undertaking an independent piece of work on the activity targets as a high level brief had been provided to the Commissioners in response to their questions. The Chair said he was looking for more of a narrative; a journey with neighbourhood teams, and what was being done to add valuable contribution to the community. It was agreed that the Executive Director of Operations, the Executive Director of Finance & Resources and the Chair of the Committee would meet up in the next few weeks to discuss the two pieces of work; the story of activity levels and a positive story about neighbourhood teams. To discuss the aim, management and how it's affecting contractual arrangements. **Action:** • The Committee is to receive a detailed activity report on the journey of the neighbourhood teams in October 2018. • The Executive Director of Operations, the Executive Director of Finance & Resources and the Chair of the Committee to meet in the next few weeks for an update and a clarification on the narrative and the advice to Commissioners and other partners. **36d(i) – Workforce Race Equality Standards (WRES) action plan** The Director of Workforce (JA) presented a WRES action plan that had been produced following workshops held with black, asian and minority ethnic (BAME) staff and the Trust Board and also based on discussions held at the July 2018 Business Committee meeting. The Director of Workforce (JA) said that a target included the percentage of BME staff in senior manager positions as compared with percentage of black and minority ethnic (BME) staff in the workforce. There was currently a gap which if in line with other NHS organisations and a low reflection on diversity measure in this Trust. The action plan was rated on a more transformational and cultural change and the on-going work is trying to engage with what the culture of the organisation is. The Director of Workforce (JA) said that the Trust was part of the NHS Employer Diversity Programme and would be looking for an overall vision, aspiration and transformation of some of the work undertaken by other organisations. The Committee Chair noted that considerable work was required in the nine WRES indicators and asked about the capacity, capability and prioritisation of the nine different areas. The Director of Workforce (JA) said that she had already secured some resource and the priority was to do some further work on the analysis to support an event arranged for November 2018. **Action:** A further update on progress was requested for the Committee meeting in January 2019. **Outcome:** The Committee received the action plan and noted the work described in the nine indicators. **36d(ii) – Neighbourhood team activity narrative** Discussion for this item was part of item (36d/27d) above.	SP SP JA

2018/19 **(37)**	**Service area focus** **Community Dental service** The Committee Chair welcomed representatives from the community dental service. A brief paper had been circulated prior to the meeting to provide background information to the Committee in advance of the discussion in the meeting. The paper laid out concerns about waiting times and process issues. The Executive Director of Operations said that before getting into deep discussions she wanted to share some good news with the Committee that the Trust had been offered a five year contract for community dental services. She said with the promise of five year contract there is also an expectation to move to a new specification that had different requirements to the current provision. The Service Manager said that the new specification indicates that wait times need to be less than 18 weeks for all patients but currently referral for first appointment for routine issues was about 26 weeks. In the new specification referrals would come from a wider footprint than currently served and she had concerns regarding the capacity to deal with this. The Executive Director of Operations said there would be further negotiation with the Commissioners about re-modelling the service for existing and new client group and the expectations in the new specification. It was noted that the waiting times had gone back up again after a cleansing exercise. There had been some long term absence which had impacted on service delivery, and having fewer clinics over the summer months. The Service Manager said that when the dental service moved to central booking system and streamlined the referral and administration processes, this reduced the waiting times considerably. This would be revisited. **Outcome:** There was a useful discussion covering existing concerns and shortcomings including the requirement for them of proposed staffing; a consideration of transferring some of our work to other providers and on improved rationalisation around 'who owns which patients'. Negotiations with the Commissioners regarding out of area coverage was being considered. The Director of Workforce (JA) agreed to discuss the offer to staff about recruitment and retention. The Service Manager agreed to re-visit some of the issues and concerns previously looked at including DNA rates that appeared to be quite considerable.	
2018/19 **(38)**	**Business planning** **38a – Trust priorities 2018/19 update** The Executive Director of Finance & Resources reported on the progress towards achieving the Trust priorities set out in the 2018/19 operational plan at the end of month 5 and a forecast for the year-end. This represented Senior Management Team's (SMT) views in advance of being presented to the Trust Board meeting on 5 October 2018 for comments and discussion. The Chief Executive said that some of the challenges were in the areas of quality improvement. After further discussions it was agreed to replace the number of priorities with	

	more narrative about progress with the Trust priorities before the plan was submitted to the Trust Board. A Non-Executive Director (RG) said the plan was not explicit in the important actions that were completed. He said it would be helpful to make it more obvious which were the completed priorities and then to have reasons for the underperforming priorities and the recovery plan for these in a different colour. **Action:** The report to be re-formatted before being received at the Board in October 2018. **Outcome:** The Committee noted the assessment of progress at the end of month 5 and the forecast for the year-end. **38b – Emergency Preparedness Annual report 2017/18** The Executive Director of Operations introduced the emergency preparedness annual report 2017/18 for discussion at the Business Committee meeting prior to submission to the Trust Board. As part of the Civil Contingencies Act the Trust was required to demonstrate that it was prepared to respond to an emergency in case of major incident and has resilience in relation to continuing to provide safe patient care. The Executive Director of Operations said that to enable the Trust to do that a self-assessment had to be completed against the relevant NHS England core standards for emergency preparedness, resilience and response assurance process. The self-assessment was included in the pack. It was noted that there were three standards that the Trust needed to address to be fully compliant; two were around having sufficient trained loggists 24/7 and one was around the Director of Operation's attendance at the regional meetings. The Operational Support Manager regularly attended in her place. As part of the process an emergency planning resilience and response policy had to be created this year. **Outcome:** The Committee received the annual report and considered the outcome of the self-assessment and agreed the rating of substantially compliant and agreed the policy document for submission to the Trust Board. **38c – Organisational Development (OD) strategy update** A presentation by the Director of Workforce (JA) provided an update on the development of a successor workforce strategy to the existing OD strategy. The Committee was invited to comment, challenge and make suggestions. The presentation covered the following draft workforce strategy framework for discussion prior to being presented at the next Trust Board meeting on 5 October 2018: • Context and alignment • Process and timetable for development & approval • Content • Deliverables underway • Next steps The Director of Workforce (JA) said that the proposed workforce strategy will succeed the previous existing OD strategy from 1 April 2019.	BM

	A Non-Executive Director (RG) said that bringing the set of priorities together was encouraging and interesting and he was most enthusiastic about the business partner model; having a corporate specialist going out to help, support and advice in a more structured way. The Committee Chair said that the presentation version was more systematic and clearly written than the summary cover note which needed amending before going to the Trust Board. The Committee Chair said he would welcome a clearer connection with the vision of the Trust going forward, which is about serving the population of Leeds and making sure that the workforce is fit for purpose. The Director of Workforce (JA) said that the strategy is about supporting the organisation's objectives and within each of those five pillars it's about being clear and articulating what the future vision will be. **Action:** A full draft workforce strategy is to be presented to the Business Committee in January 2019 and the Trust Board in February 2019. **Outcome:** The Committee noted the progress made in the development of the new workforce strategy.	JA
2018/19 **(39)**	**Project management** **39a – Projects report (Change Board)** It was noted that the change board meeting had not taken place since the last Business Committee meeting in July 2018. The Executive Director of Operations advised the Committee that she has had a conversation with the two key players; Electronic Patient Record (EPR) Project Manager and Estates and Administration Project Manager about transforming the meeting into a Programme Management Board. The development of the new terms of reference is scheduled is to be reviewed and agreed at the next change board meeting on 12 October 2018. The Executive Director of Operations said that the programme of works was progressing well. The EPR board meeting on 19 September 2018 received a highlight report indicating that all but two neighbourhood teams implemented the new ways of working. The final two will be implemented in November 2018 for completion. The administration review work was on-going and a written report would be provided to the next Committee meeting in October 2018. **Action:** A written report is to be received by the Committee in October 2018. **Outcome:** The Committee noted progress of project work. **39b – Productivity programme group update** The paper provided an overview of the Trust's approach to productivity. The Executive Director of Operations said that the work was progressing at the pace of the membership at the moment. She said work was underway to develop an efficiency plan to implement a cost improvement programme plan for next year.	SP

	Outcome: The Committee received the productivity group update. **39c – E-rostering** The Director of Workforce (JA) provided an update on the project progress since the system was procured in June 2018. The key points highlighted were that working in partnership with Allocate was working well, and the Project Manager was building the e-rostering team to network and support the Project Board with a good clinical, nursing and financial engagement. The pilot areas identified were police custody, Armley neighbourhood team and possibly Little Woodhouse Hall. There was a plan to place all bank staff on the system. The benefits were set out in the paper about utilising and creating efficiency, reducing administration and transparency of rotas for improving staff satisfaction. The current project plan was on track and there were no concerns. Wider roll-out of the system was based on benefit analysis and lessons learnt from the initial pilot. This would enable the project team to create user guides and standard operating procedures for best practice. The Director of Workforce (JA) said that at the moment the project group was concentrating on putting in the technology for phase one. Discussions were underway with pilot areas about the risk of implementing the system during winter pressures and the advice was that the benefits of the system will support staff through the winter months. A Non-Executive Director (RG) felt that there was an opportunity for a greater link to demand and supply management or caseload management and to e-rostering. The Committee noted that the project was achieving its timescales within the project plan. The project will be moving from mobilisation to pilot stage in October 2018. The project initiation document (PID) was under construction and a draft PID document had been presented to the Project Board for comments. **Action:** A Non-Executive Director (RG) to review the PID document that was in development. **Outcome:** The Business Committee noted the update and progress to plan to deliver initial benefits. **39d – CAMHS Tier 4** The Executive Director of Finance & Resources said that work was on-going and progressing to plan. He said he was waiting for the construction company Interserve determine a guaranteed minimum price. The engagement with local community took place on 13 September 2018 and further communication continues with local Councillors. The project was progressing well in terms of time scale.	JA

2018/19 **(40)**	**Performance management** **40a – Performance brief and domain reports** The Committee Chair welcomed the Head of Business Intelligence to the meeting. The Committee considered the performance brief and domain reports. The cover report provided a summary of performance during August 2018 against targets and indicators for consideration. The Quality Committee focussed on caring, safe and effective domains at its meeting on 24 September 2018. The Chair said that the summary cover paper reflected a good narrative of the performance, particularly the safe staffing issues. **Responsive domain** The responsive domain narrative had improved from the previous report. The Executive Director of Operations said that the Trust performed well in its indicators relating to waiting times with all rated green for August 2018. **Safe and caring domains** There were zero category 3 and zero category 4 pressure ulcers reported in August 2018. A Non-Executive Director (TD) said that the measure was for avoidable pressure ulcers. The percentage of patients recommending community care remained above target. A Non-Executive Director (TD) explained that the caring domain measure was for inpatients as a national performance indicator. The Executive Director of Finance & Resources said that a sentence in the report should say it was reported here for the first time in this financial year, but full discussions took place at the Trust Board meeting in August 2018. **Action:** Performance brief wording to be amended prior to presentation at Trust Board in October 2018. **Well-led domain** The Chair noted that the sickness absence rate for August 2018 for both long term and short term remained below the outturn 2018/19 target of 5.8%. The Director of Workforce (JA) said that the health and wellbeing project group were looking into sickness rates in detail. A brief update was to be provided at the next meeting in October 2018. A Non-Executive Director (RG) asked whether patient contact variance becoming substantial would cause issues. The Chair of the Committee believed that the downward trajectory was a concern. He would raise that at the next Board meeting. The Executive Director of Operations said that she was aiming to have a new profile set against current activity levels and monitor further variance with new profile. She said that this profile was redundant at the moment. The Head of Business Intelligence said that the indicator in place was measuring against a target that was not reflective of the Trust's current performance. **Action:** A sickness absence update was requested for the meeting in October 2018. **Outcome:** The Committee noted the current levels of performance.	

