Leeds Community Healthcare NHS Trust
Board Meeting (held in public)
Friday 24 May 2019, 9.00am – 12noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

NHS Leeds Community Healthcare NHS Trust

AGENDA

Time	Item no.	Item	Lead	Paper
		Preliminary business		
9.00	2019-20 (6)	Welcome, introductions and apologies: *Sam Prince, Executive Director of Operations*	Neil Franklin	N
9.05	2019-20 (7)	Declarations of interest	Neil Franklin	N
9.10	2019-20 (8)	Questions from members of the public	Neil Franklin	N
9.15	2019-20 (9)	Minutes of previous meeting and matters arising: a. Minutes of the meetings held on 29 March 2019 and 3 May 2019 b. Actions' log	Neil Franklin	 Y Y
9.30	2019-20 (10)	Patient's story: Integrated Children with Additional Needs	Steph Lawrence	N
		Quality and delivery		
9.45	2019-20 (11)	Chief Executive's report	Thea Stein	Y
9.55	2019-20 (12)	Committees' assurance reports: i. Business Committee: 24 April 2019 and 22 May 2019 (verbal) ii. Audit Committee: 26 April 2019 and 22 May 2019 (Verbal) iii. Quality Committee: 29 April 2019 and 20 May 2019 (Verbal)	 Brodie Clark Jane Madeley Ian Lewis	 Y Y Y
10.05	2019-20 (13)	Performance brief and domain reports a. Performance report April 2019 b. Performance brief annual report 2018-19	Bryan Machin	 Y Y
10.15	2019-20 (14)	Significant risks and risk assurance report	Thea Stein	Y
10.25	2019-20 (15)	Annual report and accounts 2018-19 a. ISA 260 external auditor's opinion b. Annual report c. Annual accounts d. Letter of representation	Bryan Machin	Y
10.35	2019-20 (16)	Operational plan 2018-19: end of year report	Bryan Machin	Y
10.45	2019-20 (17)	Quality account 2018-19	Steph Lawrence	Y
10.55	2019-20 (18)	Healthwatch review of patient engagement activity	Steph Lawrence	Y
11.05	2019-20 (19)	Serious incidents report and patient experience and complaints annual report	Steph Lawrence	Y
11.15	2019-20 (20)	Guardian for safe working hours: annual report 2018-19	Ruth Burnett	Y
11.25	2019-20 (21)	Workforce strategy: leadership and skills	Laura Smith/Jenny Allen	Y
		Governance		
11.35	2019-20 (22)	Well-led framework: self-assessment update	Thea Stein	Y
11.45	2019-20 (23)	Corporate governance report: • Board and committee effectiveness review • Audit Committee annual report 2018-19 • Committees' terms of reference review • NHS provider licence compliance • Standing orders/standing financial instructions: review • Register of sealings	Thea Stein	Y
11.55	2019-20 (24)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2019-20 (25)	Approved minutes for noting: a. Quality Committee: 18 March 2019 b. Audit Committee: 22 March 2019 c. Business Committee: 25 March 2019	Neil Franklin	 Y Y Y
12.00	2019-20 (26)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 2 August 2019, 9.00am -12noon

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public)
Boardroom, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA ITEM 2019-20 (9ai)

Friday 29 March 2019, 9.00am – 11.45am

Present:	Neil Franklin	Trust Chair
	Bryan Machin	Executive Director of Finance and Resources (also deputising for the Chief Executive)
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director (up to and including Item 117)
	Professor Ian Lewis	Non-Executive Director
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development (OD) and System Development (JA)
	Laura Smith	Director of Workforce, Organisational Development (OD) and System Development (LS)
Apologies:	Thea Stein	Chief Executive
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
In attendance:	Richard Gladman	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Katy Wilson	Children's Occupational Therapist and Clinical Lead for the 'Let Me Show You' App! implementation
Minutes:	Liz Thornton	Board Administrator
Observers:	Margaret Duke	Insight Programme Participant
	Cara McQuire	Risk Manager
	Catherine Duff	Interim Quality Lead for Children's Business Unit
Members of the public:	None	

Item	Discussion points	Action
2018-19 (109)	**Welcome and introductions** The Chair welcomed Board members, those in attendance and three observers to the meeting. **Apologies** Apologies were noted from the Chief Executive and the Executive Director of Nursing and Allied Health Professionals.	

	Opening remarks The Chair opened the meeting.	
2018-19 (110)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2018-19 (111)	**Questions from members of the public** No member of the public was in attendance. No questions had been notified in advance of the meeting.	
2018-19 (112)	**A patient's story: ICAN transition from children to adult services** The Board welcomed a young man, his mother and Katy Wilson, Children's Occupational Therapist and Clinical Lead for the 'Let Me Show You!' App implementation to the meeting. By using the electronic communication aid the young man was able to tell his own story to the Board. He explained that he had complex specialist health and educational needs. As a child he had attended a specialist inclusive learning centre where his individual educational, physical, personal development and well-being were taken into account in the school environment. By working with a multi-disciplinary team the school provided a holistic approach to his learning and he was well supported. The transition from children's into adult services did not work so well and he spoke about the difficulties he encountered in accessing the right support to enable him to continue his education beyond 19 and remain living at home with his family. He said that almost overnight he lost all the support and care that had been in place whilst he was at school. He described how people who didn't know him, underestimated his abilities and were making suggestions and offering him advice that was not appropriate to meet his complex healthcare needs. He told the Board how he overcame these problems through his own determination to succeed, with the help of a social worker who listened and with the support of his mother. He talked about his involvement in developing the Let Me Show You! App, which was designed to support young people with complex specialist needs through transition to adult services and his hopes for how it will make life better for people in a similar situation to him and his wish to be involved in developing it further through his voluntary work at the William Merritt Disabled Living Centre. The Chair thanked the young man and his mother for attending the Board and telling his inspirational story. A Non-Executive Director (BC) asked what plans there were to develop the App and make it more widely available. Katy Wilson explained that a number of workshops were planned to test the App in different situations. These workshops would be attended by a variety of young people with differing complex needs in order to test how the App could be adapted to meet their individual needs. He said that parents, carers, personal assistants, teachers and healthcare professionals would also be invited. A Non-Executive Director (RG) asked whether there were any plans to offer the App to other trusts locally and more widely across the country. The young man's mother said that due to her son's complex healthcare needs he attended various centres locally and nationally for treatment and he was doing an excellent job at showcasing the App. Various organisations were showing an	

	interest in using it within their services. The Chair thanked the young man, his mother and Katy for attending the meeting and telling such a powerful story. He paid tribute to the young man's personal courage, strength and determination to achieve a successful outcome to his journey through the adult education system. He added that it was an excellent example of how the use and development of technology could improve the life of patients and young people with complex healthcare needs. On behalf of the Board the Chair wished the young man and his family well for the future.	
2018-19 (113) **(113a)** **(113b)**	**Minutes of the previous meetings and matters arising** **Minutes of the meeting held on 1 February 2019 and 1 March 2019** The minutes were reviewed for accuracy and agreed to be correct records of the meetings. **Items from the actions' log** The completed actions from previous meetings were noted. All actions were on track for completion by the due deadline or were to be discussed as part of the meeting's agenda.	
2018-19 (114)	**Chief Executive's report** The Executive Director of Finance and Resources introduced the report which provided an update on Trust activities since the last Board meeting and highlighted key issues for the Board to note: • New Trust Board members • CQC Provider Information Request • New GP Contract • Race for Equality event • EU Exit preparations The Chair referred to the Race for Equality event held on 20 March 2019 which he said had been a vibrant event attended by over 100 staff from across the Trust. He observed that this was an important event which was an significant step in the organisation becoming the outstanding inclusive organisation it aspires to be and he commended those who organised the event as well as those who spoke out at it. The Board discussed the new GP contract and the development and investment in primary care networks (PCNs). The Executive Director of Finance and Resources said that the next joint development event was scheduled for 9 April 2019 and would focus on how the GP Confederation and the Trust could ensure that the PCNs were developed and supported in a way that served the people of Leeds in the best way possible. A Non-Executive Director (IL) said that it would be important for the Trust to take a strong leadership approach in the discussions. A Non-Executive Director (JM) said that the Trust must make a compelling case for change and be confident in explaining what was on offer particularly in terms of shared services. The Chair suggested that it would helpful for a briefing document to be prepared for representatives from the Trust who were attending the meeting on 9 April 2019 to ensure clarity in terms of the aims and objectives.	**Executive Director of Finance and Resources/**

	Action: A briefing note to be provided for members of the Trust who would be attending the GP confederation development meeting on 9 April 2019. The Executive Director of Operations provided an update on the EU Exit preparations. She reported that the Trust had followed national guidance in preparing for a "no-deal" exit. A small planning team had been established with key leads from workforce, medicines management, information governance and research. The Trust had also completed risk assessments against the seven areas of risk detailed in the Department of Health and Social Care's EU Exit Operational Readiness guidance document and had self-assessed as low risk. The Executive Director of Operations also advised that the Yorkshire and Humber EU Exit Team had confirmed that it was assured by the preparations put in place by the Trust and the Business Committee had received reasonable assurance from a report submitted at a meeting on 25 March 2019. The Board noted that the Trust's planning team would continue to monitor the situation and update the risk assessments appropriately. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	**Chief Executive**
2018-19 (115)	**Committees' assurance reports:** **Item 115a – Charitable Funds Committee held 1 March 2019** The report was presented by the Chair of the Committee (BC) who highlighted the key issues, namely: • More than a welcome programme – this work had been superseded by the *Hello my Name is* campaign which would be fully launched across the Trust later in the year. • Liaison with Leeds Cares – in the absence of the Executive Director of Nursing and Allied Health Professionals, consideration of the draft memorandum of understanding due to take place in the private session of the Board would be deferred. • In-house lottery scheme – further action in relation to this might be considered as the work with Leeds Cares progressed if appropriate. **Item 115b – Nominations and Remuneration Committee held 8 March 2019** The report was presented by the Chair of the Committee, the Trust Chair, who highlighted that reasonable levels of assurance had been determined on areas considered by the Committee and the recommendation received nationally that all Very Senior Managers should receive a flat rate uplift to salaries aligned with the national guidance had been approved. **Item 115c – Audit Committee held 22 March 2019** The report was presented by the Chair of the Committee and Non-Executive Director (JM) who highlighted the key issues, namely: • Internal Audit– the Committee had received assurance that all audits would be completed by the year end thanks to the support from the Executive Team and the Internal Auditors. • The draft 2019/20 internal audit plan was reviewed and would receive formal approval at the next meeting of the Committee on 26 April 2019. • GDPR – the Committee received a progress report on the Trust's actions to achieve compliance with GDPR legislation and agreed that the action plan was now in a good position and updates to the Committee would no longer be as frequent.	

- Data Security and Protection Toolkit – the Committee reviewed the final assessment and received assurance that the Trust was on track to achieve compliance with the 10 standards. The toolkit would be submitted to NHS Digital on 31 March 2019.
- Annual Governance Statement – the Committee had reviewed the first draft of the Annual Governance Statement and suggested a number of amendments.

Item 115d – Quality Committee

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

18 February 2019 (workshop)

- Specialist Business Unit outcome measures – the Committee was informed about the business unit's quality outcome measures journey and representatives from Podiatry, MSK, Physiotherapy, Dietetics, Speech & Language Therapy and Foot Protection Service attended to describe their individual approach to identifying, monitoring and analysing outcome measures and the outcome tools utilised. Service representatives confirmed that this work had led to better conversations with commissioners about service development. It was clear that there was a requirement for systems support through the Business Intelligence team in the move towards more robust outcomes information. The Committee learned that the process of analysing data was labour intensive and that specialist resource was needed to support the services to understand variance for example why seeing patients at home rather than in clinic appears to produce better outcomes.

18 March 2019

- Spotlight on Community Paediatrics – the Committee heard an overview of the Integrated Children's Additional Needs (ICAN) service which described the co-dependencies between the professional groups working within the service. The service was facing a range of challenges including a high level of vacancies, difficulties in recruiting permanent staff and reducing the number of locums. The Committee heard that parents had difficulty in navigating the numerous speciality service areas within ICAN and it was hoped that the establishment of a programme board to oversee the transformation programme would help to resolve some of these issues.
- Review of Quality Challenge Plus – the Committee received a report describing how the programme currently operates within the organisation. The Committee raised concerns about the practicality of reviewing all 56 services in one year and heard that a new process would be piloted in quarter one.
- Research Strategy – the Committee reviewed the draft 2019-23 strategy which addressed the challenging aspects of the previous strategy and proposed aims and objectives to address inherent issues. The Committee was concerned that research was not embedded within the Trust and suggested pooling resources with similar trusts, and possibly collaboration with academics. It was suggested that to raise the profile of research across the Trust it should be the theme of a Board workshop.

Action: Inclusion of research as a theme for a future Board workshop to be considered by the Senior Management Team.

Senior Management Team

Item 115e – Business Committee

The reports were presented by the Chair of the Committee and Non-Executive Director (BC) who highlighted the key issues, namely:

20 February 2019

- Digital Strategy – the Committee was appraised of the early thinking

	towards the development of a refreshed digital strategy, including details of new digital priorities, considerations and opportunities. The next steps would be to link up the Trust's strategy with those of the GP Confederation and primary care networks, link the priorities to the recently published NHS Long Term Plan as well as other national, regional and city strategies, take into account development initiatives and to consider which innovation development ideas should be pursued. Completion of these activities would allow a formal strategy document to be drawn up for Trust Board approval. There was no projected timescales for next steps in the process. The Committee was concerned about the effectiveness and the Trust's utilisation of existing technology where, it was believed, further attention was required. The Committee asked for sight of an early plan for next steps. **Item 115eii– Business Committee held on 25 March 2019** • E-rostering – the Committee was advised that the project would commence implementation phase from April 2019. Benefits were already being identified including savings on administrative time, although at present this was reported as anecdotal. Prioritisation of services still needed working out however neighbourhood teams were being seen as a priority for implementation. **Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted.	
2018-19 (116)	**Performance brief and domain reports** The Executive Director of Finance and Resources presented the report which provided a high level performance summary for February 2019. The Senior Management Team had reviewed the data and determined that the Trust's overall performance position was good. Further triangulation of data across various domains continued. ***Operational issues and pressures*** The Chair was encouraged to see that the Trust's overall performance had remained good over the winter period. The Executive Director of Operations reported that the advance preparations the Trust had made and the investment in additional capacity had proved to be beneficial in managing pressures during the winter period. She added that the introduction of more effective systems and better partnership working had led to significant improvements in the flow of patients between the acute hospital and community sector. *Child and adolescent mental health services (CAMHS)* In response to a question about the introduction of new standards around caseload numbers and time spent in direct patient contact from a Non-Executive Director (JM) the Executive Director of Operations confirmed that the expectation was that clinicians would accept six new referrals per month from April 2019 and this would be monitored on an individual basis. ***Safe and Caring domains*** The Chair was concerned to note the increase in category 3 pressure ulcers. It was noted that all had been fully investigated and validated to ascertain if they were avoidable to the Trust. These were now closed incidents which were originally reported in Datix in an earlier month. ***Effective domain*** The Board noted that the measures in this domain were reported quarterly therefore no routine information was presented and no matters had arisen to escalate.	

	Responsive domain The Trust was currently performing well against the nationally set target of 95% of patients treated within 18-weeks of referral for Consultant-led services. February performance was 97.4% and this was consistent with performance over the last year. Within this there were a number of hotspots where breaches have occurred; however numbers were small and at the end of February 2019, 38 patients had waited more than 18 weeks for treatment in consultant-led services. Breaches occurred most often because the appointment was cancelled either by the patient or the service and there was insufficient time to re-schedule within the 18-week window. ***Well-led*** The Board noted that in the well-led domain, there were a number of positive movements to draw out from the Well Led figures at the end of February 2019, and an area of reducing compliance to focus on. The area of reducing compliance was appraisal, which had dropped month-on-month during the past 3 months. It was noted that this may be partially linked to services struggling to prioritise appraisals during winter months. Actual performance remained in the mid 80 percent but was below the Trust's stretch target. To ensure that there was no further deterioration and move to improvement, a more detailed picture of service-by service compliance was being produced to support managers in identifying areas to focus on, whilst monitoring and challenge continued via the regular performance monitoring meetings. ***Financial position*** The Executive Director of Finance and Resources confirmed that the Trust's overall financial position remained consistent with previous months and it was anticipated that the revised control total of £4m would be achieved. **Outcome:** The Board noted the Trust's performance for February 2019.	
2018-19 (117)	**Significant risks and assurance report** The Company Secretary presented the report which outlined the Trust's current risk profile and detailed organisational risks scoring 15 or above following the application of controls and mitigation measures. The Board noted that there were no risks with a current score of 15 (extreme) or above on the Trust's risk register as at 7 March 2019. The Board noted the de-escalation of Risk ID 954, relating to Diabetes Service waiting times, from a score of 12 (high) to a score of 9 (high) and the reasons underpinning this. Referring to BAF risk 2.1 a Non-Executive Director (JM) asked what evidence there was to support a positive assurance movement. The Executive Director of Finance and Resources explained that the delivery of a number of internal projects had indicated an improved situation, the Business Committee had received a report from the Change Board which provided reasonable assurance and the change programme had been given a reasonable assurance opinion by Internal Auditors. The Chair asked for a risk to be included on the risk register relating to the risks associated with the Trust's relationship with the GP Confederation and the GP Contract. **Action:** The Chief Executive to consider including a new risk on the risk register	**Chief**

	or relating to the Trust's relationship with the GP Confederation/GP Contract. **Outcome:** The Board noted the contents of and the themes identified in the risk register, noted the revised BAF risk scores and current assurance levels, and approved the amendments to the 2019/20 strategic risks.	**Executive**
	A Non-Executive Director (JM) left the meeting.	
2018-19 (118)	**Annual staff survey2018** The Director of Workforce, Organisational Development and System Development (JA) presented the report which included the findings of the 2018 survey organisational results and the related work being done across the Trust. The report also set out the Trust's 2018 results compared to 2017 and national comparator data. The Director of Workforce, Organisational Development and System Development (JA) reported that 52% of staff had completed the survey which was nine percentage points above the national average of 43%. Key headlines from the staff survey included: • Levels of engagement at the Trust were up as a whole with five of the nine key measures for engagement showing significant improvement • Five of the six key measures for job satisfaction had also improved significantly since 2017 • Of the 66 questions asked in the 2018 survey the Trust's results showed a positive change in 46, no change in 11 and a negative change in 9. The Director of Workforce, Organisational Development and System Development (JA) reported that there was significant evidence that areas for improvement targeted following the 2017 results had progressed and improved. Additionally there were positive shifts in questions linked to values and behaviours. In response to a question from the Chair, the Director of Workforce, Organisational Development and System Development (JA) advised that areas of focus in the coming year would be on some aspects of the health and well-being of staff as well as diversity and inclusion; the results for these areas were currently subject to further analysis with a plan for the Senior Management Team to discuss next steps. The Director of Workforce, Organisational Development and System Development (JA) reported that next steps would be to share the granular detail within each business unit and corporate team to allow them to review their information and develop their own local action plan. The Chair placed on record his thanks to all the staff in the Trust who had completed the survey and for their feedback and engagement in the process. He also thanked both Director of Workforce, Organisational Development and System Development (JA) and Director of Workforce, Organisational Development and System Development (LS) for their commitment to progressing this work is such a positive way. The Board agreed that the positive changes were a reflection of the Trust's increased emphasis in putting people before process, looking after staff wellbeing, and encouraging openness at all levels. **Outcome:** The Board: • received and noted the 2018 Staff Survey results • noted proposed next steps in terms of dissemination of the results and	

	plans to work with local business units	
2018-19 (119)	**Estates** **(a) Office reorganisation:** **Proposed new lease for 4th floor, Stockdale House** The Executive Director of Finance & Resources presented a proposal to sign a new lease for 4th floor at Stockdale House to provide space for relocation of the Primary Care Confederation, the CAMHS management team from Little Woodhouse Hall and the Safeguarding Team from Armley Moor Health Centre. He said the lease was strategically important to meet operational needs and provide a base to allow a combined headquarter presence on the site. The annual cost of the 4th floor lease was circa £200k with £35k for a one-off cost. The Trust was committed to the rent and service charges up to October 2023. This termination date was coterminous with the other three floors. The Chair observed that the proposal had been considered in detail by the Business Committee on 25 March 2019 and the Committee had recommended that the Trust Board approved the signing of the lease. **Outcome:** The Trust Board approved the signing of the lease for the 4th floor at Stockdale House. **(b) LIFT Under Lease Plus Agreements (UPLAs) from Community Health Partnerships** The Executive Director of Finance and Resources presented the report. He explained that the Trust was required to regularise its existing occupation of the LIFT properties transferred from the Primary Care Trust in 2013. He reminded the Board that leases for the first five UPLAs had been signed in October 2018. He reported that the Business Committee had considered a detailed version of the report at its meeting on 25 March 2019 and had recommended that the Board approve the signing of the leases for a further five properties. **Outcome:** The Board approved the signing of the ULPAs for the five properties listed in the report with a probable minimum cost commitment over three years of £12.5 million and, if no changes were made to Leeds Community Healthcare's occupation, a total financial commitment to the end of the lease of £57 million.	
2018-19 (120)	**Operational plan 2019/20 including financial plan** The Executive Director of Finance and Resources presented the plan which included the financial plan for 2019/20. He explained that the Trust's 2019/20 operational plan and financial plan described how the Trust would continue to deliver high quality services and engage with partners to deliver system transformation plans supported by sustainable financial and workforce plans in a challenging financial context. The Executive Director of Finance and Resources reported that the Board planning workshop in November 2018 had informed the development of the Trust's priorities and plan. The Quality Committee had reviewed the quality priorities and plans and the Business Committee the priorities, financial plan, workforce and business plans. He explained that the plan was consistent with the final NHSI 2019/20 plan submission which would be submitted by the national deadline of 4 April 2019. In response to a question from Associate Non-Executive Director (RG) the	

	Executive Director of Finance and Resources advised that the operational plan would be translated into 'Plans on a Page' for each service and success measures would be developed and monitored by committees in-year. The Trust Chair observed that the Trust's financial plan reflected an improved but still challenging funding environment for 2019/20. The Executive Director of Finance and Resources explained that the Trust's business as usual operations and the priorities described in the Operational Plan were underpinned by the proposed income and expenditure and capital budgets and the plan demonstrated delivery of the control total £1.745m set by NHS Improvement. The Board was asked to approve the Trust's operational plan and the financial plan for 2019/20. **Outcome:** The Board approved the operational plan for 2019/20 and the supporting financial plan within it.	
2918-19 (121)	**Gender pay gap report** The Director of Workforce, Organisational Development and System Development (LS) presented the report which provided information on the Trust's 2018 gender pay gap. The key point highlighted was: • the overall 2018 gender pay gap identified for the Trust was 10.69%; with the pay for men higher than that of women The Director of Workforce, Organisational Development and System Development (LS) explained that further examination of the more detailed data from which the 10.69% figure was drawn shows that in quartiles 1, 2 and 3 the gender pay gap was in favour of women within the workforce – ranging from more than 3% to just over 1% in favour. It was only in quartile 4 that the pay gap shifts, and considerably, in favour of men within the workforce at 14.34%. In response to a question from a Non-Executive Director (BC) the Director of Workforce, Organisational Development and System Development (LS) advised the Board that analysis of the data had not found any areas of significant concern and that the Trust did not pay men and women differently for the same job. **Outcome:** The Board noted: • the data contained within the 2018 report • the narrative written to support and explain the data contained in the 2018 report • the legal requirement to upload the data to the national database and Trust website by 30 March 2019 • the publication of the narrative to accompany the 2018 report • the pay gap in quartile 4 is expected to decrease over time as individuals progress up the Agenda for Change pay scales as personal pay steps are reached • proposed actions to help address the pay gap in quartile 4 include continuing to encourage diverse applications across the Clinical Excellence Awards and consideration of taking positive action to 'target' the recruitment of females in under-represented staff / speciality groups across the Trust.	

2018-19 (122)	**Corporate governance report** The Company Secretary presented the report which included: • an update on the progress of the annual governance statement 2018/19 • 'going concern' statement • Board of Directors declarations of interest and compliance with fit and proper person requirements for 2018-19 (in draft) • non- executive membership of the Board and committees **Outcome:** The Board noted the report, annual governance statement 2018/19, going concern statement, approved the conclusion that the Trust is a going concern and noted the declarations of interest made by directors for 2018/19 (in draft). The Board also noted that no changes to the membership of each committee were proposed.	
2018-19 (123)	**Board work plan** The Executive Director of Finance and Resources presented the Board work plan (public business) for information. **Outcome**: The Board noted the work plan.	
2018-19 (124)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes: a) Charitable Funds Committee: 14 December 2019 b) Quality Committee: 21 January 2019 and 18 February 2019 c) Leeds Health and Wellbeing Board: 12 December 2018 d) Leeds Safeguarding Children Partnership Board: 9 October 2018 e) Business Committee: 23 January 2019	
2018-19 (125)	**Any other business** The Chair accepted one item of any other business. **Healthcare worker flu vaccination information for NHS England** The Executive Director of Finance and Resources introduced the report which included the Trust's performance on overall vaccination uptake rates and numbers of staff declining the vaccinations. The report also detailed the actions that the Trust has undertaken to deliver the 100% ambition for coverage this winter. **Outcome:** The Board received and noted the information provided in the report and the actions taken to achieve the 100% uptake ambition.	
2018-19 (126)	**Close of the public section of the Board** The Chair thanked everyone for attending and concluded the public section of the Board meeting. The Chair took the opportunity to place on record his thanks to Dr Tony Dearden who was attending his last meeting of the Trust Board as a Non-Executive Director. He thanked Tony for the significant contribution he had made to the business of the Trust Board and in his role as a former chair of the Quality Committee. He wished Tony well for the future.	
Date and time of next meeting **Friday 24 May 2019, 9.00am – 12.00pm** **Boardroom, Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair:
Date: ??? 2019

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (9aii)

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

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

Friday 3 May 2019 12noon - 1.00pm

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Jenny Allen	Executive Director of Finance and Resources Director of Workforce, Organisational Development (OD) and System Development
	Laura Smith	Executive Director of Finance and Resources Director of Workforce, Organisational Development (OD) and System Development
Apologies:	Dr Ruth Burnett	Executive Medical Director
In attendance:	Richard Gladman	Associate Non-Executive Director
	Diane Allison	Company Secretary
	Margaret Duke	Aspiring Non-executive Director Programme Participant
Minutes:	Liz Thornton	Board Administrator

	Discussion points	Action
2019-20 (1)	**Introductions and apologies** The Trust Chair opened the extraordinary public meeting. He explained that the purpose of the meeting was for the Board to consider two items; the CAMHS Tier 4 contract and the Performance Brief – key performance indicators 2019/20. Apologies were received from the Executive Medical Director. .	
2019-20 (2)	**Declarations of interest** There were no declarations of interest made in relation any items on the agenda.	

2019-20 (3)	**CAMHS Tier 4 contract: update** The Executive Director of Finance and Resources introduced the report which updated the Board on developments on the CAMHS T4 new build scheme and sought approval to move to the next stage. He said that the key issue for consideration by the Board was that the scheme was sufficiently developed to submit a planning application for preparing a full business case for approval by the Board in September 2019. The Board was advised that the Trust did not currently have an operational model with costs that are within the currently assumed resources available; however the Executive Director of Finance & Resources advised that the capital and revenue models were sufficiently developed to justify moving to the next stage. The Executive Director of Finance & Resources referred to the summary development cost model in the paper and said that it was important to understand the implication from Trust's perspective that the capital cost of £540k was effectively the current estimate of the equipment that would be put into the building. He said that it was a reasonable assumption and that over a two year period spending £0.5m on equipment was affordable and would not unduly impact on other capital requirements. The revenue development cost of £1.4m to the Trust was assumed to be funded from the new model of care (NMoC) delegated budget in 2018/19 and 2019/20. Interserve would develop a guaranteed maximum price (GMP) for the construction of the scheme, for agreement in September 2019 and to support as part of the full business case. The Executive Director of Finance & Resources said that if the capital development scheme was to be paused whilst finalising the revenue model, there would be a further delay for the rest of the scheme. He proposed to continue to work in parallel on both the capital and revenue models. Non-Executive Director (BC) and Chair of the Business Committee advised that the Committee had considered the paper at a meeting on 24 April 2019 and explored the level of risk and the potential financial impact that the Trust would be exposing itself to. The Committee had agreed to support the proposal but to mitigate the risk, requested that the Trust seek the support of other members of the Mental Health Collaboration: Bradford District Care Trust and South West Yorkshire Partnership Foundation Trust and explore how other NHS organisations had recently managed similar situations and what the outcome had been. The Board noted that the Board at Leeds and York Partnership NHS Foundation Trust had received the same report at its meeting on 25 April 2019 and supported the recommendations contained within it. The Board also noted that the West Yorkshire New Care Models Programme Board had supported the approach to resourcing the development of operating costs. The Board noted the wide ranging update on the scheme and agreed that the scheme continue to be developed to enable a full business case to be submitted for approval by the Board in September 2019 subject to the actions requested by the Business Committee to mitigate the risks the Trust would be exposing itself to.	

	Outcome: The Board: • approved that the scheme continue to be developed to enable a full business case to be submitted for approval in September 2019.	
2019-20 (4)	**Performance brief: key performance indicators** The Executive Director of Finance and Resources presented the report which included a proposal for the measures to be included in the 2019/20 performance brief. He explained that the report highlighted proposed new measures, measures to be removed and measures to be amended from 2018/19 reporting. The Board reviewed the proposed measures and those in development. The Board discussed at length the proposal to remove the Friends and Family Test (FFT) indicators for inpatient and community. A Non-Executives Director (BC) said that he was keen to understand the rationale for removing these indicators given the importance of measuring patient experience. The Executive Director of Nursing and Allied Health Professionals explained how problematic this indicator was often in community settings with long term clients and patients who needed intervention daily and she explained the desire to use different performance measures. The Board agreed that the FFT indicators for inpatient and community should remain in the performance brief until a new system to measure patient engagement was in place and fully understand. **Outcome:** The Board noted the proposed measures for inclusion in the 2019/20 Performance Brief and approved: • the proposed new measures • the measures to be removed subject to the FFT indicators for inpatient and community remaining in the performance brief until a new system to measure patient engagement was in place.	
2019-20 (5) (5a) (5b)	**Any other business** Two items were raised. **NHS Providers briefing 2019 local elections: purdah considerations for NHS foundation trusts and trusts** The Board noted the briefing which outlined considerations for NHS foundation trusts and trusts in the period of time known as the pre-election period, or 'purdah', leading up to the 2019 English local elections on 2 May 2019 and the European Parliament elections on 23 May 2019. **Publicity surrounding the reduction in child obesity rates in Leeds** The Chief Executive updated the Board on very extensive publicity, surrounding the success in Leeds in significantly reducing child obesity. The Chief Executive said that millions of people in the UK had been left with the impression that this achievement was entirely down to Leeds City Council (LCC), who commissioned as opposed to Leeds Community Healthcare who delivered the services concerned. It was noted that no attempt had been made to involve the Trust in a joint media release. The Board, whilst pleased to note the reduction of child obesity rates in Leeds was concerned that national publicity had not recognised the significant contribution made by the Trust's children's services in achieving this through	

	the HENRY programme.	
2017-18 (5)	**Close of the private Extraordinary Board meeting** The Trust Chair closed the Board meeting.	
Date and time of next meeting **Friday 24 May 2019** **12 noon – 1.00pm** **Boardroom, Leeds Community Healthcare NHS Trust,** **Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair: Neil Franklin
Date: 24 May 2019

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AGENDA ITEM 2018-19 (9b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 24 May 2019

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting 1 December 2018				
2018-19 (71)	**Committees' assurance reports** Chief Executive and Director of Workforce, OD and System Development to consider HR representation at the Quality Committee	Chief Executive	Trust Board 24 May 2019	To be reviewed at May 2019 Quality Committee **Verbal update to 24 May 2019 Board**
2018-19 (76)	**Patient experience report** Interim Executive Director of Nursing to provide further information in future reports on the primary themes of complaints and the number of complaints that had been fully or partially upheld.	Executive Director of Nursing and Allied Health Professionals	Trust Board 24 May 2019	Next report due to Trust Board 24 May 2019
Meeting 1 February 2019				
2018-19 (93)	**Performance brief and domain reports – effective domain** Clarification about the requirement in NICE guidance 11 for CAMHS staff to undertake training around proactive strategies for managing challenging behaviour.	Executive Medical Director	Trust Board 24 May 2019	Verbal update to the Board on 24 May 2019
2018-19 (95)	**Serious incidents report** Consider the future reporting of avoidable and unavoidable serious incidents that occur within the health system particularly where the Trust was not in control of the factors surrounding the incident.	Executive Director of Nursing and Allied Health Professionals	Trust Board 24 May 2019	Verbal update to the Board on 24 May 2019
Meeting 29 March 2019				
2018-19 (114)	**Chief Executives report***: GP Confed/LCH development session 9 April 2019* A briefing paper to be provided for Board members who were attending.	Chief Executive	For 9 April 2019	Completed
2018-19 (115d)	**Quality Committee Assurance Report: 18 February 2019 – Research strategy** Inclusion of research as a theme for a future Board workshop to be considered by the Senior Management Team.	SMT	Post meeting	Completed
2018-19 (117)	**Significant risks and assurance report** The Chief Executive to consider including a new risk on the risk register relating to the Trust's relationship with the GP Confederation/GP Contract.	Chief Executive	Post meeting	Verbal update to the Board on 24 May 2019

Actions on log completed since last Board meeting	
Actions not due for completion before 24 May 2019; progressing to timescale	
Actions not due for completion before 24 May 2019; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 24 May 2019; not having met agreed timescales and/or requirements	

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AGENDA ITEM 2019-20 (11)

Meeting: Trust Board 29 March 2019	**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, which aims to highlight areas where the CEO and senior team are involved in work to support the achievement of the Trust's strategic goals and priorities: delivering outstanding care in all our communities, staff engagement and support, using our resources efficiently and effectively, and ensuring we are working with key stakeholders both locally and nationally.

Main issues for consideration

This month's report focusses on:

- CQC Well-led inspection visit due in June 2019
- The Chief Nurse's visit to the Trust in April 2019
- Our award-winning Thank You awards
- Our participation in the ICS Financial Framework
- NHS Improvement Transitions Collaborative

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

Recommendation

The Board is recommended to:

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

Chief Executive's report

1. Trust news

1.1 CQC well led inspection visit due 3-5 June 2019

The CQC have advised that our Well-led review will take place between 3rd and 5th June 2019. This will include discussions with all Board members and senior leaders within the organisation. In addition to this there are unplanned service visits, which commenced 7 May 2019. Verbal feedback will be provided at the Board on the service visits that have concluded at this point. An upate on the Well Led framework is in the Board papers.

1.2 Chief Nurse Ruth May's visit 29/30 April 2019

At the end of April, the new Chief Nursing Officer, Ruth May visited the Trust. Ruth spent time in two of LCH's clinical services and then some time meeting the Directors of Nursing in Leeds. The Executive Director of Nursing and AHPs had invited Ruth to Leeds to see our community services and she had also had direct contact via Twitter from one of our police custody healthcare professionals, inviting her to come and see nursing in a custody setting.

Ruth spent some time with the Middleton Neighbourhood team and visited a patient in a care home. She described the care delivered as exemplary and was impressed by the breadth of the work undertaken by our neighbourhood teams. Ruth heard about our ambitions in Leeds for more integrated working with primary care colleagues and the current work being undertaken across the city.

Ruth was shown around the Elland Road Custody Suite, seeing how healthcare is delivered in a police custody setting and she was very impressed with this work. She was also impressed that the service takes student nurses particularly as an increase in clinical placement capacity for student nurses is one of her main priorities.

In addition to the visits she made two awards on the night. After discussing with the clinical leads, nominations were agreed and Ruth presented the following awards:

- Gold Chief Nursing Officer Award for lifetime achievement was awarded to June Wilson - senior nurse from the Middleton Neighbourhood Team

- Silver Chief Nursing Officer Award for a great contribution to nursing was given to the Police Custody HCP Team

1.3 NHSI Transitions Collaborative

The Trust has been successful in its application to be part of the NHS Improvement Transitions Collaborative and this commenced on 22 May 2019 with a launch event. This is a rapid improvement approach to transitions between child and adult services. As a Trust we have chosen to focus this work on CAMHS and this will help us embed the learning from the recent serious incident and the subsequent regulation 28 from the coroner. A project team is forming and further updates will be provided as this work progresses.