	Finance Domain The Executive Director of Finance & Resources reported that the Trust was slightly ahead of plan for year to date and forecasting achievement of the control total. He said that, following the award of both the 0-19 services and community dental tenders he was reviewing the impact of this positive news against emerging risks. NHS Improvement were involved in that conversation. **40b – Operational and non-clinical risks register and Board Assurance Framework update** The report provided a description of the four extreme risks which were the same as the report received by the Committee in July 2018. The summary report showed changes to note to non-clinical risks on the risk register. The Chair queried the lone working risk which had appeared for the first time this year. The Company Secretary confirmed that this risk appears each year when the evenings start to close in and people get worried. The Risk Manager undertakes a lot of work with services throughout the year to ensure that risk assessments in general are robust, including lone working to mitigate the risk. **Outcome:** The Committee noted the recent revisions made to the risk register. **Board Assurance Framework (BAF)** The Company Secretary advised the Committee that sections of the BAF assigned to the Business Committee were reviewed by a working group of Business Committee members in August 2018. The BAF was also reviewed by the SMT. The working group identified three objectives for the BAF including reconciling risk scores. It recommended three BAF scores should be reduced from 12 to 9. The working group agreed reconciling Business Committee agendas in line with the BAF risks assigned to it; looking at the reports received and ensuring they related to strategic risk assigned to this Committee. Some areas that are at risk which do not feature on BAF may be added in future. The Committee Chair said there will be more focus on the risk associated with engagement, leadership, contracts and new business into greater depth on future agendas. **Outcome:** The Committee noted the contents of the risk register and the amendments made to the BAF.	
2018/19 **(41)**	**Business Committee work plan** **41a – Proposal for Health and Safety Group (HSG) to report to Business Committee** Following SMT's review it was proposed that the Health and Safety Group, which currently reports to SMT, should report to the Business Committee as part of its governance structure. The HSG meets quarterly chaired by the Executive Director of Finance and Resources. The terms of reference were tabled for information. The Committee will be receiving HSG quarterly minutes in the future and an annual report.	

	Outcome: The Committee agreed to the health and safety group reporting into the Business Committee. **41b - Future work plan** The Company Secretary advised the Committee of an extra column incorporated into the work plan to align the documents received to strategic risks on the BAF. The work plan was reviewed by the Committee members to note papers that were due to be received at the October 2018 meeting.	
2018/19 **(42)**	**Matters for the Board and other Committees** • Workforce WRES report (reasonable assurance) • Operational plan (reasonable assurance) • Emergency preparedness annual report 2017/18 (substantial assurance) • Organisational development strategy (reasonable assurance) • Projects and productivity programme updates (reasonable assurance) • E-rostering (reasonable assurance) • Performance brief and domains report	
2018/19 **(43)**	**Any other business** **Comments and feedback noted at the end of meeting about community dental service discussion.** The Committee Chair reflected that it had been a good discussion and the Committee agreed they felt more informed about the service. The Director of Workforce (JA) said that some of the issues presented could have been resolved elsewhere, in discussion with HR representatives. A Non-Executive Director (RG) felt that it wasn't a Non-Executive level conversation but added value. The Chief Executive was of the opinion that it could have taken place with SMT but agreed that the Non-Executives added value. A Non-Executive Director (TD) added that it was a good conversation but did not specifically provide assurance; it was more of an operational conversation. The Committee Chair said that in a number of occasions the service felt they had the answer but had not progressed. The discussion at Committee helped them think again.	

Leeds Community Healthcare NHS Trust

Item 2018/19 (84bii)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 24 October 2018 (9.00am – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD)
	Richard Gladman	Non-Executive Director (RG)
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Diane Allison	Company Secretary
	Jenny Allen	Director of Workforce, OD and System Development
	Roohi Collins	Aspiring Non-Executive Director Programme
	Gareth Burns	Programme Manager (EPR) – for Item 44c
	Anita Simey	Project Manager (EPR) – for Item 44c
	Anne McGee	Head of Organisational Development & Improvement – Item 45
	Jude McKaig	Operations Manager for Clinical Education – Item 45
	Dan Barnett	Head of Business Development – Items 46a-c
	Alex Hammond	Business Development Manager – Items 46a-c
Apologies:	Thea Stein	Chief Executive
Note Taker:	Bridget Lockwood	Business Support Manager (CEO & Chair's Office)

Item	Discussion Points	Action
2018/19 **(44)**	The Committee's Chair welcomed everyone to the meeting. **Item 44a - Apologies:** Apologies were noted from the Chief Executive. **Item 44b - Declarations of Interest:** A Non-Executive Director (RG) declared an interest relating to Item 46c due to a role held with Humber Teaching Hospitals NHS Trust which provides Restorative Justice Services in Humberside. **Item 44c - Minutes of last meeting** The public and private minutes of the meeting dated 26 September 2018 were noted for accuracy and approved by the Committee. **Item 44d – Electronic patient record presentation** The EPR Programme Manager and the EPR Project Manager attended the meeting to provide an update on the EPR programme. The Committee noted that some projects had already been closed in the previous financial year, a number of projects, particularly in the Neighbourhood Teams have been closed, or would be closed by the end of the current financial year. Teams who had moved to using EPR as 'business as usual' in year included the Safeguarding and CIVAS teams, with the Neurology team due to go live the following week. The Adult Speech and Swallowing team and the ICAN teams were in the analysis phase.	

	The Committee Chair asked if "closure" meant teams were fully utilising EPR. The Project Manager confirmed this was the case and that this phase of the project included lessons learnt and a benefits realisation exercise. A Non-Executive Director (RG) asked if all Trust services would move to EPR. The Programme Manager responded that not all services would move to EPR, as there were areas where the software would not allow this, for example, the Community Dental Service. A Non-Executive Director (RG) asked if there was scope for the administration review projects to be included. It was noted that administrators would be using SystmOne and that a business analyst was currently working with the administration project team regarding the Adult Speech and Swallowing service project. The Project Manager provided a summary of the programme for the last two quarters of 2018/19 and planned activity in early 2019/20, including a particular focus on all Neighbourhood Teams using EPR as business as usual from 1 April 2019, a review of all ICAN teams, a review of the use of Care Notes and potential use of the mental health package available on SystmOne in CAMHS. The Committee noted the planned merger of the EPR and Clinical Management Systems teams in quarter two of 2019/20. The Project Manager and Programme Manager outlined key successes to date, including improved ability relating to capacity and demand, the ability to identify trends and review complex patients through EPR across teams. The Committee Chair asked if the project had been carried out within budget. The Executive Director of Operations confirmed that the project remained within budget. The Executive Director of Finance and Resources reflected that it would be interesting to see if efficiencies could be demonstrated. A Non-Executive Director (RG) commented that evidence elsewhere demonstrated that financial savings were not necessarily made but the quality of clinical interactions and the quality of data increased. The Executive Director of Operations agreed and added that savings had been made but these were not cash releasing. Savings had been made in terms of increased clinical time however, which enabled clinicians to see the right patients at the right time, and enabled daily handovers and caseload reviews to take place. The Executive Director of Finance and Resources agreed that the EPR programme had become a project around new ways of working. The Committee Chair thanked the Project and Programme Managers for a helpful presentation which had given the Committee substantial assurance regarding progress made, particularly in the Neighbourhood Teams. The Committee Chair added that he would like to see further analysis regarding the costs of the project, and that it was being delivered within budget, and, in due course, an illustration of benefits realisation. **Action:** Business Committee to receive further information regarding the EPR project budget and an illustration of benefits realisation. **Item 44d – Matters arising from the minutes and review of actions** *Item 39a – Projects report (Change Board) – CAMHS Tier 4 unit update* – The Executive Director of Finance and Resources provided an update on developments since the Trust Board had met earlier in the month. He confirmed that there would be no preconditions to the reasonable funding of	SP

	the cost of the unit over and above the project development cycle (PDC). The Committee noted that the planning submission had been delayed by two months to enable the building design to be re-considered. Decisions now needed to be made on whether to include a six bedded Psychiatric Intensive Care Unit (PICU) and high dependency area, a S136 unit, CAMHS outreach service and crisis team in the build. A Non-Executive Director (RG) asked if the Trust had confirmed an additional capital allocation from NHS Improvement. The Executive Director of Finance and Resources confirmed this but added that the additional capital would not be committed to the new build. A Non-Executive Director (TD) asked if the capital could be used on other Estates projects. The Executive Director of Finance and Resources confirmed this to be the case and added that plans for this spend had not yet been drawn up. *Item 2018/19 (39c) – e-rostering* – A Non-Executive Director (RG) confirmed that he had reviewed and was pleased with the PID document, and would be meeting with the project lead again. The Committee noted his reflection that this was a foundational project, with three pilot areas being progressed initially, in December 2018, with a wider project plan to be determined once the pilot areas could self-sustain. This was likely to be in mid-February 2019. The Director of Workforce confirmed this to be the case and added that this approach had been adopted following the learning from the EPR project. **Item 44d(i) – Neighbourhood team activity report** The Executive Director of Operations presented a report which outlined the reduction in face to face activity in Neighbourhood Teams as a consequence of transformational change in the service. The case study included as an appendix demonstrated how the changes had impacted on practice and the reporting of activity. The Committee noted that commissioners had agreed to change the activity profile to one that was more reflective of the way the service had transformed to provide fewer, more qualitative and therefore longer visits, rather than focussing on the number of visits achieved. The Committee was advised that time was being used more effectively by teams to carry out safety huddles and caseload reviews. The Committee Chair reflected that the paragraph in the report which outlined the transformation programme captured the position well and asked if this was a story that is marketable. The Executive Director of Operations felt this it was. The Director of Workforce felt that the story could also be shared and celebrated with staff. The Executive Director of Operations agreed and said that a celebration event would be arranged once all Neighbourhood Teams were live on EPR. The Committee Chair concluded that a compelling and marketable narrative, to include new ways of working and an improved experience for patients, that could be shared internally, and potentially externally, needed to be shaped further. He requested that the story be shared with the Trust Board, including a plan around marketing, in December 2018. **Action:** A Neighbourhood Team activity story to be shared at the Trust Board meeting on 7 December 2018, including a plan around marketing the transformation programme.	SP

	Outcome: The Committee received the narrative explaining the reduction in face to face activity in the Neighbourhood Teams.	
2018/19 **(45)**	**Service area focus** **Learning and development** The Head of Organisational Development and Improvement and the Operations Manager for Clinical Education attended the meeting to provide an outline of the revised leadership and management and the learning and development offers. <u>Leadership and management offer</u> The Head of Organisational Development and Improvement referred to the engagement with the Trust Board earlier in the year in the discussion around increasing the scale and range of the training offer within the Trust. The revised offer was outlined in the slides shared in the Committee papers and comprised 'Leading LCH', 'Management Essentials' and 'Manager As Coach'. The leadership development course was due to commence in January 2019, with 96 participants undertaking six programmes per year. The Management Essentials course would be available to 125 participants from February 2019 and comprised bi-monthly two day programmes. The Manager as Coach course would comprise seven to eight programmes per year and would have 80-90 participants. The Committee noted that a Leadership Competency Framework, which had been widely engaged upon, was associated with the whole leadership and management training offer and had been well received. An example of the framework was shared at the meeting. The Committee noted that a peer coaching group was also to be established from the Leading LCH cohort of managers. The Committee Chair asked how it would be determined who was to be offered the training. The Head of Organisational Development and Improvement responded that the courses were for all managers and leaders within the Trust, from Band 4 staff upwards. A paper was to be considered by the Senior Management Team in November 2018 to determine which managers should be included in the first cohort. This was likely to be a balance between the courses being mandatory for new managers who had joined the Trust within the last year, and existing managers and leaders who had been identified by their managers. A Non-Executive Director (RG) suggested that the training be offered in a celebratory way as an investment in new and existing managers, set within a career path framework, rather than simply making it mandatory to attend. He added that the offer appeared to be focussed more on values based leadership rather than on harder management skills. The Head of Organisational Development and Improvement responded that the Managing Essentials programme would be focussing on the harder skills, the leadership courses would be focussed on coaching leadership with compassion but within the context of managing staff absence, financial and other pressures. The Committee Chair commented that there appeared to be one generic offer regardless of whether managers were at a senior or junior level. He added that there appeared to be a significant amount of content to cover in the two to three day sessions.	