1.4 Youth Board – first meeting

The Youth Board, which had its first meeting on 7 May 2019, involves young people in developing children's services offered by the Trust. The Youth Board provides young people with an opportunity to take part in projects, give feedback and raise their own suggestions in developing services. Membership is young people who have experienced our services and the age range is up to 19 years of age. It is chaired by a young person with support by a member of staff from the Involvement Team. Visitors, including LCH staff may be invited to take part in workshops or discuss specific topics by prior arrangement.

1.5 Integrated Care System Financial Framework

In common with all the NHS organisations in West Yorkshire and Harrogate the Trust has agreed to be part of the ICS Financial Framework in 2019/20. All ICS's were advised that, as an indicator of their maturity as a system, and in order to access flexible transformation funds (in WY&H's case circa £8.75m) and greater control over their share of national programme transformation funds (circa £15m to £20m), they would need to agree to participate in an ICS Financial Framework. The national framework ties a minimum of 15%, maximum of 100%, of each provider's Provider Sustainability Fund to achievement of the ICS control total which is the aggregate of its providers' control totals . The proposal from the ICS to providers was to agree to the 15% minimum; all providers agreed to that.

For LCH this means that, each quarter, circa £45k of Trust PSF is dependent on the ICS meeting its control total. Any one organisation's under achievement of its control total can be offset by another's overachievement. It is expected that any risk of loss of LCH PSF would manifest itself in quarters 3 and 4 only, meaning a realistic maximum risk of £90k PSF. Of course, if LCH failed to achieve its own quarterly financial plan it would lose all of its PSF, circa £300k per quarter.

1.6 From Blog to Vlog

In addition to my weekly Blog which appears on Community Talk, the Trust's weekly on-line staff newsletter, in May I produced my first Vlog (a Vlog is a form of Blog for which the medium is video, and is a form of web television.). The topic was the Trust's strategy – and I discussed our four strategic goals: Workforce, Care, Partnership and Resources, and what these mean in terms of how we work. Feedback from staff has been good and people have felt a further level of understanding and how the strategy relates to them from watching the Vlogs.

1.7 EU Exit

The Trust has completed risk assessments followed national guidance in preparing for a “no-deal” EU exit. The risk assessments will be reviewed and updated when more is known about the outcome of current negotiations.

1.8 Newton Europe re-audit and new audit

Last year Newton-Europe was commissioned nationally to support fourteen health and social care economies including Leeds in improving flow. This work included a five week deep dive consisting a point of prevalence study of all patients in beds to identify the number who were medically optimised for discharge; a review of 80 patients who had been discharged from hospital analysing whether they had been discharged to the most ideal place after hospital and analysis of a questionnaire on the culture in the system from both a senior leadership and frontline staff perspective.

The findings showed that patients were not always discharged to an ideal and this did not promote their independence. A decision-making workstream, chaired by Julian Hartley was established to improve processes, increase capacity and create an environment where patients were discharged to the right place every time. Much work has taken place and the workstream invited Newton Europe to repeat their audit one year on to highlight the impact of the actions taken. The actual audits took place on 10 and 13 May 2019. Early findings will be reported at the Board meeting

Newton Europe has also been commissioned to undertake a different piece of work over the summer looking at decision-making at the front door. This work aims to identify whether attendance/admission is appropriate and what could have been done either in the immediate past or in the preceding weeks/months to avoid the admission. This work will take place over the summer. The cultural survey will also be repeated

2. Awards, recognition, and celebrations

2.1 Thanks a Bunch awards

In March 2019, our Thanks a Bunch award honoured a very special nurse, Maureen Marshall who celebrated her 50th year of nursing in the NHS. Maureen has been a member of the Integrated Team at the Trust for the past 20 years.

In April 2019, District Nurse Amy Robertson, was award a Thanks a Bunch when she went to great lengths to help a near end of life patient visit her sick father in Harrogate. The patient wasn’t well enough to go in the car with her family, so Amy contacted the Palliative Care Ambulance Team who said they would be happy to take the patient to visit her father and they would even wait and bring her back home whenever she was ready. Due to Amy’s compassionate care, and the support of the Palliative Care Ambulance Team, the patient got to fulfil one of her very last wishes. Amy’s quick thinking also enabled loved ones to say a very important good bye.

2.2 … and speaking of Thanks a Bunch awards

Our Communications Team has won a communications and engagement award run across private and public sector in the Best Event category for the Trust's 'Thanks a Bunch' and 'Thank You Event'. The nationally held Internal Communications & Engagement Awards highlights the impact internal communications has on a business, the role of the internal communicator within an organisation and the creative strategies developed to promote an engaged workforce.

2.3 New Queen's Nurses

The Trust has three new Queen's Nurses, the title of 'Queen's Nurse' (QN) is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. Our new Queen's Nurses are Louise Elwen, ICAN Community Nurse, Sharon Underwood, Health Visitor ICAN and Nikki Stubbs, Interim Professional Lead for Nursing QPD and Clinical Project Lead-Integrated wound care project. Well done to all three.

2.4 Specialist Services annual celebration event

On Wednesday 1 May our Specialist Services held their annual celebration event.
The theme of the day was Showcasing New Ways of Working and included presentation from teams about innovations in practice.
Highlights included a game of Play Your Cards Right with HMYOI Wetherby and Adel Beck Young People's Secure Estates, a lively singalong with the Giving Voice Choir who received a standing ovation, and speed dating (an opportunity to get to know each other).

2.5 HENRY (Health Eating and Nutrition for the Really Young) is nationally recognised.

Our 0-19 Family Health Workers and 0-19 Healthcare Support workers deliver a range of HENRY programmes for parents and young children in community settings to support families to adopt a healthier lifestyle. HENRY is Health Eating and Nutrition for the Really Young. This has recently received national recognition when it was reported that Leeds appears to be bucking the trend in child obesity with reported rates among four and five year olds declining since 2009.

3. National news

3.1 New agreement between CQC and the Healthcare Safety Investigation Branch (HSIB)

The Care Quality Commission (CQC) and the Healthcare Safety Investigation Branch (HSIB) have signed a Memorandum of Understanding setting out how they will work together to promote the safety and wellbeing of people receiving NHS care in England. The agreement confirms that the bodies will share information about the safety and quality of NHS services and evidence of safety risks or emerging themes that may indicate wider safety issues. They will also cooperate on national safety reviews and work together in the public interest to support improvements.

4. Recommendations

4.1 The Board is recommended to:

- Note the contents of this report

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AGENDA ITEM 2019-20 (12i)

Report to: Trust Board 24 May 2019
Report title: Business Committee 24 April 2019: 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 April 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

EPR project update
The Committee received a presentation and supporting documentation which provided details of the benefits realisation of the EPR project. The Committee was advised that the neighbourhoods' implementation team had identified a number of expected outcomes and had recently collated evidence to demonstrate how and to what extent each outcome had been achieved. The Committee recognised that in some cases it was difficult to establish whether improvements in the service were solely as a direct result of EPR. It was agreed that staff utilising EPR did improve the quality of patient care and reduced the risk of information governance issues. The Committee suggested that more quantitative benefits should be established in future projects, which would mean that success would be easier to measure. The Committee was advised that staff views had been collected in surveys in 2017 and again in 2019 and that there had been a more positive response to a number of questions in the 2019 survey. The Committee recognised that this evaluation of the project was ongoing and was keen that patients' views should also be taken into consideration in the next report to the Committee.

Business Development Strategy update
The Head of Business Development provided the Committee with a progress report on the Business Development Strategy 2017-20. The Committee was advised that 2018/19 had been a successful year for the Trust, with £13.55m of existing income protected and retained, and nearly £5m of additional income generated through bids and business cases. The Committee was also provided with an update on the current IAPT bid. The Head of Business Development advised the Committee that the current strategy is in its final year and requested that the Committee support the development on the new strategy. The Committee agreed that the report was an excellent paper and provided it with substantial assurance.

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

Performance Brief
The Committee reviewed the March 2019 performance data and noted that sickness absence had improved and queried whether this was because of a managed approach or a seasonal variation. It was advised that in areas where managers were proactive in their approach, improvements were noticeable. Staff retention rates were another area of improvement.

Appraisal rates were one area of reduced compliance. The Committee received a document from the Workforce Directorate proposing a reduction in the appraisal rates compliance target from 95% to 90%. Reasons for this proposal were benchmarking data indicated that the Trust appraisal rate was higher than most comparator community/mental health trusts and its performance was higher than several. The Committee discussed the need to improve the consistency and accuracy of data, as there appears to be a disparity between reported data and what staff had said about their compliance levels. The Committee requested that more work should be carried out to ensure ESR is reporting accurate data rather than adjusting the target percentage at this time.

The Committee also received a report which triangulated and analysed neighbourhood teams service quality, staffing and finance data which provided the Committee with additional insight.

Workforce quarterly report including WRES action plan

The quarterly workforce report provided an update on the delivery of the 6 priorities in the workforce strategy 20119-21. The Committee was advised that the new Leadership Development programme had excellent evaluation and there had been citywide interest in its take-up, including interest expressed by the GP Confederation. Staff survey responses indicated that staff engagement had improved in five out of the nine associated measures. The Committee recognised that Diversity and Inclusion was moving forwards at a good pace, with the Race for Equality event held in March 2019, the reverse mentoring scheme and the appointment of a disability project officer. The report provided the Committee with reasonable assurance.

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

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AGENDA ITEM 2019-20 (12ii)

Report to: Trust Board (circulated by email)
Report title: Audit Committee 26 April 2019: 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 26 April 2019.

Internal audit

The Committee noted completion of all but one internal audit in the 2018/19 internal audit plan, with the final audit in draft, awaiting manager's comments. Recently completed internal audits presented at the meeting included: estates management of healthcare centres, and arrangements for bank and agency staff, both of which concluded reasonable assurance.

The Head of Internal Audit reported that their annual opinion was one of reasonable assurance given that there were adequate and effective risk management and internal control processes to manage the achievement of the Trust's objectives. The conclusion was based on the current findings including those audits recently completed and the audit still in draft.

The Committee reviewed and approved the annual internal audit plan for the coming year (2019/20), subject to the request to try and reschedule some audits into the first half of the year.

Annual report and accounts 2018/19

The Committee were advised of the Trust's progress with the finalisation of the Trust's annual report, accounts and associated activities. All activities were proceeding to schedule.

Board sub-committees' annual reports 2018/19

The Committee's draft annual report was received and some amendments were suggested to bring the report up to date with the end of year activities. The Committees terms of reference were reviewed, and it was agreed that no changes needed to be made.

The Committee also received the annual reports of the Board's other sub-committees as part of the Committee's role in reviewing the effectiveness of governance. The annual reports were noted and recommended for submission to the Board for approval.

Counter fraud annual work plan and self-review toolkit

The Committee reviewed and agreed the counter fraud annual work plan.

The Committee reviewed the counter fraud self-review tool, which was to be submitted to the NHS Counter Fraud Authority, following agreement from the Audit Committee Chair and the Executive Director of Finance and Resources. The organisation will declare compliance with 22 of the standards and partial compliance with standard 2.2 which concerns there being evidence of contact with the counter fraud specialist as a result of awareness of the policy; this would require testing as evidence in order to declare full compliance. The Audit Committee agreed that the self-assessment was accurate and approved submission.

Partnership Governance Standards

As part of the internal audit programme 2018-19, Internal Audit reviewed some of the Trust's partnerships and recommended that governance arrangements should be discussed and agreed before the commencement of partnership working. The Audit Committee requested that the Company Secretary and Executive Director of Finance and Resources draft a set of governance standards for partnership working, which were to be applied to existing and future arrangements with consideration being given to scale and complexity of each partnership arrangement. The draft proposed standards, and their rationale, were presented to the Committee for discussion and comment.

The Committee agreed that the initial draft was a good start, and asked for a number of refinements to be made including an indication of the stage in contract development and agreement when the standards should be introduced and applied, some indication of which standards would apply depending on partnership complexity, and some additional information included in the quality governance standard concerning patient experience.

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AGENDA ITEM 2019-20 (12iii)

Report to: Trust Board (circulated by email)
Report title: Quality Committee (workshop) 29 April 2019: 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 29 April 2019 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 April 2019 Quality Committee meeting was a focussed workshop with subjects on patient and family engagement in the Children's Business Unit and on the work of the Clinical Education Team.

Workshop session one: Children's Business Unit (CBU) Patient and Family Engagement

The Committee invited representatives from CBU to provide it with details of the various means CBU uses to engage with patients and families connected with its services. Strategic objective 3 in the Children's Strategy is that 'Children and young people will have a positive experience of our services'. The CBU involvement lead explained how the feedback loop was being widened to not just ask for feedback, but to provide opportunities at the same time for families to ask further questions and then to respond to these. The Committee heard about the Little Woodhouse Hall parents' group which had been running for seven months and that there were plans to replicate this at Hannah House and in the infant mental health service. An example of an animation that had been developed in partnership and after discussion with families was shown to the Committee and an example of an FFT form redesigned by a young patient in CAMHS was circulated. A recording was played of an ICAN patient's mum who described her experience of the service and asked for the Trust to consider how it could assist siblings of children with additional needs. The Committee was updated with progress in setting up a 'Youth Board' with participants from across the CBU taking part. The importance of the Committee having direct involvement with the evolving Youth Board was recognised and members of the Committee would attend their meeting in the autumn rather than the young people coming to the Committee meeting. The Committee provided its thoughts on how the Trust could engage with children, young people and families more successfully and on how the Trust could use digital developments to improve engagement.

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

Workshop session two: Clinical Education Team

The Clinical Education team provided the Committee with an overview of activities the team is involved in, including the preceptorship programme, apprenticeships, mentoring, care certificates, and clinical skills training. The Committee heard how the preceptorship programme had achieved a retention rate of 97% for nursing staff who started in 2018/19. The Committee explored the challenges associated with the various apprenticeship schemes the Trust is involved in and issues relating to capacity to release staff to complete the apprenticeships and capacity to provide supervision. It heard about the new NMC standards to be introduced and how these could further affect capacity in the short term. The possibility of a flexible, city-wide approach was discussed as well as consideration of how the Trust could retain staff that it does offer to invest in. The Committee saw the importance of these programmes to our future workforce

capacity, and the need for Quality Committee to receive assurance about progress with quality related issues in addition to reports to Business Committee. This will be helped by HR Directors attending some Quality Committee meetings in future.

Performance brief and domain reports
The Committee reviewed the Performance Brief and noted that there had been two avoidable category 4 pressure ulcer incidents in February 2019. Contributory factors for one of these were the number of rescheduled visits to the patient because of capacity issues, and the changes in team leadership. The Committee asked about the 'Silver Command' approach, which aimed to direct available resource to where capacity was reduced and requested confirmation that this team had been supported by this approach.

Update on Risk 957: Increase in demand for the Adult Speech and Language Therapy Service
The Committee had been advised of a new risk on the risk register at its meeting in January 2019. The Committee had not been assured of the controls in place to manage the risk at that meeting and requested further information. An update was provided at the February 2019 Committee meeting that the service use an evidence-based triage tool and work has been done to ensure that people referred to the service were given a letter, copied to their GP, which advised them of the signs to look out for that would indicate a need for a more urgent appointment. The Committee learned that an incident had occurred within the service: a patient's swallowing issues had been triaged as low risk, however the patient's condition deteriorated and this was not picked up, despite the advice letter being sent, by the care home, GP practice or hospital, all of which the patient had recent contact with. The Committee asked for the risk mitigation and in particularly the advice letter to be reviewed and then for a further update to be provided to the Committee.

Serious incident: Coroner's report
The Committee received an update on the case of a death of a patient, recently reviewed at coroner's court. The Committee was advised that a regulation 28 'learning from deaths' letter had been issued to the Trust and to LYPFT. A 'joint' response was being sent to the coroner from both Trusts. The Committee was advised that the Trust's action plan, which was already in existence prior to receipt of the coroner's letter, does align with the directives given by the coroner. The action plan is to be presented at the July 2019 Committee meeting for assurance.

Quality Account
The Committee reviewed the draft Quality Account report 2018/19 for factual accuracy, and to consider whether there were any further areas of activity that needed including. The Committee commented that the report provided an upbeat message – however it agreed that the report didn't sufficiently cover the areas where the Trust needed to improve upon, particularly where the Trust's priorities for 2018/19 had not been met. A small group is to review the amended Quality Account outside of the Committee meeting and agree the revised version prior to it being received by the Board at the end of May 2019.

2019/20 KPI's approved
The proposed key performance indicators for the Safe, Caring and Effective domains of the 2019/20 Performance Brief were reviewed by the Committee and approved with a few amendments and additions to be made. The Committee noted that the Caring and Effective domains did not have many indicators and that the Caring domain in particular was difficult to measure. Some suggestions were made, to be followed up with the Business Intelligence Team.

Leeds Community Healthcare NHS Trust

Agenda 2019/20 Item (13a)

Meeting: Trust Board, 24 May 2019	**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, 15 May 2019 Quality Committee, 20 May 2019 Business Committee, 22 May 2019	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during April 2019

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

This month's Performance Brief contains the most up to date information available for the first month of the financial year.

Overall performance remained good in April.

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

Recommendations
The Committee is recommended to:

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

Performance Brief – April 2019

Leeds Community Healthcare NHS Trust

Purpose of the report

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

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

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.

It provides a focus on key performance areas that are of current concern to the Trust.

It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

Committee Dates
Senior Management Team – 15th May 2019
Quality Committee – 20th May 2019
Business Committee – 22nd May 2019
Trust Board – 24th May 2019

Recommendations

Committees and the Board are recommended to:

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

Main issues for Consideration

This month's Performance Brief contains the most up to date information available for the month of April 2019.

Overall performance remained good in April.

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

In the Safe and Caring domains the key issue to note is the reported increase in Category 3 pressure ulcers; all have been fully investigated and validated to ascertain if they were avoidable to LCH. At the beginning of the year a target of 7 Avoidable Category 3 pressure ulcers was set and 0 category 4 pressure ulcers. There were 0 Category 4 pressure ulcers reported in April. There were no identified trends noted. 2 Category 3 pressure ulcers were recorded in April. Themes are identified as part of the investigation process and similar themes continue to be noted. Themes emerging from all the Serious Incident investigation reports completed in April identify communication with teams, patients or others and documentation as most common.

There was deterioration in the percentage of patients, 81.8%, recommending inpatient care against a target of 95.0%. This is of concern to the Trust. The deterioration may in part be explained by a significant increase in responses for April. On review this is related to the Community Neurology Inpatient Unit, who usually receives one to two responses in a month but within April received 10. There is no real explanation for the increase in the response rate at this current time. There is equally no explanation for the deterioration in the percentage of patients recommending care and whilst it would appear this only represents 2 patients it is something the Clinical Governance Team are following up with the service in order to try and establish why they would not recommend care on the unit as we need to understand this in order to be able to do something about it.

The measures in the **Effective** domain are reported quarterly and will first appear in the June Performance Brief, presented in July.

In the **Responsive** domain, patient contacts are in line with profile. All measures are reported as green, achieving the target. There are 0 patients waiting more than 52 weeks for a consultant led service. In April, 97.5% of patients were waiting under 18 weeks for our non-consultant led services, which is above the target of 95.0% This measure is always above target but on closer inspection is actually a deteriorating picture since August 2018, or 9 data points below the median. As was the case for the last 7 months, 100.0% of patients were waiting under 6 weeks for a diagnostic test

At the end of the first month of 2019/20, the **Well Led** measures are very positive in a number of areas, whilst appraisals remain an area requiring ongoing focus and support.

Turnover has dropped from 13.9% at the end of March 2019 to 13.3% at the end of April 2019, a continuation of successful retention at LCH.

At 81.1% at the end of April 2019, appraisal figures have not shown the upturn expected as a result of support already put into place. Details of the additional support now being put into place are in the main body of the report.

Sickness absence is lower than in any month in either 2018/19 or 2017/18, at 4.8%. This may be linked to the combined impact of Health & Wellbeing initiatives and effective support for staff within services.

In the **Finance** domain, at the end of April the Trust is £0.2m overspent. Of this £121k relates to pay and reserves for the month are overcommitted by £16k. The overall position includes the PSF allocation as the assumption is that the Trust will deliver the control total as the year progresses and will therefore be able to claim this funding from NHS Improvement. If April was typical in terms of budget overspends, the Trust would need to take action to reduce spending by £2m to meet the control total by the end of the financial year.

Agency staffing expenditure is 28% under the cap set by NHS Improvement.

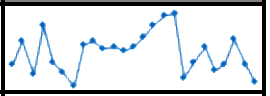
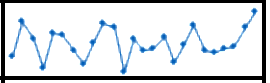
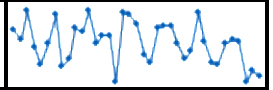
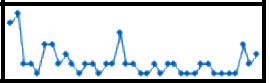
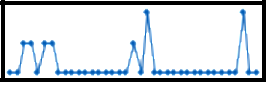
There are a net 79 WTE vacancies this month, 40 of these are in the Adult BU, 40 in Corporate and Estates Directorates and 7 in the Specialist BU.

The Trust's cash position remains very strong at £26.8m; this is marginally more than was planned.

Safe – April 2019

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

Leeds Community Healthcare NHS Trust

Safe - people are protected from abuse and avoidable harm	Financial Year	Target	YTD	Apr	May	Jun	Q1	Forecast	Monthly Time Series
Overall Safe Staffing Fill Rate - Inpatients	2019/20	>=97%	-	94.7%				●	
	2018/19		-	99.7%	101.0%	102.4%	101.0%		
Patient Safety Incidents Reported in Month Reported as Harmful	2019/20	0.56 to 1.11	1.10	1.10				●	
	2018/19		0.90	0.91	0.83	0.85	0.86		
Serious Incident Rate	2019/20	0 to 0.1	0.02	0.01				●	
	2018/19		0.05	0.05	0.03	0.04	0.04		
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	2019/20	7		2				●	
	2018/19		7	1	0	0	1		
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	2019/20	0		0				●	
	2018/19		2	0	0	0	0		

All Incidents – Comparison of two years data

This month 619 incidents were reported in Datix. This is higher than any monthly figure reported in 2018/19. Analysis shows that there was a 12% increase in the adult business unit and although figures are smaller by comparison, a 23% increase in the specialist business unit. When viewed by team breakdown there were small fluctuations across many Specialist business unit services, however a larger than expected reporting rise was seen in both IAPT and Community Neuro rehab. A reduction was seen in children's business unit reporting.

A review of the Adult business unit reporting showed more reporting than seen in previous months by 3 neighbourhood teams. It is possible that the focus on the Quality Boards, clearer definition of falls reporting and the new categories for reporting various skin damage incidents may be factors in these rises.

In April 154 (25%) of all patient incidents originated from other providers which are comparable to previous months.

There was 65 staff incidents reported in the month. 75% were reported as no harm. There were 3 moderate harm incidents and no major harms reported. The 3 moderate harm incidents were in connection with an onset of back pain; a patient was transferring and started to fall and grabbed the member of staff. A member of staff was attacked by a detained person at Huddersfield custody suite and a member of staff fell whilst getting out of a car resulting in a fractured elbow.

Patient Safety Incidents (LCH only)

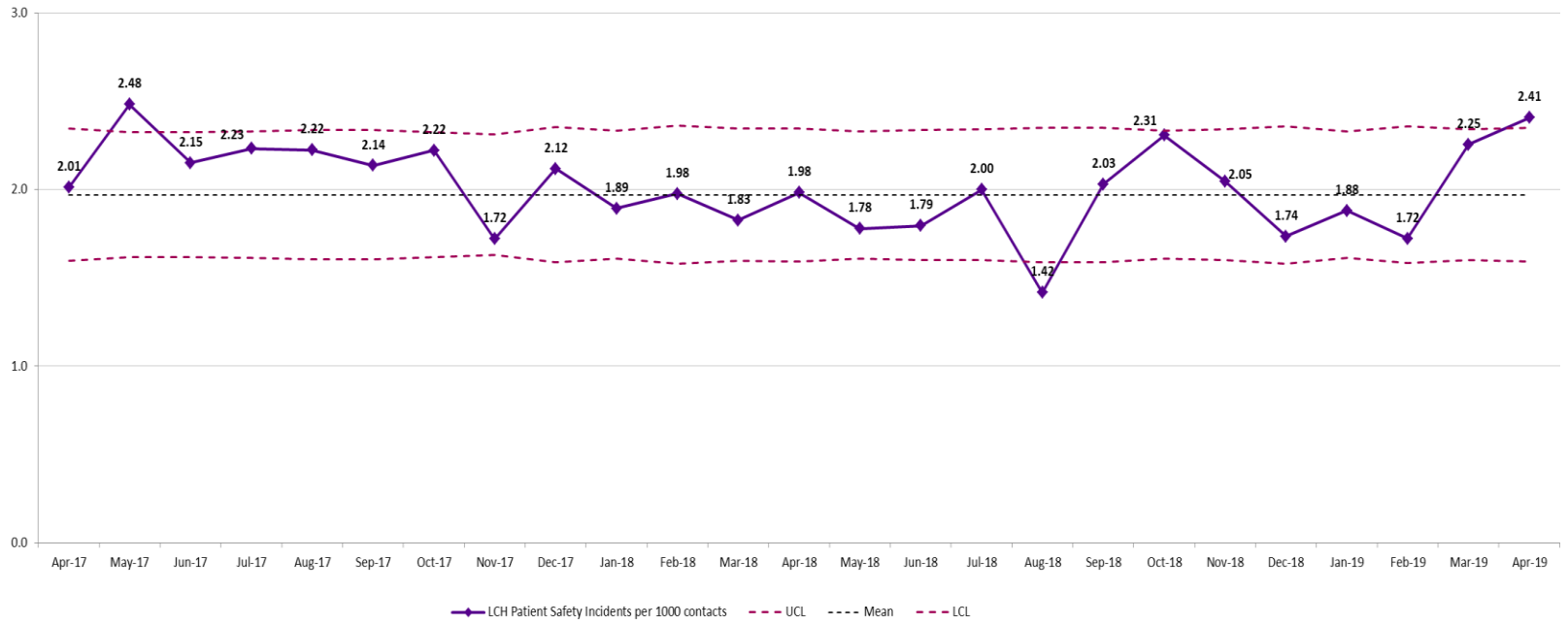
There were a total of 299 LCH PSIs reported in April 2019, this figure is higher than the average over the past 12 months but within the normal variance. Based on the average figures broken down by incident severity, the reporting increase is seen across all incident severities.

Broken down by business unit shows it shows a rise in reporting in all business units; although smaller numbers the most significant is within the Specialist services, with the community neuro rehab team and the sexual health service. Analysis of the incidents in neurorehab, show a similar number of falls reports as previous months but a small rise across a number of other categories; the rise within the sexual health service shows a similar trend.

By incident sub-category, the largest increase against the 2018/19 averages were seen in the following top 5 areas

	Apr 2019	2018/19 average
Self-harm during 24-hour care	11	4.9
Treatment, procedure - other	10	5.0
Administration or supply of a medicine	36	32.0
Discharge	7	3.3
Administration of assessment	4	0.3

The LCH PSI's per 1000 contacts SPC shows an upturn in reporting against contacts in April, bringing the figure back towards the mean.



Incidents causing harm (LCH only)

290 LCH patient safety incidents were reported, 137 (47%) of these caused harm to patients and 15% were of moderate harm and 3% recorded as major harm. These figures are not validated at this stage and the majority will still be in the investigation process.

LCH Patient Safety Incidents by Degree of Harm

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
No injury sustained	116	108	135	78	126	161	146	107	142	88	148	153
Minimal Harm	75	70	83	58	67	84	66	55	65	58	88	85
Moderate Harm	33	37	31	26	30	49	33	36	45	36	38	42
Major Harm	6	4	5	8	9	2	8	4	6	8	9	10
Total	230	219	254	170	232	296	253	202	258	190	283	290
Ratio: (moderate/major incidents : minimal/no harm incidents for LCH Patient Safety Incidents)	1:4.9	1:4.3	1:6.1	1:4	1:4.9	1:4.8	1:5.2	1:4.1	1:4.1	1:3.3	1:5	1:4.6

Moderate & Major Harm Incidents

There have been a total of 10 Major harm incidents reported in April, 7 of these were falls; 6 resulting in neck of femur fractures and 1 fractured clavicle

There were 2 category 4 pressure ulcers reported. There is no outcome of the 72 hour reviews at time of report writing therefore these could be unavoidable to LCH.

The final major harm was in relation to implementation of care; this is reporting the deterioration of a patient by LCH staff who were visiting daily and reporting findings to both the GP and the hospital; there appears to have been a 7 day delay in diagnosing a clot, however, this is currently being reviewed and it is likely to be shared with LTHT for them to investigate further.

No Harm incidents

This month no harm incidents have risen to 153 which is not dis-similar to the fixed figures for March (post re-checking of patient safety status and levels of harm reported) and represent 51% of all LCH Patient Safety incidents reported in the month.

Overdue Incidents

Whilst there are still overdue incidents there is a decrease on previous months, this appears to be as a result of a continued focus on this in the adult business unit where the majority of overdue incidents are. This focus will continue to ensure the number of overdue incidents continues to fall. The reason they are overdue is due to the fact that they haven't been closed rather than not being investigated. The majority of incidents classed as overdue for closure are no harm/low harm. Automatic Datix reminders go out to the service every week, in addition the Clinical Governance Team sends out a reminder every Wednesday.

Lessons from these reports are being collated and will be disseminated imminently.

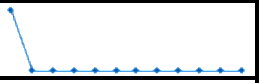
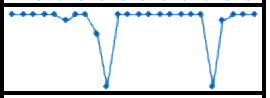
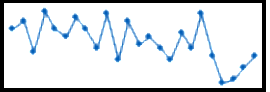
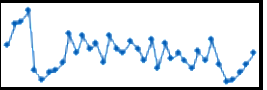
Duty of Candour

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

Caring – April 2019

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

Leeds Community Healthcare NHS Trust

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Financial Year	Target	YTD	April	May	June	Q1	Forecast	Monthly Time Series
Percentage of Respondents Recommending Care - Inpatient and Community (FFT)	2019/20	>=95%		96.8%				●	
	2018/19		-	-	-	-	-		
Percentage of Respondents Recommending Inpatient Care (FFT)	2019/20	>=95%		81.8%				●	
	2018/19		-	100.0%	100.0%	75.0%	91.7%		
Percentage of Respondents Recommending Community Care (FFT)	2019/20	>=95%		96.9%				●	
	2018/19		-	95.6%	96.5%	95.5%	95.9%		
Total Number of Formal Complaints Received	2019/20	<175		16				●	
	2018/19		144	14	16	13	43		
Number of Formal Complaints Upheld	2019/20	<175	5	5				●	
	2018/19		-	-	-	-	-		
Number of Formal Complaints Responded to within timeframe	2019/20	<175	11	11				●	
	2018/19		-	-	-	-	-		
Number of Compliments Received	2019/20	No Target	132	132				●	
	2018/19		-	-	-	-	-		

Friends and Family Test (FFT)

There are noted changes within the FFT requirements for 2019/20 where we will be able to have a more targeted approach to FFT. The Patient Engagement and Experience Team will review the new guidance and work with services to identify key areas of focus for the FFT.

Overall, 96.81% of Community patients would recommend the service to family and friends. Within inpatients, 81.82% would recommend. As stated earlier this deterioration in recommending care in the Community Neurology Inpatient Unit is of concern and is being investigated further. A further breakdown of this is provided below, by business unit.

	Number of responses received	% of which recommended	% of which would not recommend	Number of comments received	Overall response rate
ABU Services	238	93.28%	2.52%	181	5.65%
CBU Services	339	99.41%	0%	474	4.65%
CBU Inpatients	1	100%	0%	2	100%
SBU Services	677	96.75%	2.07%	702	6.43%
SBU Inpatients	10	80%	20%	7	62.5%

Complaints, Concerns, PALS and Claims

The table below highlights the number of complaints and concerns that have been received by the Patient Experience and Engagement team.

Feedback	April 2019 Received	Notable trends
Complaints	17	Any notable themes from the complaints received have been addressed in the Thematic Patient Experience Report.
Concerns	27	
Clinical Claims	0	
Non-clinical Claims	0	

In the month of April, the Patient Experience and Engagement team received notification of two claim settlements.

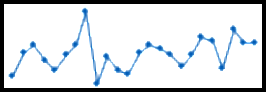
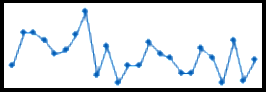
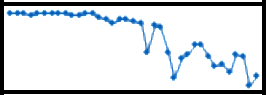
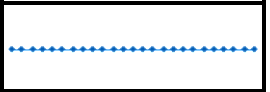
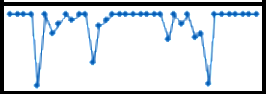
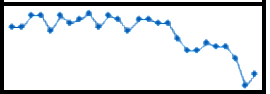
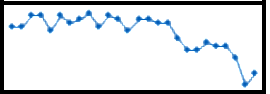
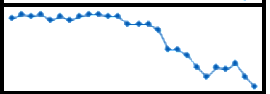
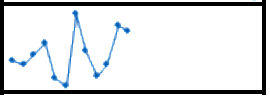
The table below is a review of the number of received and closed complaints in April.

Key Performance Indicators and Developments	Status
Acknowledged within 3 days	100% Compliance
Responded to within 180 days	100% Compliance (closed complaints)
Active PET Caseload	33 open complaints, 9 open concerns
PHSO requests	1

Responsive – April 2019

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

Leeds Community Healthcare NHS Trust

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Financial Year	Target	YTD	April	May	June	Q1	Forecast	Monthly Time Series
Patient Contacts - Variance from Profile	*2019/20*	0 to ± 5%		**-4.7%**				●	
	2018/19			**-4.4%**	**-1.7%**	**-3.0%**	**-3.0%**		
Patient Contacts	*2019/20*			124,229				●	
	2018/19			125,132	136,631	130,931	392,694		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	*2019/20*	>=92%	-	**96.2%**				●	
	2018/19		-	96.1%	97.2%	97.5%	97.0%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	*2019/20*	0		**0**				●	
	2018/19			0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	*2019/20*	>=99%	-	**100.0%**				●	
	2018/19		-	100.0%	99.1%	100.0%	99.7%		
% Patients waiting under 18 weeks (non reportable)	*2019/20*	>=95%	-	**97.5%**				●	
	2018/19		-	98.9%	98.9%	98.8%	98.9%		
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	*2019/20*	>=95%	-	**100.0%**				●	
	2018/19		-	99.2%	99.2%	99.6%	98.9%		
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	*2019/20*	>=75%	-	**61.6%**				●	
	2018/19		-	92.2%	91.4%	88.9%	98.9%		
IAPT - Percentage of people who complete treatment and recover	*2019/20*	50%	-	**51.5%**				●	
	2018/19		51.0%	49.7%	49.2%	50.7%	49.9%		

Statutory Breaches and Waiting Lists

The Trust is currently performing well against the nationally set target of 92% of patients treated within 18-weeks of referral for Consultant-led services. April performance was 96.2% and this is consistent with performance over the last year. Within this there are a number of hotspots where breaches do occur; however numbers are small and at the end of April 2019, 51 patients had waited more than 18 weeks for treatment in consultant-led services. Breaches occur most often because the appointment is cancelled either by the patient or the service and there is insufficient time to re-schedule within the 18-week window. An aim of the ICAN transformation project is to bring forward the earliest appointment time to 12 weeks. This will ensure that there is time to rebook any cancelled appointments within the 18 week window.

The Audiology service routinely meets the 6-week wait standard for diagnostic tests

There are several national targets applied to the Improving Access to Psychological Therapies (IAPT) service. Performance has dipped in terms of 75% waiting less than 6 weeks to access the service. April's performance was 61.6%. The service has an improvement plan in place. This has been agreed with commissioners as the delay is a direct result of increasing the numbers accessing the service. There is an overarching expectation that 95% of patients are seen within 18 weeks and the service routinely meets this standard. The recovery rate has slightly dipped below 50% this month. The service is not reporting any concerns with this and expects the standard to be met going forward

In addition to the national standards the Trust works to an internal target of 95% of all non-Consultant-led referrals being seen within 18 weeks (to mirror the national target). The Trust routinely meets this standard.

Childrens' Business Unit

ICAN preschool autism (National reportable RTT wait)
33 waiting 18+ weeks (as of 1st April) - Longest projected wait is 34.6 weeks. All have an appointment booked and a recovery plan remains in place.

ICAN Community Paediatric Clinic and Paediatric Neurodisability (National reportable RTT wait)

- PND – 6 children waited more than 18 weeks over March (5 of which were cancelled by patient and not sufficient time to rebook)
- CPC – 6 children waited more than 18 weeks over March (2 of which were cancelled by patient)
    - Initial Health Needs Assessments (IHNAs) for children who become looked after - 54% had appointments within the 28 day timescale None of the breaches were due to an appointment not being available i.e. patient declined or did not attend. Improved escalation plan in place which means IHNAs are not breaching due to appointments not being available. Also improved wait times for Rapid Access Clinic (now 2 – 4 weeks which was previously 5-6 weeks).