The Executive Director of Operations said it needed to be determined who should attend the course to ensure that the balance was right, recognising that some people will be compelled to attend whilst others will be excited by the opportunity on offer.

A Non-Executive Director (TD) asked if the team had the capacity to deliver the training. The Head of Organisational Development and Improvement responded the resource commitment was deliverable from within the ODI team, and was seen as a priority. There would need to be further consideration regarding the support available for other agendas as a result.

A Non-Executive Director (TD) felt that the gap regarding a training needs analysis, linked to appraisals, was a concern, and asked if aspirations ascertained in appraisals were captured collectively. The Director of Workforce, OD and System Development responded that this was not captured centrally however; the Head of Organisational Development and Improvement added that the team was considering how this could be achieved.

A Non-Executive Director (TD) felt that a significant resource would be needed in terms of time and people in order to deliver the training offer. He asked what steps were being taken to monitor how successful the training was. The Head of Organisational Development and Improvement responded that an evaluation tool was being developed and this would be shared at the next update to the Committee.

A Non-Executive Director (RG) offered a reflection that the use of external trainers was often valuable and those on the course could gain from examples and experiences that had occurred in other organisations shared as part of the training.

The Director of Workforce, OD and System Development said the offer linked to work relating to appraisals, succession planning and talent management. The Director added that the leadership programme also needed to be supported by individual needs analysis, supported by line managers and coaches.

<u>Learning and development offer</u>
The Head of Organisational Development and Improvement outlined the learning and development offer, recognising that this was not as developed as the leadership and management offer. A review was underway to confirm that the key issues identified to date were correct and to establish an approach for 2019 which would enable the improvements required.

The Director of Workforce, OD and System Development acknowledged that learning and development had been identified as a gap in the CQC Well-led Framework KLoEs, but added that the work undertaken to date was a good starting point.

The Committee Chair summarised the discussion. The Committee recognised the need, significance and importance of an improved offer to leaders and managers, along with increased capacity for talent management. The Committee recognised that compelling some managers to attend, and a generic offer for all levels of experience could be an issue. It was felt that the requirement to include so much content in two to three day programmes was challenging, and it was felt that more consideration needed to be given to the

	capability and capacity of the ODI team to deliver, along with implications for other work undertaken by the team, and further development work for the future. The Committee requested that the link between the offer, appraisals and other HR issues be improved. The Committee Chair thanked the Head of Organisational Development and Improvement and the Operations Manager for Clinical Education for attending the Committee. **Outcome:** The Committee noted progress made to date.	
2018/19 **(46)**	**Business and commercial development** **Item 46a – Business and commercial development report** (Please see private minutes) **Item 46b – Traded services income generated opportunities** (Please see private minutes) **Item 46c – Liaison and Diversion Services – North of England** (Please see private minutes)	
2018/19 **(47)**	**Project management** **Projects report (Change Board)** The Executive Director of Operations presented the Change Programme Board update which briefed on the Trust's major change projects, including, EPR, Administration Review, e-Rostering and Estates rationalisation. The Executive Director of Operations commented that the latest meeting of the Change Board had seen a step change, with projects coming together more than had been seen previously. The Change Board had agreed that a number of projects needed to be included in the oversight of the programme board, including the ICAN review and digital innovations. A Non-Executive Director (RG) reflected that the Change Programme Board appeared to be scrutinising the management of priorities across programmes and providing oversight where required. He reflected, however that the report to the Business Committee omitted the evidence base for this and requested that a single portfolio map be included in the report. The Committee Chair agreed that the current paper provided assurance that progress was being made but added that the Business Committee should have sight of a plan on a page; this would enable the Committee to provide assurance to the Trust Board. **Action:** The Executive Director of Operations to include a plan on a page in future reports. **Outcome:** The Committee received the report and noted that no issues had been escalated from the projects.	SP
2018/19 **(48)**	**Performance management** **Item 48a – Performance brief and domain reports** The Executive Director of Finance and Resources introduced the report and	

	informed the Committee that a number of conversations were taking place around how the Performance Brief needed to be reviewed in order to ensure data was triangulated more effectively. The Committee reviewed each domain in turn, as follows: **Safe and caring domains** A Non-Executive Director (TD) briefed the Committee that the Quality Committee on 22 October 2018 had taken the form of a workshop, therefore the domains had not been scrutinised in the way they would be at a full meeting of the Committee. The Executive Director of Finance and Resources queried the statement that there had been no avoidable category 4 pressure ulcers reported in September 2018. He asked if this meant there had been some unavoidable pressure ulcers, or that any pressure ulcers recorded were not attributable to the Trust. The Executive Director of Finance and Resources agreed to query this with the Acting Executive Director of Nursing. **Action:** Executive Director of Finance and Resources to query the reporting of category 4 pressure ulcers with the Acting Executive Director of Nursing. **Responsive domain** The Executive Director of Operations informed the Committee that it had recently been determined there was a six month wait for step 3 IAPT appointments. The number of people seen by the IAPT service overall was lower than it should be; 13.9% of the population against a commissioned target of 15%. The Committee noted that NHS Leeds Clinical Commissioning Group (CCG), the commissioner of the service, was under pressure from NHS England because the national target was 16.9% of the population. A six point action plan to increase referrals had been agreed with commissioners. This had resulted in 200 more people being seen by the service in the last month. Whilst this assisted with access to the service, it compounded the waiting time position. Another initiative agreed was to remove the telephone assessment and assess people at their first appointment. The Committee noted that the CCG had offered £1m to support the recruit of additional staff and that staff could be recruited recurrently. A caseload review was underway, as was a review of variation, and a reduction in the number of sites the service was provided from had been agreed in principle in an attempt to reduce travel times for staff. A Non-Executive Director (RG) queried access into the service and how capacity was to be increased. The Executive Director of Operations responded that staff time could be freed up if the pathway into the service was made smoother. In addition, it was likely that more people than should be were being referred for step 3 and those in step 3 should be moved out of step 3 sooner. This was compounded by a lack of staff to undertake step 3. **Caring** The Committee noted that the Quality Committee had had a conversation on the friends and family test, and that the percentage of staff recommending community care remained above target. **Effective** The Committee noted that performance in this domain remained good.	BM

	Well-led domain The Director of Workforce, OD and System Development provided further information regarding the increase in Operations Directorate staff leaving in year. It was noted that a number of staff left the Trust in September 2018, the report implied there was a trend of staff leaving in the estates, facilities, front of house, and assisted living teams however this was incorrect. The Director of Workforce, OD and System Development highlighted that focus was being placed on improving appraisal and statutory and mandatory training compliance. A discussion would be taking place at the Senior Management Team meeting later in the day to establish which cohorts of staff should be included in the compliance figures. It was noted that current targets included staff that were on sick and maternity leave, and on secondment, groups that had not previously been included. A Non-Executive Director (RG) asked how the stability index was calculated. The Director of Workforce, OD and System Development agreed to establish this and inform the Non-Executive Director after the meeting. **Action**: The Director of Workforce, OD and System Development to inform a Non-Executive Director (RG) how the stability index was calculated. **Finance Domain** The Executive Director of Finance and Resources informed the Committee that, following a request from NHS Improvement to increase the surplus outturn from 2018/19, the Trust had released a redundancy provision, adding a further £0.5m to the control total. As a consequence, NHS Improvement had allocated a further £1.0m from the Provider Stability Fund which brought the revised planned surplus to £4.0m. The revised control total assumed that the Trust would receive £0.7m from the CCG for unidentified savings in respect of the CCG decommissioning plans. A Non-Executive Director (RG) asked if a plan was in place regarding how capital was to be spent in the next financial year. The Executive Director of Finance and Resources said that it first needed to be established what capital monies would be allocated this financial year, and what would be allocated next year. The Committee Chair asked if the Estates update due to be presented to the Committee in November 2018 could include this plan. The Executive Director of Finance and Resources agreed to consider if this would be possible at this point in the financial year. **Action:** The Executive Director of Finance and Resources to consider if plans for capital spend for 2019/20 could be included in the Estates update due to the Committee in November 2018. **Outcome:** The Committee noted the present levels of performance. **Item 48b – Quarterly workforce report including sickness absence and report on development work with NHS Improvement** The Director of Workforce, OD and System Development introduced the paper and said that once the Workforce Strategy had been finalised, this report would be aligned to allow updates to be provided based on the pillars included in the Strategy.	JA BM

	The Committee noted that the report included an update on health and wellbeing which had been selected by the Trust as one of the four Quality Improvement projects. The specific areas identified for review had been selected by the Health and Wellbeing Steering Group and the ODI team were working with the Yorkshire and Humber Leadership Academy on these. The Trust continued to be part of the NHS Improvement Health and Wellbeing Programme. The Director of Workforce, OD and System Development informed the Committee that the new Head of Systems and Intelligence was due to start work at the Trust the following week which would increase the strategic workforce analytics capability within the team and assist with the triangulation of data. An update was given on the Trust's short term approach to sickness management. It was noted that sickness absence was currently recorded as 5.4% which was lower than the same period in the previous year, however, the rate was tracking the pattern of the previous year. General Managers and HR colleagues were undertaking a review of the top ten cases in each business area and the Director of Workforce, OD and System Development commented that these often related to some very ill individuals. The primary causes of absence continued to be stress and emotional factors which was in line with other NHS Trusts and other sectors. The Executive Director of Operations highlighted that the Senior Operations performance panel had received a presentation from the Specialist Business Unit the previous day. The rate of sickness in the Business Unit was currently 3.92%, the lowest it had ever recorded. The Committee heard that the improvement had been seen since the General Manager had started to review cases with managers and had found ways, such as a change of hours, to get people back to work. Whilst this was recognised as being time consuming for General Managers, the Executive Director of Operations said that General Managers needed to be given this time in order to carry out the case reviews. A Non-Executive Director (RG) reflected that the long term sickness rate had been recorded at 3.8% for some time and asked how many people this related to. The Director of Workforce, OD and System Development did not have this information to hand but it was noted that the recent reviews had revealed that this group of staff were genuinely ill. The Committee Chair asked if more agency staff could be secured to support teams where team members were off sick given the agency cap was not being breached. The Executive Director of Operations agreed that, where it is known that a staff member will be off work sick for some time, securing additional resource to support teams would be helpful, even if this meant taking a financial risk. A Non-Executive Director (TD) asked how successful the staff bank had been. The Director of Workforce, OD and System Development confirmed that this was being reviewed and the team were working with agencies to try to fill gaps in resourcing as part of winter and short team resourcing plans. The Director of Workforce, OD and System Development added that nationally there were on average 11% vacancies in clinical posts, demonstrating that the issue was not unique to the Trust. Other solutions, such as supporting the new Nursing Associate role, were also being pursued.	