- When children in the CAMHS service are referred for assessment for autistic spectrum disorders they are also referred to PND to rule out any medical conditions. These children were previously included in the reportable waiting figures. After taking advice these children have been removed from the reportable list as the intervention by CAMHS to refer them to PND stops the clock. However they continue to be monitored internally to ensure their treatment is timely

SLT - 146 waiting 18+ wks (as of 1st April):
133 children waiting over 18 weeks on mainstream waiting list and a large number waiting 12-18 weeks that are risk of breaching 18 week wait. This is a worsening position from last month. Required additional administrative support is being sought.

CAMHS Next Steps waits:
The average wait for a Next Steps routine appointment is now 8.8 weeks, a demonstrable improvement on 16.5 weeks at the end of February. There are 18 children waiting over 12 weeks, due to patient choice, cancellations etc. The longest wait is 26 weeks and this does relate to patient choice.

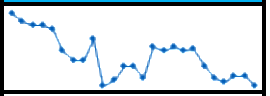
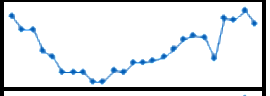
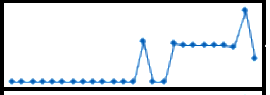
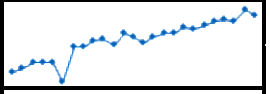
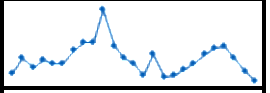
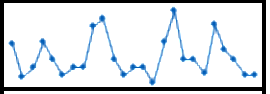
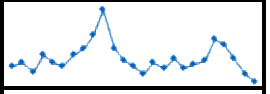
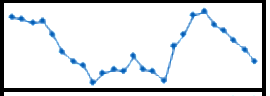
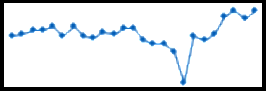
CAMHS Neurodevelopmental Pathway (1st Apr):
The wait for children entering CAMHS and being immediately directed to the Neurodevelopmental pathway (autistic spectrum disorders) is 12.7 weeks. This reflects a change of pathway where previously children would need to be seen at a Next Steps appointment before being added to an internal waiting list for an autistic spectrum disorder assessment. There are 159 children waiting over 12 weeks.

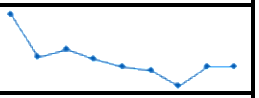
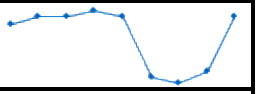
Mindmate SPA
Ongoing issues regard demand and capacity at Mindmate SPA and introduction of online self-referral and queries. Impact on triage time (now up to 7 weeks). A recovery plan is in place.

Well-Led – April 2019

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

Leeds Community Healthcare NHS Trust

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Financial Year	Target	YTD	April	May	June	Q1	Forecast	2 Yr Monthly Time Series
Staff Turnover	2019/20	<=14.5%	-	13.3%				●	
	2018/19		-	13.9%	13.6%	14.6%	14.0%		
Reduce the number of staff leaving the organisation within 12 months	2019/20	<=20.0%	-	16.8%				●	
	2018/19		-	13.0%	13.0%	13.2%	13.1%		
Executive Team Turnover	2019/20	<=14.5%	-	3.8%				●	
	2018/19		-	0.0%	6.7%	0.0%	2.2%		
Stability Index	2019/20	>=85%	-	87.0%				●	
	2018/19		-	85.6%	85.2%	85.6%	85.5%		
Short term sickness absence rate (%)	2019/20	<2.2%	-	1.4%				●	
	2018/19		-	1.9%	1.6%	2.2%	1.9%		
Long term sickness absence rate (%)	2019/20	<3.6%	-	3.4%				●	
	2018/19		-	3.5%	3.5%	3.3%	3.5%		
Total sickness absence rate (Monthly) (%)	2019/20	<5.8%	-	4.8%				●	
	2018/19		-	5.4%	5.1%	5.5%	5.3%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2019/20	>=95%	-	81.1%				●	
	2018/19		-	81.9%	80.2%	79.9%	80.7%		
6 universal Statutory and Mandatory training requirements	2019/20	>=95%	-	93.5%				●	
	2018/19		-	91.4%	89.9%	89.6%	90.3%		

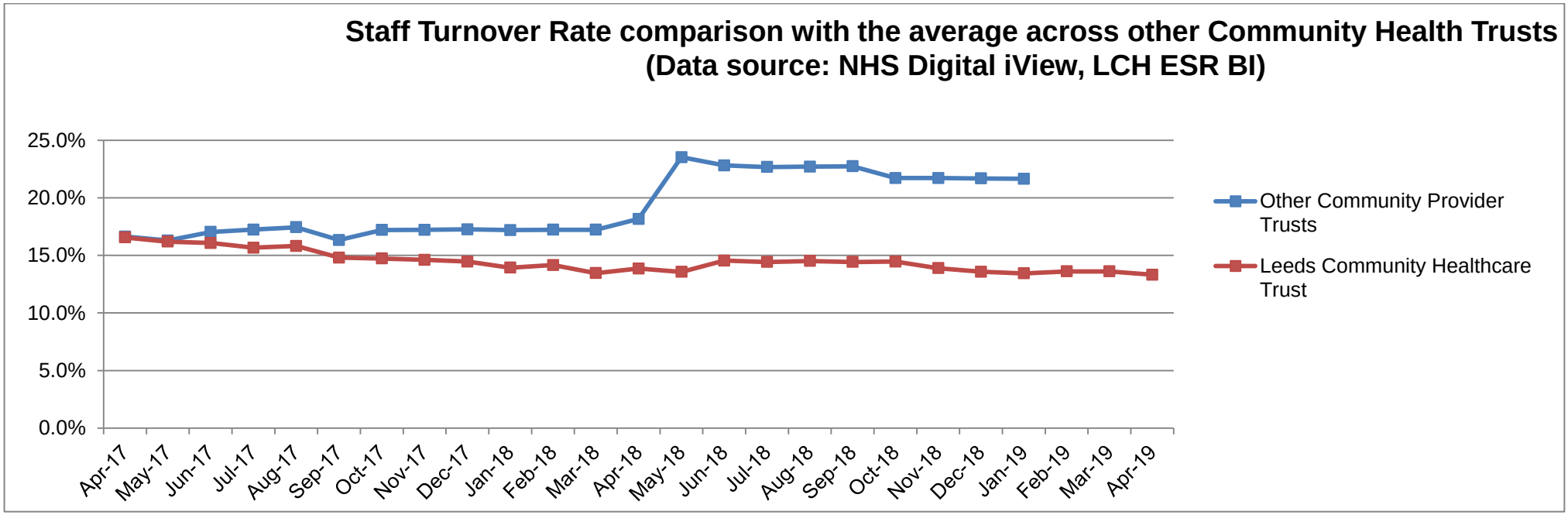
Medical staff appraisal rate (%)	2019/20	100%	-					●	
	2018/19		-	100.0%			100.0%		
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2019/20	>52.0%	-					●	
	2018/19		-	63.0%			63.0%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2019/20	>52.0%	-					●	
	2018/19		-	64.0%			64.0%		
Response Rate for Staff FFT	2019/20	>22.0%	-					●	
	2018/19		-	24.0%			24.0%		
WRES indicator 1 - Percentage of BME staff in the overall workforce	2019/20	No Target	-	9.6%					
	2018/19		-						
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2019/20	No Target	-	3.2%					
	2018/19		-						
Total agency cap	2019/20	£545k	£545k	**£392k**				●	
	2018/19		£6,410k	£438k	£417k	£549k	£1,403k		
Percentage Spend on Temporary Staff	2019/20	No Target	6.1%	6.1%				●	
	2018/19		6.8%	7.1%	7.5%	8.8%	7.8%		

Retention

The overall trend continues to be positive with turnover continuing to reduce. Turnover is reporting at 13.3% which is below the 2019/20 outturn target of 14.5%. The stability rate is 87% which is above the target of 85%.

Staff leaving within the first 12 months of employment remains well below a target of 20% at 16.8%, and has reduced since last month.

The Trust continues to benchmark favourably against its Community Trust peers, as shown in the graph below:-



Work to improve our health and wellbeing offer, approach to talent management, leadership and management development, staff engagement and a number of specific recruitment and retention initiatives should further support an increase in stability levels and turnover rates during 2019/20.

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

Health and Wellbeing (HWB)

The sickness absence rate has continued on a downward trend and is now reporting 4.8% (this consists of 1.4% short term and 3.4% long term). This is below the Trust target of 5.8%.

This is the first monthly instance of a sub-5% organisational sickness absence level for over 2 years. Whilst this is not in itself of statistical significance, and further monitoring is required, it does correlate with the organisation's work on health and wellbeing, particularly on Mental Health; and with the broader cultural move towards #justandfairculture and #peoplebeforeprocess.

Linked to the above, the HWB Engagement Group and HWB Steering Group have both met during April and the key points from these groups are as follows:-

- HWB Action plan refined and submitted to NHSi as part of the HWB Programme
- During Equality, Diversity and Human Rights week (13-20 May) – there will be a personal staff story around mental health, with signposting to effective use of a Wellness Action plan to support staffs mental wellbeing in the workplace .
- Launch of the provision of trained Mental Health First Aiders as a point of contact for staff experiencing a mental health issue or emotional distress. This interaction could range from having an initial conversation through to supporting the person to get appropriate help.
- Training for Managers on the Equality Act 2010 and Reasonable Adjustments has commenced

Appraisal Rates

The overall Appraisal Rate continues on a downward trend, currently standing at **81.1%,** although there have been some improvements within the Specialist Business Unit and Corporate Directorate this month.

AfC Staff Appraisal Rate (12 Month Rolling - %)

Imp Traj to 95%	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
833 Overall	83.3%	84.9%	87.5%	88.2%	86.3%	85.4%	84.2%	82.9%	81.1%
833 Adult Business unit	82.1%	86.3%	90.7%	93.3%	90.6%	89.2%	88.2%	86.1%	80.8%
833 Children's Business Unit	83.4%	84.4%	84.3%	82.6%	79.9%	80.4%	79.9%	78.5%	77.9%
833 Corporate Directorate	81.6%	84.2%	85.1%	83.2%	77.9%	85.2%	83.2%	78.3%	79.3%
833 Operations	89.2%	88.0%	90.5%	89.0%	88.9%	88.9%	90.6%	89.2%	86.8%
833 Specialist Business Unit	84.3%	82.9%	86.4%	88.4%	88.5%	85.1%	82.5%	82.5%	83.4%

The following remedial actions are in place to address the current position:

- Ongoing discussions with Business Unit and Corporate Leaders regarding use of organisational reporting systems and how data is reported. This links to the overall ESR continuous improvement project.
- Further support and communications around manager self-reporting of appraisal rates to ensure maximum recording at service level
- Detailed analysis of performance at team / service level to identify areas for targeted support and improvement; discussions have been initiated and plans are in place
- Appraisal skills development is available as part of the Management Essentials programme, and a bespoke training session is also offered to teams by the ODI Team
- Appraisal discussions form a fundamental part of our emerging Talent Management approach and there will be an increasing focus on the importance of appraisal during 2019/20.

Statutory and Mandatory Training

The upward trend for compliance against the universal statutory and mandatory training requirements continues this month, currently standing at **93.5%** against the 95% target**.** All Business Units and Corporate teams have demonstrated an improvement this month.

The Statutory/mandatory Compliance Project has supported the progress in this area. The focus is on ensuring competencies, courses and levels are correctly configured in ESR; and are accurately matched to the correct staff groups.

In addition, high risk teams are identified and supported through targeted communication and related initiatives.

Weekly reports on statutory & mandatory compliance continue to be sent to SMT, to ensure ongoing scrutiny.

Imp Traj to 95%	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**	**Apr-19**
833 Overall	88.7%	88.4%	90.3%	90.0%	90.6%	92.7%	93.5%	92.5%	93.5%
833 Adult Business unit	88.5%	87.5%	90.6%	89.8%	91.0%	92.7%	92.6%	91.6%	92.7%
833 Children's Business Unit	89.7%	89.6%	91.5%	90.6%	91.3%	92.6%	94.2%	92.7%	93.5%
833 Corporate Directorate	91.1%	91.3%	94.1%	92.8%	92.2%	94.8%	95.4%	94.2%	95.3%
833 Operations	83.5%	81.6%	83.7%	87.5%	88.4%	92.4%	93.7%	92.8%	94.2%
833 Specialist Business Unit	89.7%	90.4%	90.6%	90.6%	90.0%	93.0%	94.0%	93.7%	93.9%

Staff Engagement

The engagement work which was outlined in last month's Well-Led report continues, linked to Staff Survey results 2018, and Q4 Staff Friends and Family Test feedback.

Engagement spans a number of areas including:

- Development sessions continue to happen with all business units. These are planned throughout the year to maintain focus and momentum on the engagement work, as well as to ensure support in their reporting in to Performance Panel on progress being made around response to staff feedback
- Specific team development / engagement interventions

- Promotion of an improvement-focussed culture driven by frontline teams around the message of “Making Stuff Better”
- Continuing engagement of BAME Network around the WRES action plan
- Continuing work by the Health & Wellbeing Engagement Forum around key priorities including mental health and wellbeing
- Continuing assessment of cultural intelligence information including Staff Friends & Family Test: the next survey goes live on 22 May; results will be reported in July 2019.

Finance – April 2019

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

Leeds Community Healthcare NHS Trust

Finance	Financial Year	Target	YTD	April	May	June	Q1	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	*2019/20*	£0.3m	**£0.5m**	**£0.5m**				●
	2018/19		£4.0m	£0.2m	£0.3m	£0.3m	£0.3m	
Capital expenditure in comparison to plan (£k) - YTD	*2019/20*	£30k	£0k	£0k				●
	2018/19		£1,880k	£21k	£46k	£236k	£303k	
CIP delivery (£m) - YTD	*2019/20*	£193k	**£177k**	**£177k**				●
	2018/19		£4.7m	£0.3m	£0.3m	£0.3m	£1.0m	

Income & Expenditure Summary

At the end of April the Trust is £0.2m overspent. Of this £121k relates to pay and reserves for the month are overcommitted by £16k. The overall position includes the PSF allocation as the assumption is that the Trust will deliver the control total as the year progresses and will therefore be able to claim this funding from NHS Improvement. If April was typical in terms of budget overspends, the Trust would need to take action to reduce spending by £2m to meet the control total by the end of the financial year. Whilst there is good reason to think that April is not typical, very careful monitoring of budget performance will be required with options being developed to reduce spending levels if necessary.

Income

Contract income is marginally less than planned as a penalty has been prudently included for police custody based on the performance in Quarter 4 last year although the April shift fill data is not yet available. The risk may not materialise as staffing levels are now higher than they were last year. Non-contract income is in line with plan. The equipment service income does not include funding for additional staff that had been agreed historically with Commissioners; a contract meeting is scheduled for May to discuss this.

The Trust operates on a predominantly block contract basis so income risk is unlikely to be a significant issue in the achievement of financial targets. The position assumes all CQUIN income is achieved.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure is £121k over the planned (budgeted) position at the end of April. Of this £20k is in respect of Leeds Equipment Service, where non recurrent funding ceased at the end of March but the staff remain in post. This may be resolved following a meeting with Leeds City Council in May. There is a further £12k in respect of the First Contact Practitioners (FCP) who are in post however funding has not been agreed within the System. The FCP are part of the £68k pay overspending in the Specialist BU the balance relates to the Sexual Health and Police Custody services which are currently overstaffed compared with budget.

There are a net 79 WTE vacancies this month, 40 of these are in the Adult BU, 40 in Corporate and Estates Directorates and 7 in the Specialist BU.

£96k of the total overspending at the end of Month 1 is in the Corporate Directorate where historic cost savings plans in respect of the roadmap contribution (£500k), corporate CIPs (£300k) and procurement (£200k) along with new £200k unidentified savings from the 2019/20 planning round are reported. Most of the corporate overspending is in respect of the planned cost savings. The procurement savings target should be delivered as the year progresses; the others remain a significant risk.

Reserves for the year are £200k overcommitted at the end of April; whilst not a particular concern given the value and the time of year, this is an unusual situation for the Trust to be in and means BUs and Directorates need to manage to their delegated budgets as there is no central pot to mitigate financial overspends or support additional ad-hoc expenditure.

Agency staffing expenditure is 28% under the cap set by NHS Improvement.

Non-pay is a net £12k overspent at the end of the first month of the year. Most of this is in the “other” category where the savings requirements are reported.

The forecast outturn, without the impact of corrective action, would require £2m of savings based on April’s expenditure levels. Of this £0.5m is within the Children’s BU, £0.3m in the Specialist BU. The most material area to address is the general savings requirements highlighted above.

Delivery of Cost Improvement Plans

CIP delivery is strong with all but the £0.2m unidentified savings agreed through the planning process being delivered at this early point in the year.

Business Unit Budget Performance

The Business Units have a net total of 39 WTE vacancies for April; there are 40 vacancies for the Adult Business Unit and 7 WTE for the Specialist Services and Children’s have 7 WTE more staff than budgeted.

The Specialist Business Unit is £0.1m overspent at month 1 in respect of pay costs particularly in police custody and sexual health. It is forecast to be overspent by £0.3m overall of which pay is £0.8m which is being offset by an underspending on non-pay of £0.5m.

Children's Business Unit is breakeven at the end of April and forecast to be a net £0.5m overspent at the year-end; with a pay overspending of £0.9m in respect of locums being offset by £0.4m of underspending on non-pay.

The Adult Business Unit has a very small underspending at the end of the first month of 2019/20 and is forecast to end the year £0.1m underspent overall; a £0.1m overspending on pay being offset by underspending on non-pay.

Capital Expenditure

The Trust has an initial planned capital resource limit (CRL) of £2.0m for the year; however trusts are being asked to review their capital expenditure downwards for 2019/20 and any revision to the plan will be reflected in a revised CRL.

Capital expenditure was not planned for or incurred in April.

Cash

The Trust's cash position remains very strong at £26.8m; this is marginally more than was planned.

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code has exceeded the 95% target for paying invoices for all measures in April.

Use of Resources Risk Rating

The Trust's risk rating at the end of April is 1 overall, which is the lowest risk.