	A Non-Executive Director (TD) recognised the positive progress made in the Specialist Business Unit. He queried if national bodies had responded regarding the national workforce crisis. The Director of Workforce, OD and System Development said that within the HR Director network there was a call to think about things differently, such as supporting the development of individuals within organisations, and working more collaboratively across organisations. The Committee Chair asked how the different Workforce/HR initiatives were being linked, such as sickness absence and morale, and how appraisals were being linked with training and development offers within the Trust. The Director of Workforce, OD and System Development responded that this horizontal alignment was core and would be actioned and outcomes monitored through the workforce strategy. The Committee Chair reflected that HR was more than sickness and appraisals and suggested that he speak with the Director of Workforce, OD and System Development outside the meeting. **Outcome:** The Committee noted the contents of the quarterly workforce report. **Item 48c – Quality, staffing and finance: triangulation (Neighbourhood Teams) - update** The Executive Director of Operations introduced the report which provided an update on the management of demand and capacity in the Neighbourhood Teams for the period April to September 2018. The report sought to provide assurance that the careful management of demand and capacity had not impacted adversely on the quality of the service provided, or on other key performance indicators. The Executive Director of Operations added that capacity going into the winter months was a concern, however, service quality and the standard of care provided to patients was not being affected. Instead, capacity issues were affecting staff morale and teams were feeling the pressure. The Executive Director of Finance and Resources queried the fact that staff said they were busy but the time spent on each contact was longer. He queried if the assessment process could be shortened in order to increase capacity. The Executive Director of Operations responded that this would need to be discussed with the Acting Executive Director of Nursing but her understanding was that assessment times for new patients needed to be 90 minutes, slightly less for patients known to the service. A Non-Executive Director (TD) reflected that staff often do not feel stress as a result of the time they spend with patients. A discussion took place regarding how staff morale could be monitored and it was noted that the staff friends and family test was one of the indicators. The Director of Workforce, OD and System Development commented that the staff survey response rate within the Trust was currently 23%, double the national average, which suggests that staff are engaged although this did not mean that they were happy. The Committee Chair thanked the Executive Director of Operations for a helpful report. **Outcome:** The Committee received the update report.	

Item 48d – Productivity programme group update
The Executive Director of Operations provided a verbal update on the programme group's work which was basing discussions on the Carter review productivity programme. The Committee noted that the Senior Management Team were to consider later in the day whether the Trust would benefit from having a strategic partner on productivity.

Outcome:
The Committee noted the verbal update.

Item 48e – Operational and non-clinical risks register
The Company Secretary introduced the report and highlighted that the number of extreme risks had reduced from four risks to two risks. The Committee noted that this was due, in part, to one extreme risk relating to recruitment and retention in the neighbourhood teams being split into two risks (IDs 949 and 950) which had individually been scored as high rather than extreme risks. A Non-Executive Director (TD) asked if the risks should be scored higher given the level of pressure in the teams. The Executive Director of Operations said that whilst neighbourhood team capacity was discussed frequently within the Trust, the position had not been escalated and was being mitigated.

The score for risk ID 940 (risk of delays to new CAMHS Tier 4 service model) had been reduced from 16 to 9 and the Executive Director of Operations explained that this was due to the risk being initially scored too highly and mitigations were in place to reduce the risk.

A Non-Executive Director (RG) asked if the risk score for risk ID 939, relating to the new CAMHS Tier 4 building costs, should now be reduced. The Executive Director of Finance and Resources confirmed that the score was to be reviewed and it was likely to be reduced.

Outcome:
The Committee noted the recent revisions made to the risk register.

Item 48f(i) – Estates management audit
The Committee noted that the Audit Committee had requested that the Business Committee and Quality Committee see the final audit reports relevant to the respective business of the committees. The estates management assurance review was the first of two reports to be considered by the Business Committee.

The Executive Director of Finance and Resources informed the Committee that work was underway to remedy the position regarding fire risk assessments and the timescales for delivery would be met.

Outcome:
The Committee noted the final internal audit assurance review of estates management.

Item 48f(ii) – Payroll follow up review
The Director of Workforce, OD and System Development confirmed that six of the seven recommendations in the report had now been delivered. The seventh recommendation was out of the Trust's control because it related to the national ESR programme. The Committee noted that this had been highlighted at the Audit Committee.

	Outcome: The Committee noted the final Internal Audit Payroll Follow Up Review. A Non-Executive Director (RG) highlighted that the Audit Committee Chair had requested that the scheduling of audit reviews be amended and the Executive Director of Finance and Resources confirmed that he had taken this as an action to work through with the Company Secretary. The Committee Chair commented that he did not feel that the Business Committee should be part of the audit process but that the Committee would note progress relating to audits pertinent to the business of the Committee. He added that the responsibility for the completion of audits rested with the organisation, not with the Business Committee.	
2018/19 **(49)**	**Minutes to note:** **Health and Safety Group minutes** The Executive Director of Finance and Resources confirmed that the following matters had been highlighted to the Senior Management Team • After a long standing issue with staff members not volunteering to be first aiders, 20 had now volunteered • An escalation process for the withdrawal of care had now been agreed and it was confirmed that the ultimate decision would be taken by the Executive Director of Operations and Executive Director of Nursing. The Executive Director of Finance and Resources added that the Health and Safety Group was now working well and ways to improve its effectiveness were being considered. **Outcome:** The Committee noted the Health and Safety Group minutes for the meeting held on 20 September 2018.	
2018/19 **(50)**	**Business Committee work plan** **Future work plan** The work plan was reviewed by the Committee members and no changes were requested. **Outcome:** The Committee agreed the work plan.	
2018/19 **(51)**	**Matters for the Board and other Committees** • Electronic Patient Record (EPR) update – agreed as substantial assurance • E-rostering – agreed as reasonable assurance • CAMHS Tier 4 build update • Learning and development offer • Neighbourhood Team Activity Report • Business and commercial development report – agreed as reasonable assurance • Update on projects • Performance Brief report – agreed as reasonable assurance • Liaison and Diversion Services partnership bid.	
2018/19 **(52)**	**Any other business** None recorded.	

Leeds Community Healthcare NHS Trust

Agenda item 2018-19 (84c)

Audit Committee

Boardroom, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Friday 20 July 2018
8.50am–11.30am

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Interim Company Secretary
	Clare Partridge	External Audit Partner (KPMG)
	Tim Norris	Internal Audit Manager (TiAA Limited)
	Beric Dawson	Counter Fraud Specialist (TiAA Limited)
	Jenny Allen (JA)	Director of Workforce (for Item 23c)
	Dominic Mullen	Local Security Management Specialist (for Item 26b)
	Narissa Leyland	Head of Information Governance & Data Protection Officer (for Item 27d)
Apologies:	Peter Harrison	Head of Internal Audit (TiAA Limited)
Minutes:	Bridget Lockwood	Business Support Manager

Item	Discussion Points	Action
2018-19 (22)	**Welcome, introductions and preliminary business** The Chair welcomed members and attendees.	
2018-19 (22a)	**Apologies** Apologies were noted from Peter Harrison.	
2018-19 (22b)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda. Item 2018-19 (23c) - It was noted that the Director of Workforce's (JA) husband works for KPMG, the external auditors of Leeds Community Healthcare.	
2018-19 (22c)	**Minutes of the previous meeting 23 May 2018** The minutes of the meeting held on 23 May 2018 were reviewed and agreed as an accurate record subject to the following amendment: *Item 18d: Financial statements 2017/18: ISA 260 audit memorandum* Spelling correction in the first bullet – 'conformation' to be amended to 'confirmation'.	
2018-19 (22d)	**Actions' log** The Chair asked that verbal updates be given on the actions agreed at the previous meeting: • *Audit of focus on falls:* The Executive Director of Finance and Resources confirmed that he had discussed with the Executive Director of Nursing the concerns raised regarding the 50/50 split	

	between investigations carried out in line with the standard operating procedures and those not and this was due to a technical issue around recording which had been corrected immediately. The Executive Director of Nursing had added that she felt that the actions taken by management in response would be sufficient to address the issues related to the investigation and evaluation of incidents resulting from falls, and that this would be monitored effectively and impact assessed. • *Safeguarding children*: The Executive Director of Nursing had confirmed that membership of the Safeguarding Committee was under review. The Executive Director of Nursing had pointed out that the number of absences noted in the Internal Audit report had included those that were invited to attend and not only core members. The Internal Audit Manager confirmed that he reviewed the list of outstanding actions with the Deputy Director of Finance prior to each Audit Committee meeting. **Matters arising from the previous meeting held 23 May 2018** One item was raised : • *Safeguarding children training on ESR*: The Executive Director of Nursing had provided an update to the Executive Director of Finance and Resources. She felt that the position on this had improved, a new approach to safeguarding training had been piloted in the Integrated Sexual Health Service and this would be rolled out to other services over the next two months There were no other matters arising from the minutes.	
2018-19 (23a)	**Internal audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that three audits had been completed: IT procurement, emergency response planning and data quality (audiology). The Committee discussed the executive summaries and management actions included in the report and noted that two of these indicated a reasonable assurance opinion, one audit, emergency response planning, indicated a limited assurance opinion. *IT procurement* This audit had been determined as reasonable assurance with two recommendations, relating to the absence of an IT procurement strategy and the need for a more structured approach to the allocation of devices for mobile working. A Non-Executive Director (RG) queried the likelihood that the second recommendation be implemented by the end of December 2018. The Executive Director of Finance and Resources responded that a new approach to phase out the use of older devices would be introduced before December, however, it was likely that it would take longer than this to physically action the replacements. **Action:** The Executive Director of Finance and Resources to outline a more structured approach to the replacement of old devices at the next meeting. *Emergency planning* The audit had been assessed as limited assurance with two urgent recommendations relating to the oversight of the business continuity plan process, including a single register and audit of plans, and around compliance with the Civil	**Executive Director of Finance and Resources**

	Contingencies Act's requirement for a major incident communications test. The Chair of the Committee felt reassured by the prompt response to the recommendations which had been demonstrated. The Internal Audit Manager confirmed that the Executive Director of Operations was keen to ensure any gaps in process or compliance were rectified. A Non-Executive Director (IL) asked if the audit had included a review of testing. The Internal Audit Manager confirmed that testing had been reviewed but he did not have the results. The Executive Director of Finance and Resources said that everyone that could respond to the communications test on 13 July 2018 had responded. The Internal Audit Manager added assurance that key elements of major incident planning were working effectively. The Chair of the Committee asked if a group had oversight of, and would follow up on any testing. The Executive Director of Finance and Resources responded that currently no group had oversight of this to ensure this was followed up in a rigorous way. **Action:** Executive Director of Finance and Resources to ask the Executive Director of Operations to confirm the mapping process for any tests performed and where the results were to be reported. *Data quality* The Committee noted that the audit had been assessed as reasonable assurance; the six week wait process had been shown to be robust, accurate and well documented. The Internal Audit Manager outlined the overall conclusions of the report which included; patient response times within six week wait time may be inappropriate, breaches could be reduced by proactively offering cancelled appointments to potential breach cases, and there was a lack of feedback to the Audiology team regarding future booked appointments which would potentially breach. The Internal Audit Manager highlighted that the Trust was actually overstating waiting times, by up to two weeks, and work was underway within the service to establish if the 'clock' could be started later in the process. The Committee reviewed progress against the *Annual Plan for 2018/19* and noted that the audit of complaints management had started and the Internal Audit Manager had attended a Clinical Effectiveness Group workshop the previous day. It was noted that, due to the recent new appointments to the Director of Workforce role, the audits relating to sickness and absence had been moved to quarter 3 and bank and agency had been scheduled for quarter 4. The Internal Audit Manager stated that he was confident that there was a structured approach to delivery. The Internal Audit Manager highlighted the proposal to remove the audit of BAF and risk management given the scrutiny that had been given to this process in recent years and to replace it with an audit of the Data Security and Protection toolkit. Whilst accepting the proposal for 2018/19 the Chair of the Committee expressed her view that an audit focussed around BAF/risk management should be included in the plan each year and the Internal Audit Manager agreed to include it in the plan for 2019/20. A Non-Executive Director (IL) asked how clinical audit was being incorporated in the audit of the Clinical Effectiveness Group. The Internal Audit Manager confirmed that the review was being carried out with this in mind and he added that he would	**Executive Director of Finance and Resources**

	arrange to speak with the Non-Executive Director (IL), in his role as Chair of the Quality Committee as part of the audit process. A Non-Executive Director (RG) asked if there was a confidence that all audits planned would be completed within year as some had been moved to later in the year. The Internal Audit Manager responded that he was confident all audits would be completed in year and the Executive Director of Finance and Resources confirmed that any proposed changes to the timings of audits had been discussed and agreed with him. The Chair of the Committee commented that scheduling of audits was improving and requested confirmation that the audits scheduled for quarter 2 would be completed in time for these to be reported to the next meeting of the Audit Committee. The Internal Audit Manager provided assurance that he would be working to that timeline. **Action:** Internal Audit Manager to discuss clinical audit with the Chair of the Quality Committee as part of the audit of the Clinical Effectiveness Group. **Outcome:** The Committee noted the contents of the summary internal controls assurance report, including conclusion of three audits and changes to the schedule of the Annual Audit Plan for 2018/19.	**Internal Audit Manager**
2018-19 (23b)	**Internal audit actions report** The Executive Director of Finance and Resources introduced the report and the Committee members discussed the following recommendations: *Neighbourhood Team capacity and demand* It was noted that the revised due date of 30 September 2018 had been agreed previously. *Contract management* The Committee noted that the Executive Director of Finance and Resources had requested a more fundamental review of the governance around contract management and therefore the deadline for completion had now been set as 30 September 2018. *Corporate governance – SMT terms of reference* The Committee discussed the recommendation that terms of reference should be developed for the Senior Management Team (SMT) and the decision by the Chief Executive that the recommendation not be adopted. The rationale for this decision was queried by the Chair of the Committee and Non-Executive Directors and it was requested that an outline of SMT functions be shared with the Committee. **Action:** The Executive Director of Finance and Resources to ask the Chief Executive to draft a summary of SMT functions for the next meeting. *Corporate governance – SMT sub groups* It was noted that further discussion was needed regarding the governance around the Health and Safety Group, the only group currently reporting to SMT. *Payroll* A Non-Executive Director (RG) reflected that it was good to see the paper, under Item 2018/19 (23c), which provided further information on this audit. The Internal Audit Manager confirmed that the recommendations shown in the report related to	**Executive Director of Finance and Resources**

	the position prior to management actions being taken and that a subsequent review would take place once these actions had been completed. **Outcome:** The Committee noted the status report.	
2018-19 (23c)	**Payroll audit: update report** The Director of Workforce (JA) attended the meeting to present the report and provide a further update on management actions carried out against the seven recommendations made as part of the audit. Processes and actions put in place had also been tested and continued to be monitored. *Process documentation and forms* The Director of Workforce (JA) confirmed that a set of Standard Operating Procedures had been developed and were being continually reviewed. The Workforce Information Manager was testing the accuracy of the payroll forms submitted, whether the forms were completed on time and whether authorisation to make changes was in place. As part of this, a different culture around the processing of information was being engendered within the team, along with a review of the team structure to ensure cross cover was in place and reduce the risk of occurrence of single points of failure. *Overpayments* The Director of Workforce (JA) informed the Committee that information relating to overpayments had previously only been provided at the SLA meetings with the provider of payroll services, Leeds Teaching Hospitals NHS Trust. The Payroll Manager had confirmed he was keen to move to monthly reporting of this information, and to work with the HR team and relevant managers around any discrepancies found. The Committee noted that overpayments found in the first quarter of 2018/19 had been £2k compared to £8k for the same period in 2017/18. A Non-Executive Director (IL) asked if there were any IT system changes that could be made in order to minimise the risk of incorrect processing of information. The Director of Workforce (JA) responded that a lot of effort was being put into reviewing the Electronic Staff Record (ESR) system and funding had been secured for recruitment to a post to carry out this piece of work for the remainder of the financial year. The Chair of the Committee asked if overpayments were reclaimed when identified. The Director of Workforce (JA) confirmed that attempts are made to do this but provided assurance that the reduction in the amount of overpayments demonstrated the accuracy of the payroll process each month. The Chair of the Committee asked if the scope of the Workforce Information team was being reviewed. The Director of Workforce (JA) responded that she was confident that the culture in the team was more positive and added that the Workforce Information Manager was moving the team to being more analytical than transactional. The Chair of the Committee asked the Internal Audit Manager to reflect in any further review of the implementation of the audit recommendations whether the culture of the team felt different and he agreed to do so. **Outcome:** The Committee thanked JA for her update and noted the findings in the report.	
2018-19 (23d)	**Cyber security incident response management** The Executive Director of Finance and Resources presented the report which outlined progress made on management actions following the ICT Review of	

	Cybercrime Security Incident Response Management. A Non-Executive Director (RG) noted that a number of incidents had not been captured on Datix and asked if this position had changed. The Executive Director of Finance and Resources confirmed this to be the case and highlighted that one of the risks on the Risk Register had been escalated because of incident reporting. The Chair of the Committee suggested that a test of cyber security incident plans and procedures in October was preferable to December 2018. **Action:** Executive Director of Finance and Resources to consider earlier testing. **Outcome:** The Committee received assurance that plans are robust and being delivered.	**Executive Director of Finance and Resources**
	External audit **Annual audit letter** The External Audit Partner introduced the report which reflected the information included in the ISA 260 audit memorandum which had been reviewed by the Audit Committee at the meeting on 23 May 2018. **Outcome:** The Committee noted the annual audit letter 2017-18 **External audit technical update** The External Audit Partner introduced the monthly health sector update for information. A Non-Executive Director asked if regulation around IR35 had been increased recently. The External Audit Partner confirmed that procedures around IR35 had been reviewed with the Trust when introduced and processes had been embedded since but there had been no recent change in regulation. **Outcome:** The Committee noted the technical update.	
2018-19 (25) **2018-19** (25i) **2018-19** (25ii) **2018-19** (25iii) **2018-19** (25iv)	**Charitable funds annual report and accounts 2017/18** **Covering paper: Charitable funds annual report and accounts** The Committee noted the position outlined in the covering paper. **Charitable funds annual report and accounts** The Committee received the annual report and accounts for the Trust's charity. The independent examination had been carried out by Sedulo (accountants). There were no concerns and the accountants had come across no other matters in connection with the examination to draw to the Trust's attention. **Letter of Comment** The Committee noted the letter of comment received from Sedulo who had carried out an independent examination of the charitable funds accounts. There were no areas of concern to note. **Letter of Representations** The Committee noted the letter of representations from Leeds Community Healthcare NHS Trust to Sedulo Leeds Limited.	

	Action: External Audit Partner to determine if further disclosure was required regarding fundraising. **Outcome:** • The Committee noted the annual report and accounts 2017/18 and associated documentation • The Committee recommended the adoption of the annual accounts by the Charitable Funds Committee at its next meeting on 21 September 2018 (now taking place on 2 October 2018)	**External Audit Partner**
2018-19 (26a)	**Counter fraud and security management** **Counter fraud annual report 2017/18** The Counter Fraud Specialist presented the annual report which summarised counter fraud activity undertaken at the organisation in 2017/18. Appended to the report was a copy of the Self Review Toolkit which had been submitted to the NHS Counter Fraud Authority at 31 March 2018. The Committee noted the four key areas to be reviewed as part of the self-review toolkit; strategic governance, inform and involve, prevent and deter, and hold to account. The Trust had been selected for a focussed inspection against the NHS Counter Fraud Authority's 2017/18 Standards for Providers, Fraud, Bribery and Corruption. This took place in June 2017, the outcome of which an overall rating for Inform and Involve was green, the rating for Hold to Account was red. This was due to deadlines not being met around the speed of which the system had been updated and information uploaded prior to the inspection. The Committee noted that 22 standards were rated green in the self-review toolkit, one was rated amber which related to the recent implementation of the new Counter Fraud and Corruption Policy. The Chair of the Committee asked if the Trust expected to receive another spot inspection. The Counter Fraud Specialist responded that following the outcome of the last inspection he did not expect a further inspection in the near future. The Chair of the Committee thanked the Counter Fraud Specialist and added that the Committee were reassured by the report. **Outcome:** The Committee noted the Counter Fraud Annual Report 2017/18	
2018-19 (26b)	**Security management annual report 2017/18** The Local Security Management Specialist attended the meeting to outline the security management annual report for 2017/18. The Committee noted the decrease in the number of incidents over a four year period and that the number of physical assaults against staff had reduced. The Local Security Management Specialist highlighted the incidences of vandalism at Halton Clinic and the intruder at Little Woodhouse Hall. He added assurance that the door had since been properly secured at Little Woodhouse Hall. The Chair of the Committee raised concern about the intruder incident at Little Woodhouse Hall given the level of scrutiny that had taken place around the security and safety of the building over the past year. The Local Security Management Specialist responded that a full investigation had been carried out and it had been found that the door closure mechanism had not been strong enough. The Local	

	Security Management Specialist had spent a lot of time on site and undertook regular checks. A Non-Executive Director (IL) confirmed that the Quality Committee had received further assurance when the Executive Director of Nursing had taken a report for consideration following the incident in September 2017. A Non-Executive Director (RG) asked how the Trust compared with other organisations. The Local Security Management Specialist responded that the Trust had lower reporting rates than other local Trusts, and he added that there was a network group of security specialists where information, incidents and knowledge about potential issues relating to specific patients who were a risk was shared. A Non-Executive Director (IL) asked if the app was in place to assist lone-working staff. The Local Security Management Specialist responded that a business case for the roll out of smartphones across the organisation is pending approval. The safety alert device which was trialled last year was found not to be effective so it had been decided to proceed with a panic button on a smartphone which would enable escalation to a monitoring station and the ability to leave an amber alert should a member of staff be entering a location that was assessed to be high risk. The External Audit Partner asked if the photographs that were included in the report should have been appended. The Local Security Management Specialist confirmed that the photographs could be included in the report. The Counter Fraud Specialist complimented the Local Security Management Specialist on his reports and frontline presence which was not as evident in other organisations. The Chair of the Committee thanked the Local Security Management Specialist for a thorough report and commented on and how much the work he undertook and this was appreciated.	
2018-19 (27a)	**Governance** **Board assurance framework report 2018/19** The Interim Company Secretary introduced the Board Assurance Framework (BAF) 2018/19 report. The report had been revised from the version reviewed last year and had been realigned with the annual operational plan. The Interim Company Secretary confirmed that the BAF had been reviewed by the Senior Management Team, Quality Committee, Business Committee and Trust Board. The Chair of the Committee queried the consistency of how the scores were applied throughout the document and asked if there was any guidance in place for Directors to use when scoring risks. The effectiveness of the controls in place was questioned where the initial and current scores were rated the same score. With this in mind the Committee reviewed the BAF in detail and commented on each of the strategic risks in terms of key controls, gaps in controls, sources of assurance and gaps in sources of assurance. The key points made were: • Risk 1.1: It was noted that the Quality Committee had determined that the current score was to remain at 16 given the areas of concerns identified at Hannah House following the CQC inspection report. Controls were to be reviewed to determine if the current score had improved, or if the controls were adequate. Target score of 4 to be reviewed to determine if this was realistic • Risk 1.2: Gaps in control – should there be some gaps in control identified given that 1.2.7c (learning events) had been determined as inadequate • Risk 1.3: Limited assurance re QIP plan – control(s) to be added to address	