Appendix 1 – April 2019

Well- Led Additional Information

Leeds Community Healthcare NHS Trust

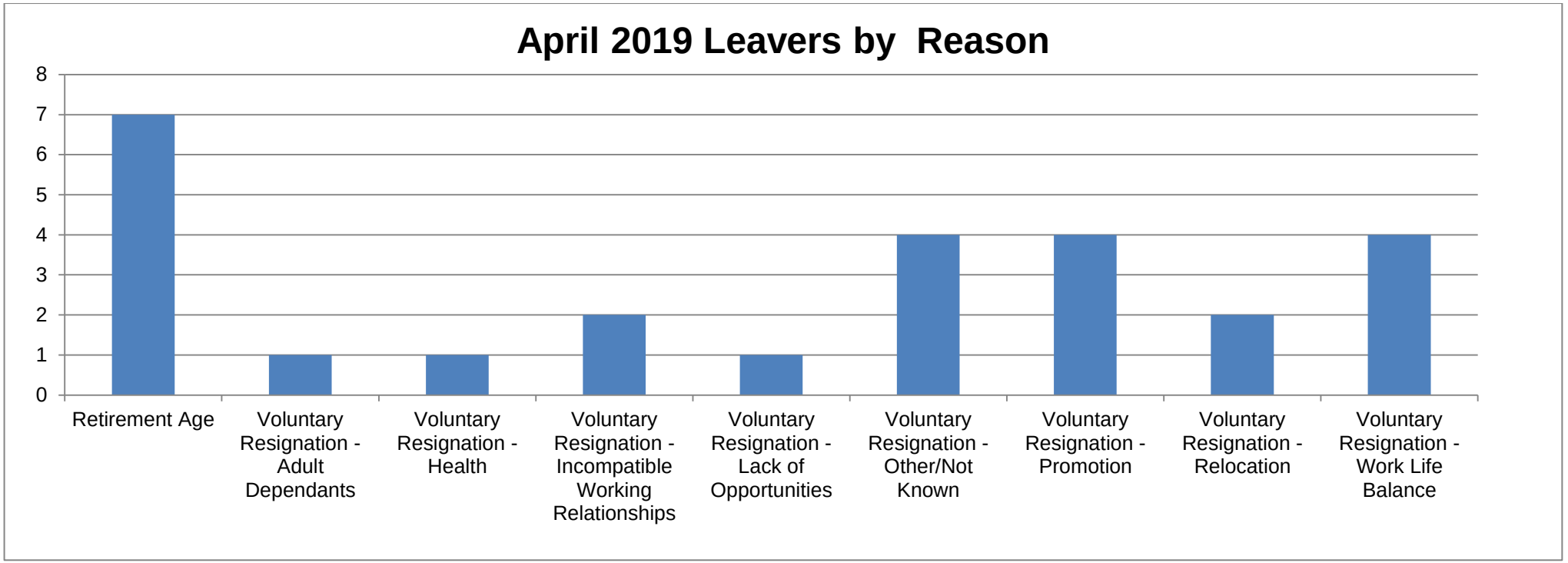
In April 2019 there were 26 leavers across the Trust.

The distribution of leavers by Business Unit, staff group and reason for leaving is set out below:

Business Unit	April 19 Leavers
Adult Business unit	6
Children's Business Unit	9
Corporate / Operations	4
Specialist Business Unit	6
Executive Directors	1
Grand Total	**26**

Staff Group	April 19 Leavers
Clinical Services and Scientific	5
Administrative and Clerical	6
Allied Health Professionals	4
Nursing and Midwifery Registered	11

Medical and Dental	0
Estates	0
Grand Total	**26**



Appendix 2 – April 2019

Safe and Caring Domain

Leeds Community Healthcare NHS Trust

Serious Incidents and Pressure Ulcers

STEIS Reportable Incidents

There were two SI's reported to the CCG in April 2019 These were both pressure ulcer incidents. 1 x category 4 and 1 x unstageable.

One delog requests were made and confirmed by the CCG in April. This was a report of a death following a self-referral to the IAPT service reported in January 2019

Three Serious Incident investigations were signed off/ closed in April. All were identified as being avoidable to the organisation and all were pressure ulcers (2 x category 3 and 1 x unstageable) Middleton, Woodsley and Yeadon Neighbourhoods were the reporting Teams.

Incident Sub-Category	Avoidable incident attributable to LCH Care	Unavoidable Incident	Total
Category 3 Pressure Ulcer	2	0	2
Unstageable Pressure Ulcer	1	0	1
Total	**3**	**0**	**3**

The themes from these investigations are recorded as

- Assessments- Delay; Assessments or other documentation not completed
- Poor Case management
- Staff Training- Insufficient Knowledge/Skills – training was completed but understanding or review of use not checked

Action plans from the SI investigations have been added to datix and monitoring of completion of the individual actions is monitored by the Clinical Governance Team.

Action Plans

Datix has now been upgraded to the latest version and as a result of this; automatic reminders of overdue actions and actions approaching their deadlines for completion are now being sent out.

Data for overdue action plan and closed action plan will be included on the next report, however Overdue actions owners from 2017/18 have been emailed individually to request urgent update and closure of their actions plans.

Pressure Ulcer Focus - New Pressure Ulcers in April

47 pressure ulcers incidents were identified in the April data.

One category 4 pressure ulcers was reported in April This was reported by the Seacroft Neighbourhoood this report underwent a 72 hour review and was found to be unavoidable and it has now been closed.

Closed Pressure Ulcer Incidents in April

37 pressure ulcer incidents were investigated and closed. One incident was found to be avoidable to LCH, There were 4 category 3 ulcer, 14 unstageable ulcers and 1 category 4 ulcers. All were reported by different teams across the area.

Table of Pressure Ulcers investigated and closed in April

Avoidability	Category 2	Category 3	Unstageable	Category 4	Total
Avoidable incident attributable to LCH Care	1	2	0	0	**1**
Unavoidable incident or accident	18	2	14	1	**35**
Total	**20**	**6**	**15**	**1**	**42**

Themes from Closed, Avoidable Pressure Ulcers

There were a total number of 6499 incidents within LCH in 2018/19 with 55 SI as compared to 6709 incidents recorded in 2017/2018 with 78 SI. The incidents have decreased by 3% in the last year and the SI has also decreased by 29%.
There were a total of 198 themes recorded in 2018/2019 compared to 80 themes recorded in 2017/2018. There has been an increase in the following themes:

- Assessment- Not complete in line with policy
- Communication- Breakdown with the team
- Documentation not updated/ reviewed
- Record keeping- Poor quality.

Some teams have had a significant increase on the themes recorded, the following teams have had 8 and above more themes recorded in 2018/2019 as compared to 2017/2018:

- Yeadon increased by 14
- Woodsley increased by 8
- Seacroft increased by 11
- Pudsey increased by 12
- Morley increased by 10
- Meanwood increased by 10

In 2018/2019 there was a total of 712 incident that affected Staff, the vast majority of the incidents were verbal abuse (142), physical abuse, assault or evidence (51), damaged or broken equipment (39) and injury from sharp (31). There were also a total of 436 recorded incidents that affected the trust. The vast majority of the incidents were medication related

Appendix 3 – April 2019

Detailed Financial Tables

Leeds Community Healthcare NHS Trust

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus £1.7m	£0.5m	£0.2m	£1.7m	G
Remain with EFL of £0.53m			£0.5m	G
Remain within CRL of £2.0m			£2.0m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	100%	5%	95%	G
BPPC Non NHS Invoices Number 95%	98%	3%	95%	G
BPPC Non NHS Invoices Value 95%	98%	3%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £1.68m recurrent in year	£0.14m	-	£1.678m	G
CIP Savings £0.635m planned non recurrent in year	£0.036m	-31%	£0.435m	R

Table 2 Income & Expenditure Summary	April Plan WTE	April Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m
Income								
Contract Income			(12.2)	(12.2)	0.0	(144.7)	(144.6)	0.1
Other Income			(0.7)	(0.7)	0.0	(9.0)	(8.8)	0.1
Total Income			***(13.0)***	***(13.0)***	***0.0***	***(153.6)***	***(153.4)***	***0.2***
Expenditure								
Pay	2,701.1	2,622.2	9.7	9.8	0.1	109.4	111.2	1.8
Non pay			3.1	3.1	0.0	36.8	36.9	0.1
Reserves & Non Recurrent			0.2	0.3	0.0	3.0	0.9	(2.1)
Total Expenditure	***2,701.1***	***2,622.2***	***13.0***	***13.2***	***0.1***	***149.2***	***149.0***	***(0.2)***
EBITDA	**2,701.1**	**2,622.2**	**0.1**	**0.2**	**0.2**	**(4.4)**	**(4.4)**	**(0.0)**
Depreciation			0.2	0.2	(0.0)	2.0	2.0	0.0
Public Dividend Capital			0.1	0.1	0.0	0.8	0.8	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	0.0
Retained Net Surplus	**2,701.1**	**2,622.2**	**0.3**	**0.5**	**0.2**	**(1.7)**	**(1.7)**	**0.0**
	Variance =	**(78.9)**						

Table 3 Month on Month Pay Costs by Category	April £k
Directly employed staff	8,932
Seconded staff costs	229
Bank staff	232
Agency staff	392
Total Pay Costs	**9,785**

Table 4 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Forecast Outturn Variance £k
Drugs	64	70	6	
Clinical Supplies & Services	858	786	(71)	
General Supplies & Services	412	410	(2)	
Establishment Expenses	512	489	(23)	
Premises	1,091	1,122	31	
Other non pay	200	271	71	
Total Non Pay Costs	**3,136**	**3,148**	**12**	**68**

Table 5 Savings Scheme	2019/20 YTD Plan £k	2019/20 YTD Actual £k	2019/20 YTD Variance £k	2019/20 Annual Plan £k	2019/20 Forecast Outturn £k	2019/20 Forecast Variance £k	2019/20 Forecast Variance %
Estates	12	12	0	145	145	0	0%
Non Pay Inflation	29	29	0	345	345	0	0%
MSK Radiology	8.3	8.3	0	100	100	0	0%
IAPT - NR vacancies	5	5	0	60	60	0	0%
Dental - M&S Disposables	3	3	0	40	40	0	0%
ABU Leadership Team	10	10	0	115	113	(2)	-2%
Adults Community Geriatricians	7	7	0	85	85	0	0%
Infection control	1	1	0	15	15	0	0%
Interest received on cash at bank	5	5	0	60	60	0	0%
Contribution from new investments	75	75	0	900	900	0	0%
IT Kit	21	21	0	250	250	0	0%
Un-identified CIP agreed by SMT	17	0	(17)	200	0	(200)	-100%
Total Efficiency Savings Delivery	**193**	**177**	**(17)**	**2,315**	**2,113**	**(202)**	**-9%**

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m
Specialist Services	38.6	693.7	686.2	(7.5)	3.5	3.5	0.1
Childrens Services	30.3	695.5	702.0	6.5	2.7	2.7	(0.0)
Adults Services	42.4	888.4	848.8	(39.6)	3.6	3.6	(0.0)
Ops Management & Equipment	1.7	50.2	51.7	1.6	0.1	0.2	0.0
Service Line Totals	**112.9**	**2,327.8**	**2,288.8**	**(39.0)**	**9.9**	**10.0**	**0.1**
Corporate Support & Estates	27.6	373.3	333.4	(39.9)	2.4	2.4	0.1
Total All Services	**140.5**	**2,701.1**	**2,622.2**	**(78.9)**	**12.3**	**12.4**	**0.1**

Table 7 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.0	(0.0)	(0.0)	0.6	0.6	0.0
Equipment/IT	0.0	(0.0)	(0.0)	1.0	1.0	0.0
Electronic Patient Records	0.0	0.0	(0.0)	0.5	0.5	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0
Totals	**0.0**	**(0.0)**	**(0.0)**	**2.0**	**2.0**	**0.0**

Table 8 Statement of Financial Position	Plan 30/04/2019 £m	Actual 30/04/2019 £m	Variance 30/04/2019 £m	*Opening 01/04/19 £m*	Planned Outturn 31/03/20 £m	Forecast Outturn 31/03/20 £m	Forecast Variance 31/03/20 £m
Property, Plant and Equipment	29.1	29.1	0.1	*29.3*	30.7	30.7	0.0
Intangible Assets	0.0	0.0	0.0	*0.1*	0.0	0.0	0.0
Total Non Current Assets	**29.1**	**29.2**	**0.1**	***29.4***	**30.7**	**30.7**	**0.0**
Current Assets							
Trade and Other Receivables	9.6	8.9	(0.6)	*8.8*	7.9	7.9	0.0
Cash and Cash Equivalents	26.7	26.8	0.0	*23.2*	25.8	27.4	1.7
Total Current Assets	**36.3**	**35.7**	**(0.6)**	*32.1*	**33.7**	**35.3**	**1.7**
TOTAL ASSETS	**65.4**	**64.8**	**(0.6)**	***61.5***	**64.3**	**66.1**	**1.7**
Current Liabilities							
Trade and Other Payables	(12.6)	(10.5)	2.2	*(12.1)*	(13.4)	(13.4)	(0.0)
Provisions	(0.4)	(0.6)	(0.2)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(13.0)**	**(11.0)**	**2.0**	***(13.4)***	**(13.8)**	**(13.8)**	**(0.0)**
Net Current Assets/(Liabilities)	**23.3**	**24.6**	**1.4**	***18.7***	**19.9**	**21.5**	**1.7**
TOTAL ASSETS LESS CURRENT LIABILITIES	**52.3**	**53.8**	**1.5**	***48.0***	**50.6**	**52.3**	**1.7**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	***0.0***	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**52.3**	**53.8**	**1.5**	**48.0**	**50.6**	**52.3**	**1.7**
TAXPAYERS EQUITY							
Public Dividend Capital	0.4	0.4	(0.0)	*0.3*	0.3	0.4	0.1
Retained Earnings Reserve	21.4	22.8	1.5	*17.2*	19.7	21.3	1.6
General Fund	18.5	18.5	0.0	*18.5*	18.5	18.5	0.0
Revaluation Reserve	12.0	12.0	(0.0)	*12.0*	12.0	12.0	0.0
TOTAL EQUITY	**52.3**	**53.8**	**1.5**	**48.0**	**50.6**	**52.3**	**1.7**

Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	98%	95%	G

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	58	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	3.1	1	20%	0.2
Underlying performance	I&E margin	0%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-28%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

NHS
Leeds Community Healthcare
NHS Trust

Agenda Item 2019/20 (13b)

Meeting: Trust Board, 24 May 2019	**Category of paper** *(please tick)*	
Report title Performance brief annual report 2018-19	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 15 May 2019 Quality Committee, 20 May 2019 Business Committee, 22 May 2019	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during the Financial year 2018/19.

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.

Main issues for consideration

This year-end report on performance against the KPIs for 2018/19 shows good performance overall. There has been real sustained improvement on some measures (e.g. staff retention), continued consistent achievement (e.g. serous incident rate) and areas where there remains a challenge to get performance consistently where we want it to be (e.g. IAPT patients treated within 6 weeks of referral).

Recommendations
The Committee is recommended to:

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

Performance Brief – 2018/2019 Year End

Leeds Community Healthcare NHS Trust

Purpose of the report

This report provides the final set of 2018/19 KPIs to the Senior Management Team, Business Committee, Quality Committee and Trust Board on quality, performance, compliance and financial matters of Leeds Community Healthcare NHS Trust. The full Performance brief for March 2018 was provided to the Business and Quality Committees in April.

This year-end performance brief should be considered in conjunction with the report on achievement of Trust priorities on the Board agenda on 24 April 2019.

Committee Dates
Senior Management Team – 15th May 2019
Quality Committee – 20th May 2019
Business Committee – 22nd May 2019
Trust Board – 24th May 2019

Recommendations

Committees and the Board are recommended to note the year-end Performance Brief.

Main issues for Consideration

This year-end report on performance against the KPIs for 2018/19 shows good performance overall. There has been real sustained improvement on some measures (e.g. staff retention), continued consistent achievement (e.g. serous incident rate) and areas where there remains a challenge to get performance consistently where we want it to be (e.g. IAPT patients treated within 6 weeks of referral). Across the domains in this annual round up of Performance, the summary position is as follows:

In the **Safe** domain, all measures were reported as green and having achieved their targets with the exception of Avoidable Category 4 Pressure Ulcers. Disappointingly, the Trust reported 2 in February 2019. The annual target was to report 0 category 4 pressure ulcers. The final position was the same as the previous year and it remains the Trust's ambition to achieve 0 avoidable Category 4 Pressure Ulcers in 2019/20.

The Trust achieved all of its targets in the **Caring** domain in FY 2018/19.

Performances across the measures in the **Effective** domain have been variable, with challenges within the Quality Challenge + domains being reflected. The Quality Challenge + process has been subject to review and the new process for 2019/20 is expected to resolve these challenges. The measures in this domain have been reviewed for 2019/20, aiming to provide a better reflection of the significant amount of progress within the Trust on providing high quality effective care.

In the **Responsive** domain, patient contacts are in line with profile after the profile for Neighbourhood Teams, which contributes a significant percentage of activity to the Trust was amended in year following an in depth and collaborative approach with NHS Leeds CCG. The Trust performed well across all the measures in this domain, with the exception of the IAPT KPI noted above.

Amongst the **Well Led** measures there have been some notable achievements during 2018/19; and some areas for improvement where we are focusing increased levels of support in 2019/20.

Of particular note is the overall LCH retention performance: the organisation has performed well this year; and markedly better than its benchmarked peers, with stability levels above target and turnover levels not breaching the 14.5% target threshold in any of the 2018/19 quarters. At the end of March 2019, turnover was at 13.6%.

Overall, sickness absence levels in 2018/19 made a small improvement compared with 2017/18, meeting the year end outturn target of <5.8%. The year-end completion rate for appraisal was higher than in 2017/18 and 95% of respondents to the 2018 Staff Survey in LCH reported that they had received an appraisal in the last 12 months. Statutory & mandatory training compliance ended the year at 92.9% (2017/18 year end was 91.3%).

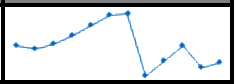
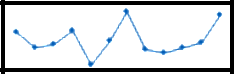
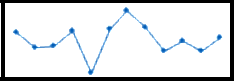
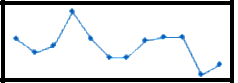
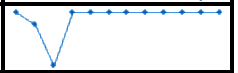
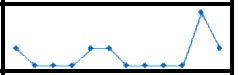
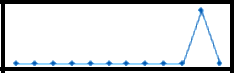
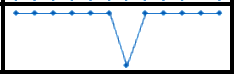
Particular highlights in this domain contributing to good performance across a variety of measures in 18/19, included diversity and inclusion with our highly successful #RaceforEquality event as well as the relaunch of our Leadership Development programme; Staff Survey results were good and benchmarked well against peers and other NHS organisations with LCH within the top quartile for all results across the country.