	this • Risk 1.4: Risk score – initial score to be reviewed • Risk 2.1: Gaps in controls – adequacy of controls to be reviewed given that the initial and current scores were the same. Risk to be updated given recent work undertaken and controls now in place regarding programme management. Estates programme to be added • Risk 2.2: Gaps in controls – target score to be reviewed. Controls to be reviewed to determine if they were sufficient to achieve the target score • Risk 2.3: no amendments suggested • Risk 2.4: Risk score: target score of 8 to be reviewed, taking into consideration that external factors may confirm this to be a high scoring risk • Risk 2.5: Gaps in controls: this was queried but the Chair of the Committee accepted that the controls in place were felt to be adequate • Risk 3.1: Gaps in control – it was acknowledged that the new Director of Workforce would update controls in place but noted that the assessment of this risk did not correspond with the reports seen by the Business Committee • Risk 3.2: it was felt that the scores and controls in place were appropriate for this risk • Risk 3.3: Gaps in control – further inclusion needed re leadership • Risk 3.4: it was felt that the scores and controls in place were appropriate for this risk • Risk 4.1: Gaps in control – further assurance to be provided regarding internal management and committee processes • Risk 4.2: it was felt that the Trust Board, as the responsible committee, needed to have more oversight of this risk and it was agreed that this would be highlighted in the report to the August meeting of the Board • Risk 4.3: Gaps in control – these needed to be populated and reviewed by the Quality Committee • Risk 4.4: further assurance to be provided around this risk and the controls in place to achieve target score • Risk 4.5: Gaps in control: to be reviewed in order address the four areas that were stated as limited adequacy of control	
	Action: The Executive Director of Finance and Resources to ask lead Directors to review initial and current scores to determine if actions taken to date had effected any movement in score. Target scores also to be reviewed to determine if the controls outlined were adequate, and if the target score was realistic given those controls in place. **Action:** The Executive Director of Finance and Resources and Interim Company Secretary to determine SMT approach to a review of BAF risk scores. **Action:** Quality and Business Committees to review BAF risks once an SMT review has been completed. **Action:** Trust Board to review BAF risk 4.2 (Work in partnership to deliver integrated care and care closer to home) as the responsible committee for this risk.	**Executive Director of Finance and Resources** **Executive Director of Finance and Resources** **Interim Company Secretary** **Interim Company Secretary**
2018-19 (27b)	**Risk management update** The Interim Company Secretary introduced the report which sought to provide an update on the development and effectiveness of risk management processes in the Trust.	

	In response to the CQC inspection report recommendations, a health check questionnaire had been completed and any gaps determined were being addressed with individuals and monitored through an action plan. The Chair of the Committee queried the change in the schedule of reporting risks to the Quality Committee. The Interim Company Secretary clarified that the Committee would continue to receive risk register reports for six formal meetings per year, and added that should any new or escalated risks need to be put before the Quality Committee in a month when a workshop was scheduled, the risks would be discussed at the workshop.	
2018-19 (27c)	**Information governance report** The Head of Information Governance and Data Protection Officer attended the Committee to present this and the following report. Areas highlighted for the Committee to note included the risks that were being monitored, and actions taken, regarding compliance with GDPR and the resources needed to support the new Data Protection Officer role. **Outcome:** • The Committee noted actions taken since the last report in December 2017 • Noted the planned improvement actions	
2018-19 (27d)	**GDPR update** The Head of Information Governance and Data Protection Officer introduced a progress report which outlined the Trust's actions to ensure compliance with GDPR legislation. The Committee were asked to note this in the context of this being the beginning of the process for compliance, with a lot of further work to take forward. The action plan had been reviewed, actions were being embedded and a data mapping exercise was underway for completion by the end of October 2018. Asset owners would be identified by January 2019. Resource had been secured in order to support the implementation of the action plan. The Chair of the Committee asked if the resource secured was sufficient given the work required and this was confirmed as being adequate. The Chair of the Committee pledged support in terms of prioritising this work in order to ensure that deadlines were met and compliance achieved in the timescales outlined. The Chair of the Committee requested regular updates on GDPR, including concise action plans and timescales for completion. **Action:** The Executive Director of Finance and Resources to submit regular updates on GDPR, including concise action plans and timescales **Outcome:** The Committee received assurance that the Trust's GDPR plans are robust and being delivered.	**Executive Director of Finance and Resources**
2018-19 (28a)	**Financial controls** **Tenders and quotations waivers** The Executive Director of Finance and Resources introduced the report and highlighted that all three items on the Tender/Waiver Register related to the EPR team. He confirmed that the contracts would not be extended beyond March 2019. **Action:** The Executive Director of Finance and Resources to confirm that the HR processes referred to in reference number 18-03 on the Tender/Waiver Register	**Executive Director of Finance and**

	related to recruitment processes that had been exhausted. **Outcome:** The Committee noted the report.	**Resources**
2018-19 (28b)	**Losses and special payments report** The Executive Director of Finance and Resources introduced the report and informed the Committee that a review of petty cash floats was underway as a result of two items listed as losses. **Outcome:** The Committee noted the report.	
2018-19 (28c)	**Register of gifts, hospitality and sponsorship** The Interim Company Secretary introduced the report and the gifts, hospitality and sponsorship register for 2017/18 which was appended. The Interim Company Secretary informed the committee that a review of the Managing Conflicts of Interests Policy was to take place, specifically the identification of 'decision making staff' and to clarify when staff details would be removed when no longer relevant. The Counter Fraud Specialist commented that an estimated value should always be declared on the Register, and that 'not known' was not considered acceptable. The Chair of the Committee asked if staff report conflicts of interest and where this was reported. The Interim Company Secretary responded that conflicts of interest were not currently reported to a group, and added that a communication had been sent out to staff to encourage conflicts of interest to the reported. **Action:** Interim Company Secretary to review Managing Conflicts of Interest Policy and submit to SMT for review by December 2018. **Outcome:** • The Committee noted the gifts and hospitality register • The Committee was supportive of a review of the Managing Conflict of Interests Policy and would review this following a review by SMT	**Interim Company Secretary**
2018-19 (29)	**Minutes of noting** **Information Governance Group: 17 April 2018 & 13 June 2018 (draft)** The minutes were noted and no questions raised.	
2018-19 (30)	**Committee's Workplan** There were no items removed or changes made to the workplan.	
2018-19 (31)	**Matters for the Board and other committees** The Chair noted the following items to be referred to Board colleagues: • Internal Audit update • Recommended adoption of the Charitable Funds accounts for 2017/18 • Counter Fraud annual update • Security Management annual update • Review of Board Assurance Framework 2018/19 • GDPR update	
2018-19 (32)	**Any other business** There were no matters of any other business raised.	

	Date and time of next meeting Friday 19 October 2018 9.00 am – 11.30 am Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	

Leeds Community Healthcare NHS
NHS Trust

Charitable Funds Committee Meeting
22 June 2018
Meeting Room 1, Stockdale House
9:00am – 10:30am

Agenda item
(84d)

Present	Brodie Clark	BC	Committee Chair / Non-Executive Director (NED)
	Neil Franklin	NF	LCH Trust Chair
In attendance			
	Bryan Machin	BM	Director of Finance & Resources
	Marcia Perry	MP	Executive Director of Nursing
Apologies:	None received		
(Minute Taker)	Jeanette Hardwick	JH	PA to the Interim Director of Workforce

Item No	Discussion Item	Actions
2018-19/01	Welcome and Introductions (i) Apologies: none received (ii) Declarations of interest: There were no declarations of interest (iii) Minutes of meeting 16 March 2018 and matters arising: These were accepted as a true record of the meeting (iv) Review of the action log <u>*Item 2016-17 (28iii)*</u> The Committee revisited this action and the Chair requested that the Executive Director of Nursing provide confirmation that the action has been completed and what the feedback was. **Action**: Executive Director of Nursing. <u>*Item 2016-17 (37)*</u> The Committee reviewed this action and the Chair requested that the funding model be reviewed and agreed. **Action**: Executive Director of Nursing. <u>Item 2017-18 (iv)</u> The Committee revisited this action and a discussion was held about creating a standard for improvements to the waiting areas at health centres. The Executive Director of Finance and Resources explained that a specific standard would be difficult to introduce because the Trust does not own all the buildings it occupies, and shares space with other organisations.	**Executive Director of Nursing** **Executive Director of Nursing**

Item No	Discussion Item	Actions
	The Chair stated that he would like to know what improvements the Trust could make and who would be responsible for ensuring the work was done. The Executive Director of Finance and Resources responded that, at this stage, no-one is responsible, and this is the gap that has been identified. To progress this matter the Executive Director of Finance and Resources agreed to instruct Peter Ainsworth to conduct an assessment of the waiting areas at all Leeds Community Healthcare health centres, over a period of the next 6 months. **Action**: Executive Director of Finance and Resources. *Item 2017-18 (15d)* The Executive Director of Nursing reported that she would set up a meeting with the CEO of Leeds Teaching Hospitals Trust (LTHT) Charitable Funding, and that she believed it was now an appropriate time as the Committee was more clear about it's agenda. The Chair requested that the outcome of this meeting be discussed at SMT and then reported back to this Committee before September 2018. **Action:** The Executive Director of Nursing. The Trust Chair suggested two items to explore at the meeting, namely, whether the Trust may bid for LTHT charitable funds and the process involved; and what could potentially be done jointly between the Trust and LTHT, for example, children's services. The Trust Chair further suggested that The Executive Director of Nursing have a discussion with Ian Lewis before the meeting with LTHT, to decide what the Trust's approach might be. The Committee agreed on the importance of this action being taken forward, due to a reduction in the Trust's available charitable funds.	**Executive Director of Finance and Resources** **The Executive Director of Nursing**

Item No	Discussion Item	Actions
2018-19/02	**Charity Development update** The Executive Director of Finance and Resources reported that in terms of the Charity development work it had been a challenging few months. A support officer at band 3 level had been appointed to take the development work forward, however it soon became apparent that this was not the correct level or band for the post. A new job description has been redrafted at band 5 level, and has been advertised as a secondment opportunity for a fixed period of time. Interviews for the role were taking place today, and it was hoped that an appointment would be made. This appointment will be fundamental in taking the work forward. The Executive Director of Nursing stated that if an appointment was made, and if the Trust decided to go ahead with introducing a staff lottery, the Charity should be in a more favourable place by the autumn. Following the above update the Committee discussed the potential risks of recruiting to the band 5 role in advance of the review in September 2018. The Committee agreed that prior to the recruitment of a band 5, a decision had to be reached on what the Committee wanted to achieve, the business priorities and the implications of workload for staff in the Trust. The Committee further discussed and agreed that a collaborative relationship with LTHT Charitable Funding must first be explored, and that the Committee must be clear on the advantages of fund raising independently or in partnership, whether to adopt a specific generic approach, or to fund raise for specific projects. The Trust Chair stated that the Committee must be clear about its future direction, that the Senior Management Team (SMT) must be involved in the decision making and that the Board must take more ownership of the work of the Committee. The Trust Chair requested that a meeting with the CEO of LTHT Charity Funding be set up regardless in order to determine whether the Trust can bid against their funds. The outcome of this meeting should then be followed up with an SMT conversation and reported back to the Committee before September 2018.	
2018-19/03	**Charitable Funds application process** The Executive Director of Nursing introduced the proposed new application process for charitable funding, and recommended this the Committee. A brief discussion was held and the Committee approved the new application process subject to the removal of page 2. **Action:** Executive Director of Nursing. The Committee agreed that the new process would be in place with immediate effect.	**The Executive Director of Nursing**

Item No	Discussion Item	Actions
2018-19/04	**Charitable funds finance update** (i) Finance report The Committee noted and accepted the report (ii) Draft annual report and accounts The Committee noted and accepted the annual report and accounts.	
2018-19/05	**Evaluation and feedback on projects questionnaire** See item 2 on the agenda.	
2018–19/06	**Charitable Funds – request for funding** The Executive Director of Finance and Resources presented a request for funding to refurbish outdoor space at Hannah House. A discussion was then held by the Committee about whether this should be funded by the Trust's charitable funds or the Hannah House funds, or whether to approach people and external organisations that have previously donated to or shown an interest in Hannah House. The Committee agreed in principle to the requested funding, however the Chair requested that the Executive Director of Nursing provide the Committee with a more detailed case about who the potential funder could be. **Action:** The Executive Diretor of Nursing The Executive Director of Finance and Resources raised a concern about resourcing the aforementioned request and balancing priorities, and a brief discussion was held. The Committee agreed that should The Executive Director Nursing require additional resources, she would inform the Committee.	**The Executive Director of Nursing**
2018-19/07	**Staff lottery** The Executive Director of Nursing introduced the first draft of a paper setting out the process of establishing a staff lottery within the Trust, and a discussion was held. The Trust Chair stated that it was helpful that some neighbouring trusts already had a staff lottery in place, and this could help with the mapping process. The Trust Chair furthermore advised of the need to be well organised when testing the water through staff consultation. The Trust Chair suggested a possible approach and this was discussed. It was agreed that a letter to staff about a possible lottery should also request feedback from staff. The Executive Director of Finance and Resources raised the need to be cognisant of governance processes around running a lottery, and resourcing the oversight of this. The Committee approved the preferred option to establish an internal staff lottery.	
2018-19/08	**Matters for the Board** • Charity development – where the Committee is at • Reflection on the process for revising what this Committee is	

Item No	Discussion Item	Actions
	about, and the benefit to the Trust • Hannah House project • Staff lottery project	
2018-19/09	**Any other business** There was no other business	
2018-19/10	**Date and time of next meeting:** 21 September 2018, 9am – 10.30am, Meeting Room 1, 1st floor, Stockdale House	

HEALTH AND WELLBEING BOARD

WEDNESDAY, 5TH SEPTEMBER, 2018

PRESENT: Councillor R Charlwood in the Chair

Councillors S Golton, P Latty, L Mulherin 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 Alastair Cartwright – Digital Programme Director for Leeds City and NHS Leeds Clinical Commissioning Group

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Shona McFarlane – Deputy Director, Adults and Health, LCC
Sue Rumbold – Chief Officer, Children and Families, LCC

Third Sector Representative
Rachel Koivunen - Forum Central

Representative of Local Health Watch Organisation
Dr John Beal – Chair, Healthwatch Leeds
Hannah Davies – Chief Executive, Healthwatch Leeds

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

Representative of Leeds GP Confederation
Jim Barwick – Chief Executive of Leeds GP Confederation

19 Welcome and introductions

The Chair welcomed all present and brief introductions were made.

20 Appeals against refusal of inspection of documents

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

21 Exempt Information - Possible Exclusion of the Press and Public

There were no exempt items.

22 Late Items

There were no formal late items, however there was some supplementary information in relation to Item 11 “West Yorkshire & Harrogate Health and Care Partnership – a Memorandum of Understanding”, which was not available at the time of agenda publication. (Minute 29 refers)

23 Declarations of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests.

24 Apologies for Absence

Apologies for absence were received from Cath Roff, Dr Sara Munro, Dr Alistair Walling, Steve Walker, Moira Dumma, Supt. Sam Millar and Heather Nelson. The Board welcomed Shona McFarlane, Andy Weir, Alastair Cartwright and Sue Rumbold as substitutes.

25 Open Forum

No matters were raised under the Open Forum.

26 Minutes

RESOLVED – That, subject to an amendment to include Councillor Mulherin’s apologies, the minutes of the previous meeting held 14th June 2018 were agreed as a correct record.

27 Priority 4 - Housing and the Environment Enables all People of Leeds to be Healthy

The Director of Resources and Housing submitted a report in support of discussions on the importance of greater collaboration on housing, the environment and health issues.

The following were in attendance:

- Neil Evans, Director of Resources and Housing (LCC)
- Tony Cooke, Chief Officer for Health Partnerships
- Jenny Fisher, Principal Design Officer (LCC)

The Director of Resources and Housing introduced the report and spoke to a PowerPoint presentation, highlighting the following key areas:

- Housing as a key determinant of health and wellbeing, and understanding the connection between housing and employment.
- The Board identified one of the greatest challenges as being low quality conditions in the private rented sector, particularly in our deprived communities and in the context of a decline in home ownership
- The increase in residential dwellings in the City Centre, and the need for health infrastructure to support the new influx of residents.

- Homelessness trends across the city, including a reduction in the amount of temporary accommodation used to home families. However, the Board were informed of the prominence of issues associated with 'street users', particularly in relation to drug and alcohol abuse.
- The focus on ensuring future developments included child friendly community spaces.

During discussions, the Board considered the following:

- Models of co-location were reported to be successful in shared buildings such as Tribeca House. Although the Board recognised that this approach was not always practical, Members encouraged consideration of co-location for housing and health / social care teams where possible.
- The trend of more affluent areas influencing planning decisions through Neighbourhood Plans, and the need for further engagement with deprived communities to ensure that planning decisions are community led.
- The use of Local Care Partnerships to integrate housing officers into health / social care teams and the third sector.
- That health and care colleagues would benefit from greater knowledge of planning and design, particularly in relation to legislation and barriers to housing improvements.
- The planned increase in residential dwellings in the city centre, and thus the need for strong health and social care infrastructure to support families, along with green spaces.
- That spaces and places undergoing development and redesign must be welcoming for all ages and demographics of our population.
- The need for more systematic lobbying to rise the standards for privately rented homes across the city, to tackle poor living conditions in the sector. This issue was agreed to be incorporated into the Board's work plan.
- The availability of digital technology in future developments and for future generations, as a tool to ensure better connectivity between communities and the services they require.

RESOLVED –

a) To note the Board's suggestions to further integration between housing, environment and health partners at both strategic and operational levels.
b) To note the Board's discussions around priority areas for future consideration and collaboration on housing issues which have an impact on health.
c) To agree to use the learning from the NHS England Healthy New Towns and best practice (including Wakefield Housing, Health and Social Care Partnership) to provide strategic direction and influence for partners including the NHS, Local Care Partnerships, LCC Planning and Highways.

d) To endeavour to help drive the work forward locally and regionally in line with a Health in all Policies approach and the Leeds Health and Wellbeing Strategy.
e) To note the aims, principles and progress of the Planning and Design for Health and Wellbeing group to date.

28 Draft Safer Leeds Community Safety Strategy (2018-2021)

The Director of Communities and Environment and the Chief Officer, Community Safety submitted a report which presented the draft Safer Leeds Community Safety Strategy 2018-21 and provided an opportunity for the Board to provide views; help shape the Strategy and discuss ongoing strategic support around system changes and operational response; where improving health and wellbeing outcomes are directly connected to community safety priorities.

Head of Safer Leeds, Simon Hodgson, introduced the report, and highlighted the following key areas:

- The key ambitions and shared priorities, in line with the Leeds Health and Wellbeing Strategy 2016-2021, and a new approach distinguishing between outcomes focused on victims, offenders and locations.
- Some examples of critical issues, including reference to the prevalence of New Psychoactive Substances (NPS) among street users and the launch of 'Big Change' – an alternative giving scheme coordinated by the third sector to support homelessness.

During discussions, the Board considered the following:

- The need for stronger partnerships with the prison service. The Board were informed that prisoners are currently released on a Friday, which can be detrimental for those with a history of drug and alcohol problems.
- The Board suggested a whole city approach was necessary to deal with some of the critical issues outlined in the report, which could be addressed through the Joint Strategic Assessment (JSA).
- Members noted that the impact of drug and alcohol problems on children and families could be more evident in the report, however welcomed the reference to safeguarding against criminal exploitation in the report. The Board requested that the Strategy focuses on the whole family, with vulnerable families needing tailored support.
- The Board welcomed the publication and implementation of a new drug and alcohol strategy for the city.

RESOLVED –
a) To note and endorse the strategic priorities outlined in the Safer Leeds 'Community Safety Strategy' for 2018-21.
b) To note the Board's discussion in relation to the action the HWB can take collectively and at organisational level to help achieve the

outcome that ‘people in Leeds are safe and feel safe in their homes, in the streets and the places they go’.

c) To note the Board’s discussion in relation to the consultation on the strategy as part of the HWB’s role in providing strategic, place-based direction around wider determinants of health, linked to the Leeds Health and Wellbeing Strategy.
d) To note feedback provided on pertinent issues that support on-going discussions around ‘system changes’ and ‘operational response’; where improving health and wellbeing outcomes are directly connected to community safety priorities.

29 West Yorkshire and Harrogate Health and Care Partnership Update

The Chief Officer, Health Partnerships; and the Head of Regional Partnerships submitted a report which provided an update on the progress of the Memorandum of Understanding.

The following were in attendance:

- Tony Cooke, Chief Officer for Health Partnerships
- Rachael Loftus, Head of Regional Health Partnerships

The Head of Regional Health Partnerships and the Chief Officer for Health Partnerships introduced the report and highlighted the key amendments to the Memorandum of Understanding following consultation, which included:

- A stronger focus on ensuring local government have a key role in democracy and decision making.
- Emphasis on the need for coordination across boundaries to enable quick and easy access to services when people need them the most.
- The introduction of a partnership board at West Yorkshire level, to engage the public and the third sector, and increase political engagement.

The Board commented that the document was a much improved version, welcomed the changes, and thanked the Chair for ensuring the Board maintained influence. However, Members were keen for the document to be viewed as a ‘living’ document, to reflect future changes, particularly in relation to commissioning.

RESOLVED –

a) To note discussions around the text of the Memorandum of Understanding contained in Appendix 1.
b) To agree to sign up to the spirit and content of the Memorandum of Understanding.

30 Leeds System Resilience Plan

The System Resilience Assurance Board (SRAB) submitted a report which provided an overview of the Leeds Health and Care System approach to the

recovery, management, sustainability and transformation of the unplanned health and care system in Leeds.

The report included the Leeds System Winter Plan 2018/19 and a review of the outcomes from winter 2017/18. The report also set out the key performance indicators for 2018/19 to track progress against urgent demand care; acute flow and the Home First Strategy.

The following were in attendance:

- Sarah Miller, Head of Nursing, Neurosciences (LTHT)
- Debra Taylor-Tate, Senior Commissioning Manager (Leeds CCG)
- Liz Ward, Head of Independent Living Service (LCC)
- Fiona Allport, Clinical Pathway Lead for Rehabilitation and Self-Management (LCH)
- Gillian Meakin, Project Manager, Virtual Respiratory Ward and Neurology Services (LCH)

The Board received a presentation on the Stroke Pathway service as an example of change and best practice for care, record keeping and collaboration between partners.

An overview of partnership working between the Independent Living Service and Leeds Community Healthcare Neighbourhood Teams was provided setting out the approach taken to ensure timely discharge from care through a review of patient entry criteria, staff knowledge of the service and how referrals were made.

The following key areas were highlighted during discussions:

- The need to reference links to the LCC Children and Families Services.
- Acknowledgement that pressures still existed when seeking to secure beds following clinical discharge.
- Acknowledgment that the health and care sector was working more closely in partnership and on balance, would be better prepared for this winter's pressures.

The Board noted the offer from the representative of Leeds Older Peoples Forum to work with the SRAB.

RESOLVED - To note the Board's feedback and comments on the approach to developing the Leeds System Resilience Plan.

(Councillor Golton, Thea Stein, Phil Corrigan and Gordon Sinclair left the meeting at this point.)

31 Arts and Health and Wellbeing

Mick Ward, Chief Officer, Transformation & Innovation, (LCC Adults & Health) introduced a report containing a proposal to develop work on the Arts in Leeds, focusing on the potential for the Arts to contribute to improved health

and wellbeing. The Board noted that health and wellbeing groups and artists had already expressed an interest in being involved with this developing project, which aimed to establish a network for groups to communicate, participate and share.