Financial performance for 2018/19 was good. In the Trust's draft accounts which were submitted on 24 April, all statutory targets were met. In fact, of all the financial KPIs monitored by the Business Committee and Board during the year the only target not achieved was recurrent CIP delivery which was missed by 3% and for which mitigating action was identified earlier in the year.

Safe – 2018/2019 Year End

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

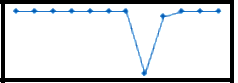
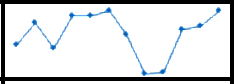
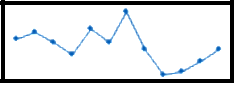
Leeds Community Healthcare NHS Trust

Safe - people are protected from abuse and avoidable harm		Target	YTD	Q1	Q2	Q3	Jan	Feb	Mar	Q4	Forecast	Rolling 12 Month Trend
Overall Safe Staffing Fill Rate - Inpatients	2018/19	>=97%	-	101.1%	101.1%	97.8%	97.1%	100.7%	99.4%	99.1%	●	
	2017/18		-	97.7%	98.7%	98.1%	99.4%	99.6%	99.1%	99.1%		
Patient Safety Incidents Reported in Month Reported as Harmful	2018/19	0.57 to 1.11	0.90	0.86	0.85	0.88	0.84	0.86	0.99	0.90	●	
	2017/18			0.92	0.86	0.82	1.03	1.00	0.68	0.90		
Potential Under Reporting of Patient Safety Incidents	2018/19	1.3 to 2.59	1.91	1.85	1.82	2.03	1.88	1.72	1.91	1.84	●	
	2017/18			2.22	2.20	2.01	1.90	1.99	1.84	1.90		
Serious Incident Rate	2018/19	0 to 1.97	0.05	0.04	0.05	0.04	0.05	0.00	0.02	0.02	●	
	2017/18			0.05	0.05	0.04	0.07	0.07	0.07	0.07		
Percentage VTE Risk Assessment Completed	2018/19	>=95%	94.9%	79.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18			-	-	98.3%	91.7%	70.0%	90.0%	83.9%		
20% Reduction in Avoidable Category 3 Pressure Ulcers	2018/19	10	7	1	2	0	0	3	1	4	●	
	2017/18			2	6	1	1	0	1	2		
0 Avoidable Category 4 Pressure Ulcers	2018/19	0	2	0	0	0	0	2	0	2	●	
	2017/18		12	0	0	3	0	0	0	0		
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2018/19	100%	92.0%	100.0%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18		100.0%	100%	100%	100%	100%	100%	100%	100%		

Caring – 2018/2019

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

Leeds Community Healthcare NHS Trust

Caring - staff involve and treat people with compassion, kindness, dignity and respect		Target	YTD	Q1	Q2	Q3	Jan	Feb	March	Q4	Forecast	Rolling 12 Month Trend
Percentage of Staff Recommending Care (Staff FFT)	2018/19	>=73%	-	83.0%	82.4%	Staff	85.0%			85.0%	●	
	2017/18		-	81.0%	75.0%	Survey	80.7%			80.7%		
Percentage of Respondents Recommending Inpatient Care (FFT)	2018/19	>=95%	-	91.7%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18		-	100.0%	96.7%	90.5%	-	100.0%	100.0%	100.0%		
Percentage of Respondents Recommending Community Care (FFT)	2018/19	>=95%	-	95.9%	96.9%	95.0%	96.2%	94.9%	97.0%	96.0%	●	
	2017/18		-	95.3%	95.5%	96.0%	96.3%	96.3%	95.0%	95.0%		
Written Complaints - Received	2018/19	<211	120	43	40	37	5	8	11	24	●	
	2017/18			50	57	52	22	10	20	52		

Effective – 2018/2019

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

Leeds Community Healthcare NHS Trust

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence		Target	YTD	Q1	Q2	Q3	Q4	Forecast
Compliance with Other NICE Guidance Within 2016	2018/19							
	Full Compliance	38	21	6	12	21	35	
	Action Plan in Place		1	-	1	1	3	
	Not yet due		16	32	25	16	-	
Number of Mandatory Audits	Due to start in Q	All audits started	29	6	0	6	1	
	Started in Q		23	17	2	3	1	
Number of LCH Generated Audits Started (as a percentage of all LCH generated audits)	2018/19	>=80%	-	31.2%	9.2%	6.4%	7.1%	
	2017/18		-					
Compliance with Clinical Supervision	2018/19	>=80%	-	81.9%	83.0%	85.6%	-	
	2017/18		-	80.0%	61.0%	70.0%	72.0%	
Number of Unexpected Deaths in Bed Bases	2018/19	No Target		0	2	1	2	
	2017/18		-	0	2	1	0	
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2018/19	No Target		4	3	5	1	
	2017/18		-	1	1	2	3	
Percentage of services rated good or outstanding following the Quality Challenge+ Peer Review	2018/19	>=70%		100.0%	0.0%	50.0%	69.0%	
	2017/18		-	-	-	-	-	
Percentage of services rating themselves as good/outstanding through the Quality Challenge+ Self Assessment	2018/19	>=80%		82.0%	88.0%	100.0%	0.0%	
	2017/18		-	-	-	-	-	

Quality Challenge+

During April 2018 - March 2019 all clinical services had submitted their self-assessments and no services rated themselves as inadequate. There had been a lower number of quality visits undertaken than expected during Q2 and Q3 but this had been rectified during Q4 (16 visits completed). This has been caused by:

- Capacity issues for some visitors
- Visitors changing job roles or leaving LCH, meaning they are unable to conduct a Quality Visit
- Capacity issues within some services, meaning they are unable to accommodate a Quality Visit.

Quality Challenge+ process underwent a review during Q4, in order that any learning and improvements could be implemented that could made it even better for 2019-20. Following engagement through different channels such as; services, forums and feedback following a survey as new process was agreed by Quality Committee in March 2019. The process still consisted of two parts which are a self-assessment and one quality walk to be completed during the next financial year but the documentation had changed from 10 standards to the five CQC domains only. The learning from the previous year and changes for the next financial year have been disseminated and shared with services.

Clinical audit:

During 2018-19 the number of clinical audit registered with the clinical audit & effectiveness team was 129, which included 28 priority 1 (must do) audits were identified as potentially relevant to LCH . This showed an increase to the number identified on the rolling clinical audit programme 2018-19 at the start of the financial year. On further scrutiny three (3) had not commenced as not relevant to LCH, whilst a further one (1) had commenced but abandoned during quarter 1. LCH participation in the abandoned clinical audit that had been reliant on LTHT uploading data onto the national database, which had not occurred. Learning from these including priority 2 (should do) and priority 3 (would like to do) has been taken forward into 2019-20.

All clinical audits commenced during 2018-19 will be monitored throughout 2019-20 until the audit cycle has been completed.

Other key activity:

- The review of the Clinical Audit Policy was completed
- The 2019/20 Clinical Audit Programme has been ratified by Quality Committee in March 2019
- Liaison with services to ensure that all documentation audits were submitted by the end of Q4.
- Liaison with services to receive quarterly position statements on all Clinical Audits, escalating as appropriate.
- 3 Introduction to Clinical Audit Training (part 1) sessions have been delivered. Positive feedback received including appetite for the formal training
- Quality account submission completed
- Internal Audit Assurance Review completed .

Responsive – 2018/2019

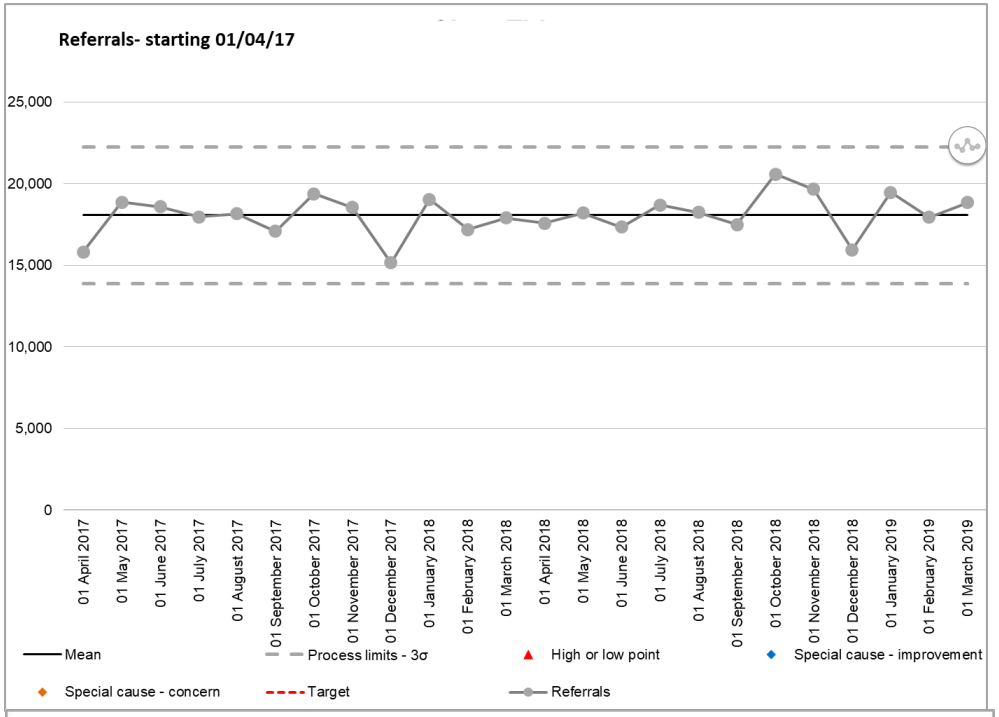
By responsive, we mean that services are organised so that they meet people's needs

Leeds Community Healthcare NHS Trust

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		Target	YTD	Q1	Q2	Q3	Jan	Feb	March	Q4	Forecast	Rolling 12 Month Trend
Patient Contacts - Variance from Profile	2018/19	0 to ± 5%	-3.0%	-3.0%	-6.4%	-3.1%	3.7%	-0.9%	-1.0%	0.6%	●	
	2017/18			-5.9%	-7.5%	-1.5%	-7.1%	-10.2%	-12.2%	-9.4%		
Patient Contacts - Variance from 2017/2018	2018/19	-	-	-4.2%	-7.1%	-8.3%	2.3%	1.4%	2.1%	1.9%	●	
	2018/19		-	392,694	373,902	379,919	138,325	118,483	128,631	385,439		
	2017/18		-	409,858	402,291	414,157	135,216	116,889	125,986	378,091		
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2018/19	>=92%	-	97.0%	97.8%	96.7%	97.5%	97.4%	95.6%	96.8%	●	
	2017/18		-	99.6%	99.5%	98.8%	99.2%	99.1%	97.6%	97.6%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	2018/19	0	0	0	0	0	0	0	0	0	●	
	2017/18		0	0	0	0	0	0	0	0		
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2018/19	>=99%	-	99.7%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	●	
	2017/18		-	99.5%	100.0%	100.0%	100.0%	100.0%	97.9%	97.9%		
% Patients waiting under 18 weeks (non reportable)	2018/19	>=95%	-	98.9%	98.4%	98.2%	98.2%	97.9%	97.2%	97.8%	●	
	2017/18		-	98.8%	98.8%	98.9%	99.0%	98.9%	98.6%	98.6%		
IAPT - Percentage of people treated within 18 weeks of referral	2018/19	>=95%	-	98.9%	99.6%	99.3%	99.5%	99.8%	99.6%	99.6%	●	
	2017/18		-	100.0%	98.6%	99.2%	99.8%	98.9%	98.5%	98.5%		
IAPT - Percentage of people treated within 6 weeks of referral	2018/19	>=75%	-	98.9%	78.8%	69.8%	69.7%	72.9%	66.7%	69.7%	●	
	2017/18		-	96.1%	94.4%	96.2%	95.9%	95.1%	91.8%	91.8%		

In 2018/2019, the Trust received 220,049 referrals which was an increase of 2.9% over 2017/18. December saw the lowest demand, October the highest.

There is an increase in demand, when comparing two data points, this year and last, but when demand data is displayed as an SPC chart demand is subject to normal variation only.



Total Activity is defined as patient interactions. They may be face to face with a patient or may be non-face to face, such as a telephone call.

When viewed over a time series, since April 2017, total activity is subject to normal process variation only.

Patient Contacts are broadly in line with agreed activity profiles, or targets.

In collaboration with NHS Leeds CCG, the profile for Neighbourhood Teams was revised to more appropriately reflect the further embedding of the New Ways of Working across Teams.

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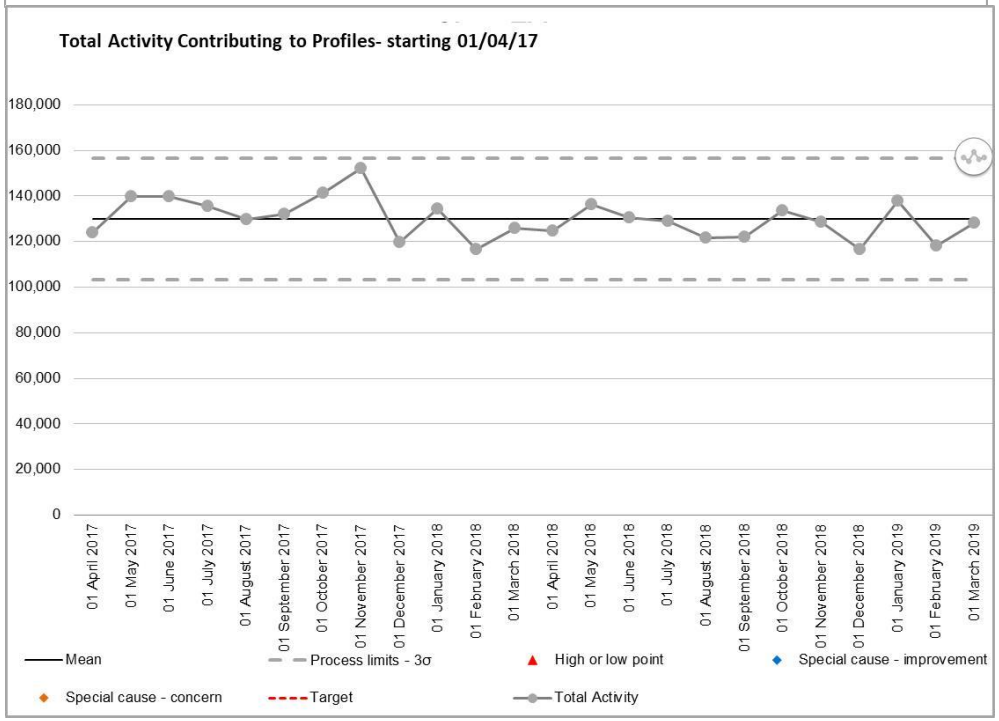
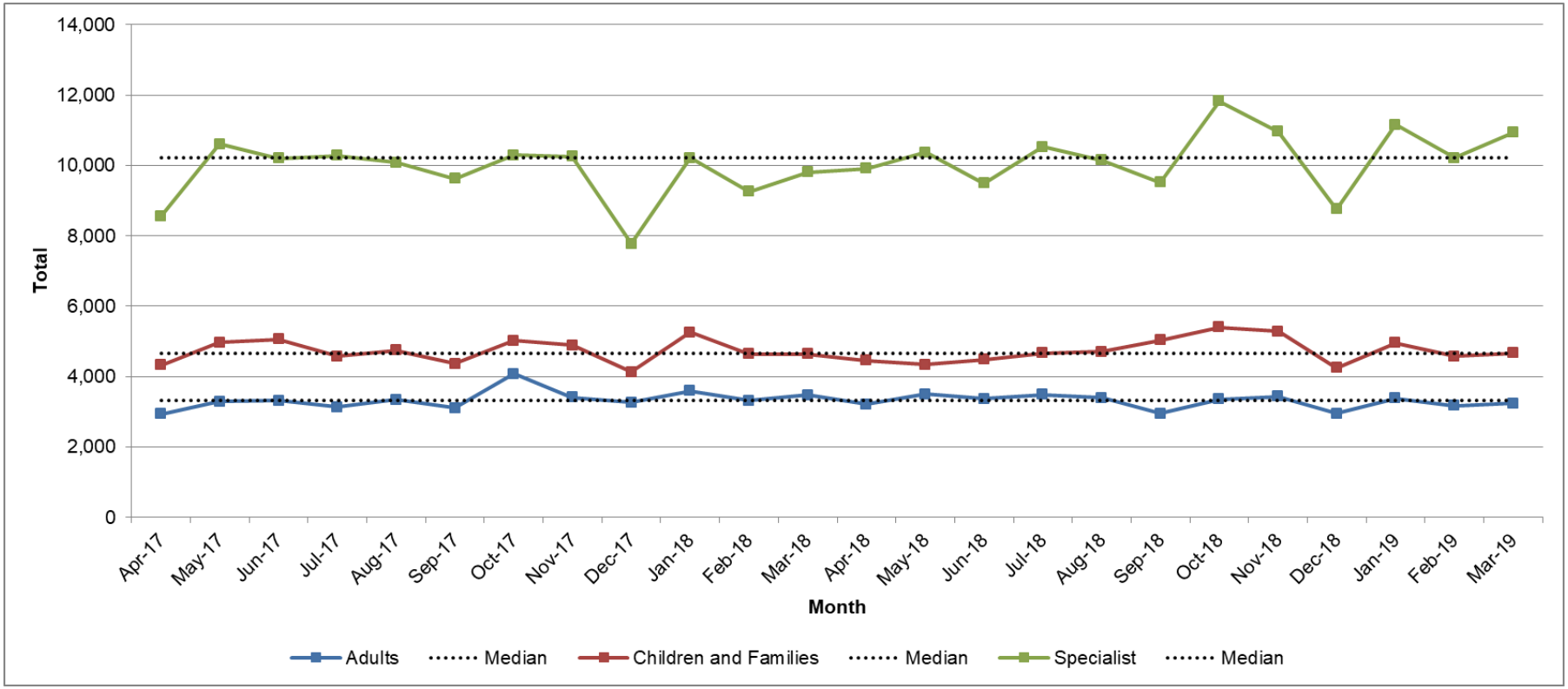


Breaking demand into Business Unit (chart below), we see the relative volumes with Specialist having the biggest demand. The Musculoskeletal (MSK) service, accounts for nearly half (48%) of all demand within the Specialist business Unit and about one third (27%) of all demand across the Trust.