During discussions, the Board acknowledged the role Art can play in the workplace for the general health and wellbeing of staff and Board members as employers were encouraged to support art in the workplace. The success of a recent play supported by Leeds GP Confederation on the theme of dementia was noted, with the Board noting a suggestion that consideration could be given to this type of presentation being supported by HWB in the future.

Additionally, Jim Barwick agreed to act as the lead HWB member to support the emerging creative Leeds Arts and Heath Network and a focus on arts and health in the work of the Board.

RESOLVED –

a) To note the powerful contribution the arts can make to health and wellbeing.
b) To agree to support and develop within direct provision and commissioned services art interventions as a tool to meet health and wellbeing outcomes.
c) To agree to influence arts based commissioning and arts organisations to have a stronger focus on improving health and wellbeing.
d) To support the establishment of an Arts and Health and Wellbeing Network in the city.
e) To note that Jim Barwick was identified as the lead champion from the Health and Wellbeing Board to support this work.

32 For Information: Connecting the work of the Leeds Health and Care Partnership

The Board received, for information, a copy of the report from the Chief Officer for Health Partnerships (LCC) which provided an overview of the work from the April Health and Wellbeing Board informal workshop and the July Health and Wellbeing Board To Board meeting.

RESOLVED – To note the contents of the report.

33 For Information: BCF Quarter 1 2018/19 Return Performance Monitoring

The Board received, for information, a copy of the joint report from the Chief Officer Resources & Strategy, LCC Adults & Health and the Deputy Director of Commissioning, NHS Leeds CCG, detailing the BCF Performance Monitoring return for 2018/19 Quarter 1, which were previously submitted nationally following circulation to members for comment.

RESOLVED – To note the contents of the report.

34 For Information: Leeds Health and Care Quarterly Financial Reporting

The Board received, for information, a copy of the report of 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 contents of the report.

35 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next meeting as Wednesday 12th December 2018 at 1.00 pm (with a pre-meeting for Board members at 12.30 pm)

Leeds Safeguarding Adults Board

DRAFT FOR APPROVAL Minutes - Meeting held on 20th July 2018

Board Membership		
Name	**Representing**	**Attended**
Richard Jones CBE	Independent Chair – Leeds Safeguarding Adults Board	✓
Maureen Kelly (Member and Deputy Board Chair and Chair – Executive Group: SARs)	Leeds CCGs, Member of Executive Group, Chair of LSAB Executive Group: SARs	x
Cath Roff	Leeds City Council, Adults and Health	x
Shona McFarlane	LCC Adults and Health, Member of Executive Group	x
Nigel Parr	LCC, Adults and Health, Chair of , LSAB Quality Assurance and Performance Sub Group	✓
Max Naismith	LCC, Adults and Health, Chair of MCA LIN Sub Group	✓
Philip Bramson (Member and Chair, LSAB Citizen Engagement Sub-group)	Advonet for Third Sector Leeds, Chair of Citizen Engagement Sub Group	✓
Gill Marchant	NHS Leeds Clinical Commissioning Group, Chair of Learning and Development Sub Group	x
Superintendent Samantha Millar	West Yorkshire Police, Member of Executive Group	x
Jo Harding	NHS Leeds Clinical Commissioning Group	✓
Suzanne Hinchliffe CBE	Leeds Teaching Hospitals NHS Trust (LTHT)	x
Helen Christodoulides	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Karen Sykes	Leeds Teaching Hospitals NHS Trust (LTHT)	✓
Cathy Woffendin	Leeds and York Partnership NHS Foundation Trust (LYPFT)	✓
Lindsay Britton-Robertson	Leeds and York Partnership NHS Foundation Trust (LYPFT)	✓
Marcia Perry	Leeds Community Healthcare NHS Trust (LCH)	✓
Sally Morgan	Healthwatch Leeds	✓
Max Lanfranchi	National Probation Service	x
Karen Willcock	Her Majesty's Prisons and Probation Service (HMPPS)	✓
Sharna Duggan	West Yorkshire Community Rehabilitation Company	✓
Mandy Sawyer	Leeds City Council: Housing Leeds	✓
Emma Stewart	Alliance of Service Experts	x
Julie Staton	Leeds City Council: Public Health	✓
Zoe Hiner	HMP Wealstun	x
Kelly Pearce	HMP Leeds	x
Kathryn Richardson	West Yorkshire Fire and Rescue Service	x
Craig Bedford	West Yorkshire Fire and Rescue Service	✓
Emma Mortimer	Leeds Safeguarding Adults Board Strategy Unit	✓
Kieron Smith	Leeds Safeguarding Adults Board Strategy Unit	✓
Ruth Stevens	Leeds Safeguarding Adults Board Strategy Unit [Minutes]	✓

Item No.	Item

1 Chair's Welcome

Richard Jones, LSAB Independent Chair welcomed members to the Leeds Safeguarding Adults Board meeting.

Members of the Board introduced themselves and apologies were noted.

1.ii) Minutes of the Leeds Safeguarding Adults Board meeting held on 27th April 2018 and matters arising

The minutes of the meeting held on Friday 27th April 2018 were accepted.

It was agreed that minutes will in future be summary notes with actions.

2 Safeguarding Insights: Gipsil and Engage Leeds

The Board has decided to meet in community venues throughout 2018-19 and in doing so to invite services to talk to the Board about their services and safeguarding. Mel McQueen (Engage Leeds) and Liz Minnett (Gipsil) were invited as both have services based in the Old Fire Station. They provided a talk to the Board about the work that they do supporting adults with housing needs in Leeds.

The discussion that emerged from the presentation related to challenges for services in providing support for adults with complex needs and who make unwise decisions, are vulnerable but seem to have capacity to make those decisions.
Discussion also took place about:

- Transitions
- Managing risk in the community
- The importance of partnership working
- An apparent increase in hoarding and self-neglect and the interface with alcohol use and mental health;
- The importance of early intervention and preventative work.

Max Naismith referred the Board to the Adults and Health Directions Panel where people with high risk and a need for a collaborative approach when dealing with these cases. Max offered to provide the Board with further information about this approach at a future board; this was welcomed. Jo Harding referred to work being undertaken with regard to the Mental Health pathway and the Mental Health Strategy for Leeds and the potential impact of this upon working with people in circumstances such as those described by Liz and Mel.

Richard thanked Liz and Mel for their insightful presentation.

3 Board Governance

3.1 Annual Report

Kieron Smith spoke to the LSAB Annual Report 2017-18.

The main discussion points were as follows:

- The report was welcomed; members liked the use of pictures of people in the report and the accessibility of it;

Item No.	Item

- The length of the Report may be off-putting to some people, although this, it was noted, depended upon the audience for the report;
- Members felt that the focus on the Board ambitions was important;
- Mandy Sawyer noted that contributions from members are made in isolation, and she felt it would be helpful contributions to also reflect on collaborative approaches to safeguarding next year.

3.2 Strategic Plan

Kieron Smith presented the draft LSAB strategic plan 2016-19 and the plans for 2018-19, noting that this is the third year of the plan. He highlighted the following:

- The plan is focussed on the development and embedding of the Leeds Approach to Safeguarding multi-agency policy and procedures.
- There were a few responses within the consultation period and these are included within the plan.

Members welcomed the plan. It was suggested that the Third Sector be included within the plan in response to the comment that they did not see themselves included.

3.3 Multi Agency Policy and Procedures

Richard introduced the Leeds Approach to Safeguarding Multi-agency Policy and Procedures, commenting om the positivity of having a citizen-led approach. Kieron provided an update on progress of this project. He explained that the procedures will be put on the website with a consultation period until 10th September 2018.

- The draft policy and procedures will be emailed to Board Members for their views
- Each organisation will need to identify who will be the lead to feedback regarding the procedures.
- There is a PowerPoint that can be used as a tool to help facilitate the conversations within organisations about what the implications are. It is an opportunity to inform the strategy unit to support the process.
- It was agreed that an evaluation approach will be built in to the embedding of the procedure from the start.

3.4 LSAB Budget

Emma Mortimer gave a presentation to the Board regarding the budget and funding proposals.

West Yorkshire Trading Standards – this funding is for £6,000 to help purchase call blockers which help people with dementia who are at risk of getting scammed via phone calls.
This funding was agreed by the Board.

Self-neglect Conference – this is a multi-agency event being run by the LSAB. The request was for £4,500 which was agreed by the Board. Richard noted that the Executive Group had suggested a further, repeat event take place in May 2019; this was also agreed by members.

Commissioning - A independent service is planned to be commissioned to talk to people who are subject to the safeguarding process via an advocacy service. It is planned to have this service in place by the end of the year. This will cost approximately £25,000 over two years. Further information will be presented to the Board in October 2018.

Item No.	Item
4	**Multi-agency intelligence – What does the Board need to know?**

Board members discussed mapping what data or intelligence the Board needs to know to inform its work.

Nigel Parr, Chair of the Performance and Quality Assurance Sub-group led discussion. Highlights from the exercise are as follows:

- Police computer systems are not able to record adults and vulnerability so it is hard to filter for vulnerabilities and care needs. There could be potential to match up intelligence if an expert was commissioned.
- It is about how we understand the challenges and themes and how these relate to all agencies.
- The CCG has standardised all data that the health trusts provide in the form of KPIs. These work effectively for all trusts and could be provided to the Quality and Performance Sub-group.
- The Leeds Health and Care Plan could be looked at to see how it feeds into such discussions

Members commented that:

- There is joint work across agencies and it is the sub-group's role to connect it.
- The data needs to show us how the quality of care is like in Leeds and whether the workforce is competent.
- There is a technical challenge and it needs to be decided what the Board needs to know in order to prioritise this work.

These are important issues for the Sub-group to take forward and report to the Board later in the year.

Action: Chair of the Quality Assurance and Performance Sub-group to progress the discussion points highlighted above and report back to the Board.

5	**Review, Learning and Development**

Emma Mortimer gave an overview of the work of the Learning and Development Sub-group on behalf of Gill Marchant, the Chair who was unable to attend the Board meeting.

It was noted that the sub-group is now established and members noted this progress.

- For Safeguarding Week, eight briefings were held which covered the themes that have emerged from safeguarding reviews across the three Leeds safeguarding boards. Approximately 140 people attended these briefings and more are now being run as the demand for these is high.

- A multi-agency self-neglect conference is being held in October 2018.

- A project may be commissioned regarding analytical report writing to support people on how to write reports in a standardised manner for all safeguarding reviews.

6	**LSAB Executive, Executive: SARs and Work Plan Updates**

The group noted the updates.

Item No.	Item
7	**Board Member Updates**
7.1	The group were informed that Paul Money QPM is Chief Officer for Safer Leeds.
8	**Reflections**
8.1	Members commented that there had been useful discussion, particularly as a result of the presentation from Engage Leeds and Gipsil.

Leeds Safeguarding Adults Board

Actions from 20th July 2018

Item No.	Action	Person / organisation responsible
Item 4	Chair of the Quality Assurance and Performance Sub-group to progress the discussion points highlighted by members during the discussion about intelligence needed by the Board and report back. (February Board)	Nigel Parr, Chair QAP Sub-group

Leeds Safeguarding Adults Board

Continuing Actions from Previous Board Meetings

Board Date	Agenda Item	Action	Lead Person/ Agency	Target Date	Comments
15th June 2017 and 14th November 2017	Item 4	Presentation re DoLS Audit to Board. DoLS audit and the initial report is expected in December 2017, the final report will be shared with the LSAB.	Max Naismith	March 2018	
26th September 2017	Item 2	West Yorkshire Trading Standards Safer Project to provide an annual report to the LSAB.	West Yorkshire Trading Standards	July 2019	
14th November 2017	Item 7	The MCA LIN Sub-group will provide the Board with recommended Mental Capacity Act tools and an update on its Advanced Care Planning work.	Max Naismith	March 2019	