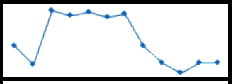
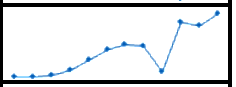
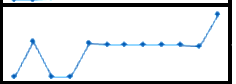
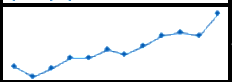
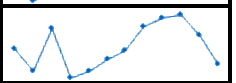
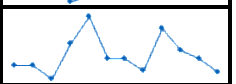
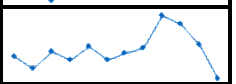
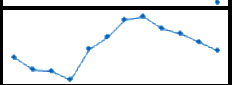
Whilst overall our services are responsive, seeing IAPT patients with 6 weeks or referral has been a challenge which has been reported on throughout the year. A new service is being commissioned for commencement in October 2019. LCH has submitted its bid in collaboration with partners and, if successful, we expect to see improvement in access times.

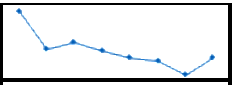
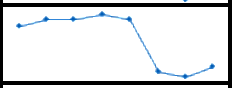
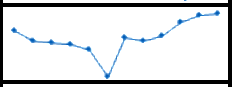
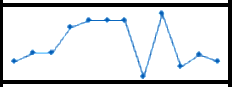
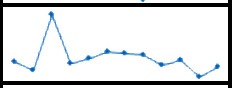


Well-Led – 2018/2019

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

Leeds Community Healthcare NHS Trust

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		Target	YTD	Q1	Q2	Q3	Jan	Feb	March	Q4	Forecast	Rolling 12 Month Trend
Staff Turnover	2018/19	<=15.0%	-	14.0%	14.5%	14.0%	13.4%	13.6%	13.6%	13.5%	●	
	2017/18		-	15.2%	14.4%	14.8%	13.3%	13.5%	13.9%	13.9%		
Reduce the number of staff leaving the organisation within 12 months	2018/19	<=20.0%	-	13.1%	14.4%	14.9%	17.5%	17.3%	18.3%	17.7%	●	
	2017/18		-	16.3%	12.0%	11.0%	11.0%	12.1%	12.0%	12.0%		
Executive Team Turnover	2018/19	<=14.5%	-	2.2%	4.2%	6.2%	6.0%	6.0%	12.0%	8.0%	●	
	2017/18		-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%		
Stability Index	2018/19	>=85%	-	85.5%	86.0%	86.3%	86.8%	86.7%	87.5%	87.0%	●	
	2017/18		-	83.8%	82.5%	85.3%	85.4%	85.0%	85.8%	85.8%		
Short term sickness absence rate (%)	2018/19	<2.2%	-	1.9%	1.6%	2.1%	2.4%	2.1%	1.7%	2.1%	●	
	2017/18		-	1.8%	1.9%	2.5%	3.5%	2.4%	2.1%	2.1%		
Long term sickness absence rate (%)	2018/19	<3.6%	-	3.5%	3.8%	3.8%	3.7%	3.6%	3.4%	3.6%	●	
	2017/18		-	3.5%	3.4%	4.0%	4.1%	3.6%	3.4%	3.4%		
Total sickness absence rate (%)	2018/19	<5.8%	-	5.3%	5.4%	5.8%	6.2%	5.7%	4.9%	5.6%	●	
	2017/18		-	5.2%	5.4%	6.5%	7.5%	6.0%	5.6%	5.6%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2018/19	>=95%	-	80.7%	82.3%	87.3%	85.4%	84.2%	82.9%	84.2%	●	
	2017/18		-	86.6%	82.5%	78.3%	79.7%	80.3%	79.8%	79.8%		
Medical staff appraisal rate (%)	2018/19	100%	-	100.0%	100.0%	78.0%				100.0%	●	
	2017/18		-	100.0%	100.0%	100.0%	100.0%			100.0%		

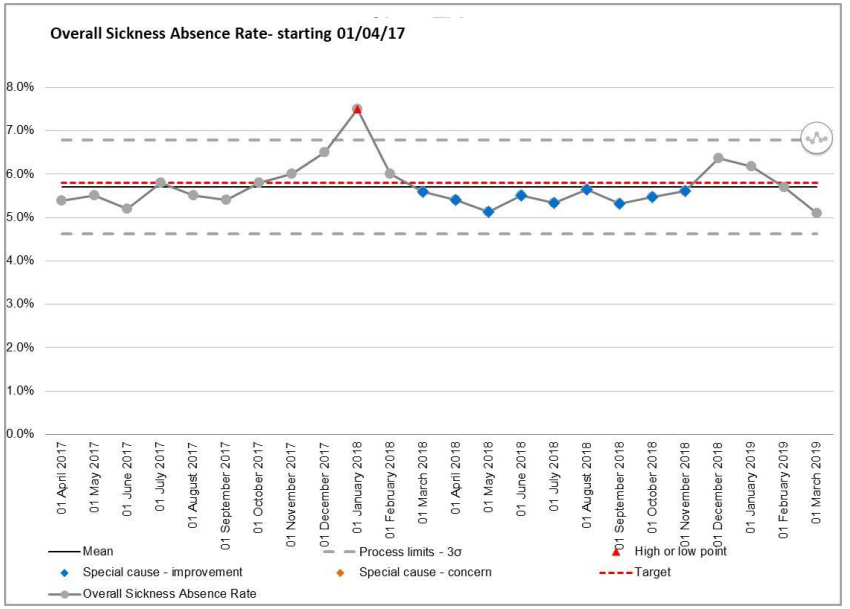
WRES indicator 1 - Percentage of BME staff in the overall workforce	2018/19	No Target	-			9.7%	9.6%	9.4%	9.6%	9.5%		
	-		-									
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2018/19	No Target	-			3.2%	2.7%	2.6%	2.7%	2.7%		
	-		-									
6 universal Statutory and Mandatory training requirements	2018/19	>=95%	-	90.3%	88.9%	90.3%	92.7%	93.5%	93.9%	93.3%		
	2017/18		-	91.0%	90.5%	90.2%	90.9%	90.6%	91.3%	91.3%		
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2018/19	>52.0%	-	63.0%	60.3%	Staff				68.0%		
	2017/18		-	54.0%	53.9%	Survey		56.7%		56.7%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2018/19	>52.0%	-	64.0%	65.1%	73.5%				69.0%		
	2017/18		-	62.0%	60.0%			62.5%		62.5%		
Response Rate for Staff FFT	2018/19	>22.0%	-	24.0%	23.5%					22.0%		
	2017/18		-	22.2%	21.0%			24.5%		24.5%		
Response Rate for Inpatient FFT	2018/19	23.1%	-	38.9%	96.1%	107.2%	19.0%	40.0%	27.8%	28.9%		
	2017/18		-	15.4%	11.8%	175.0%	0.0%	76.5%	61.1%	61.1%		
Response Rate for Community FFT	2018/19	6.8%	-	7.4%	6.2%	6.3%	5.9%	3.9%	5.2%	5.0%		
	2017/18		-	6.9%	4.6%	7.4%	5.8%	5.9%	5.4%	5.4%		
Total agency cap	2018/19	£535k	£6,410k	£1,403k	£2,766	£4045k	£434k	£388k	£493k	£5,360		
	2017/18		£6,089	£1,544k	£3,123k	£4532k	£459k	£442k	£656k	£6,089		
Percentage Spend on Temporary Staff	2018/19		6.8%	7.8%	7.1%	6.9%	6.2%	6.5%	6.1%	6.8%		
	2017/18		8.0%	8.1%	8.1%	7.7%	6.5%	7,5%	9.5%	7.8%		

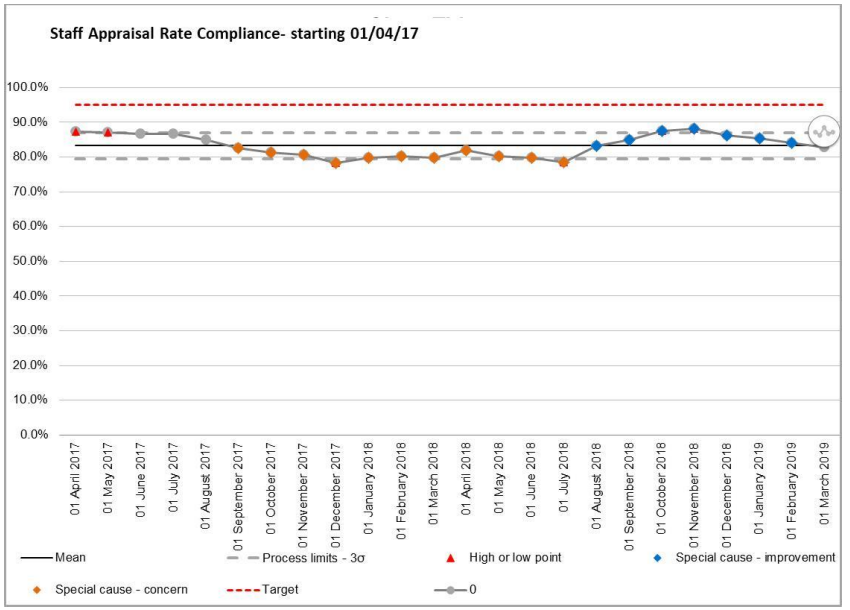
Amongst the Well Led measures there have been some notable achievements during 2018/19; and some areas for improvement where we are focusing increased levels of support in 2019/20.

Of particular note is the overall LCH retention performance: the organisation has performed well this year; and markedly better than its benchmarked peers, with stability levels above target and turnover levels not breaching the 14.5% target threshold in any of the 2018/19 quarters. At the end of March 2019, turnover was at 13.6%.

Sickness absence followed a common pattern during 2018/19, with heightened absence during winter months. Overall, sickness absence levels in 2018/19 made a small improvement compared with 2017/18, meeting the year end outturn target of <5.8%.

The year-end completion rate for appraisal was higher than in 2017/18 and 95% of respondents to the 2018 Staff Survey in LCH reported that they had received an appraisal in the last 12 months. Targeted work is taking place in 2019/20 to assist services in both completing and recording good quality appraisals; and to continuously improve the LCH systems and processes for recording and reporting compliance.

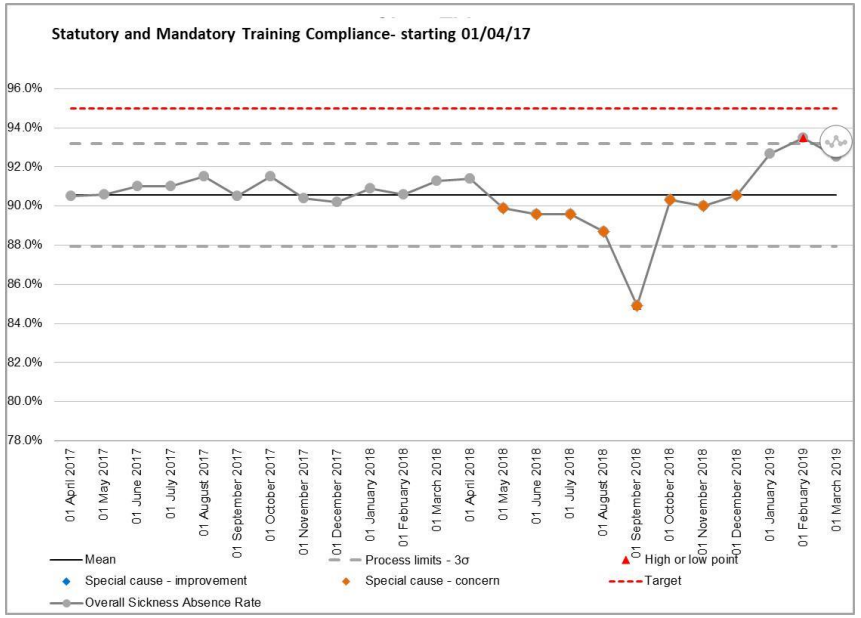




Statutory and mandatory training compliance ended the year at 92.9% against a 95% target (2017/18 year end was 91.3%).

2019/20 will see an ongoing focus on target achievement across all of our Well Led areas and in particular on our diversity and inclusion goals in line with our current WRES* and imminent WDES* action plans (*Workforce Race Equality Scheme; Workforce Disability Equality Scheme).

Underpinning our work on all of the above for 2019/20 is our LCH Workforce Strategy and its commitment to workforce engagement, leadership development and #justandfairculture.



Finance – 2018/2019

Leeds Community Healthcare NHS Trust

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

Finance		Target	YTD	Q1	Q2	Q3	Jan	Feb	March	Q4	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2018/19	£4.0m	£4.0m	£0.3m	£1.6m	£3.7m	£3.7m	£4.0m	£4.0m	£4.0m	●
	2017/18		-£3.3m	-£0.9m	-£2.1m	-£2.9m	-£2.8m	-£3.0m	-£3.3m	-£3.3m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2018/19	£4.0m	£4.0m	£2.5m	£4.0m	£4.0m	£4.0m	£4.0m	£4.0m	£4.0m	●
	2017/18		-£3.3m	-£3.0m	-£3.0m	-£3.0m	-£3.2m	-£3.3m	-£3.3m	-£3.3m	
Forecast underlying surplus	2018/19	£1.4m	n/a	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	-£1.4m	
Capital expenditure in comparison to plan (£k) - YTD	2018/19	585k	£1,880k	£303k	£574k	£1348k	-£325k	£409k	£518k	£1,950k	●
	2017/18		£1.4k	£0.2m	£0.3m	£0.6k	£0.6k	£0.9k	£1.4k	£1.4k	
Capital expenditure in comparison to plan (£m) - Forecast	2018/19	£1.9m	£1.9m	£3.2m	£3.4m	£3.4m	£1.9m	£1.9m	£2.0m	£2.0m	●
	2017/18		£1.4m	£1.8m	£1.8m	£1.6m	£1.7m	£1.6m	£1.4m	£1.4m	
CIP delivery (£m) - YTD	2018/19	£0.5m	£4.7m	£1.0m	£1.9m	£3.2m	£0.5m	£0.4m	£0.4m	£4.5m	●
	2017/18		£2.8m	£0.6m	£1.2m	£2.1m	£2.4m	£2.6m	£2.8m	£2.8m	
CIP delivery (£m) - Forecast	2018/19	£4.7m	£4.5m	£4.7m	£4.7m	£4.5m	£4.5m	£4.5m	£4.5m	£4.5m	●
	2017/18		£2.8m	£3.4m	£2.9m	£2.9m	£2.9m	£2.9m	£2.8m	£2.8m	
Use of Resources Risk Rating (from Oct 2016)	2018/19	2	1	1	1	1	1	1	1	1	●
	2017/18		1	1	1	1	1	1	1	1	

Financial performance for 2018/19 was good. In the Trust's draft accounts which were submitted on 24 April, all statutory targets were met. In fact, of all the financial KPIs monitored by the Business Committee and Board during the year the only target not achieved was recurrent CIP delivery which was missed by 3% and for which mitigating action was identified earlier in the year. The Accounts will be audited and presented to the Board on 24 May for approval.

Target	Target	Performance	Achieved
Planned surplus on income & expenditure	£5,656k	£5,656k	☑
Remain within External Finance Limit	(£3,100k)	(£3,100k)	☑
Remain within Capital Resource Limit	£2,051k	£1,950k	☑
Capital Cost Absorption Rate	3.50%	3.50%	☑
Agency control total	£6,410k	£5,365k	☑
Use of Resources	2	1	☑
Better Payment Practice Code:			
Non NHS invoices (number & value)	95% & 95%	96% & 95%	☑☑
NHS invoices (number & value)	95% & 95%	98% & 98%	☑☑
CIP recurrent savings in year	£3,228k	£3,058k	☒
CIP non-recurrent savings in year	£1,500k	£1,500k	☑

The Trust commenced 2018/19 planning to meet a control total (target income and expenditure surplus) of £2.5m including £1.3m Provider Sustainability Funding (PSF). During the year we took advantage of an opportunity offered by NHS Improvement to improve our planned surplus by £0.5m in return for £1m additional Provider Sustainability Funding. This additional PSF will be used to support the costs of the new CAMHS unit. We also received further PSF of £1.6m at the end of the financial year as part of the national share out of PSF not earned by Trusts during the year. Our year end surplus was £5.6m, as required by our original plans plus subsequent allocation of PSF.

The Trust's capital investment strategy continues to be one of aiming to invest all its internally generated capital resources and remaining within the capital resource limit agreed with NHS Improvement. During 2017/18 the Trust spent just less than £2m on the continuing roll-out of our Electronic Patient Record, upgrading and maintaining our buildings, clinical equipment and information technology.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (14)

Meeting: Trust Board 24 May 2019	**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: N/A	**For information**	

Purpose of the report:

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

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

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

Main issues for consideration:

There are no risks with a current score of 15 (extreme).
There are four high risks scoring 12.

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

- Staff sickness absence, vacancies, retention of staff
- An increased demand for services
- Work processes

Risks have been analysed for the last three years to provide thematic information for the Board to understand persistent threats to the Trust's objectives. Management of the risk register including numbers of risks added per year and the level of risks being rejected is included in section 9, to demonstrate the robust data quality processes involved in ensuring the risk register remains a valid and useful tool.

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 committees and the Board. It is suggested that risk scores for BAF risks 4.1 and 4.2 are lowered.

Recommendations

The Board is recommended to**:**

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

Significant Risks and Board Assurance Framework (BAF) report

1.0 Introduction

1.1 This report, which is presented at Senior Management Team (SMT) monthly, and every two months to the Board, provides an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures. The report also provides a description of risk movement since the last risk register report was presented to SMT in April 2019.

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

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

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

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

2.0 Background

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

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

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

3.0 Summary of current risks scoring 15 or above

3.1 There are no risks with a current score of 15 (extreme) or above on the Trust risk register as at 2 May 2019.

4.0 New or escalated risks scoring 15+

4.1 Since the last report to the Board in April 2019, there have been no new risks scoring 15 or more.

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

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

5.1 Since the April 2019 report, there have been no closed risks previously recorded at 15 or above.

5.2 No risks have been deescalated below 15 since April 2019.

6.0 Summary of risks scoring 12 (high)

6.1 High risks (scoring 12)

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

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

Table 1 High risks (scoring 12)

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

7.0 Summary of all risks currently scoring 8 or above

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

7.2 At present, the Trust's risk register comprises of 30 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate

and headquarters functions. This is a higher number of risks when compared with 26 risks on the previous report.

7.3 **Risks scoring 8 or above**

7.3.1 The chart below shows the number of risks by area of the business, logged on the Trust's risk management database (Datix) as at 2 May 2019

Table 2 risks by area of the business

Directorate	Risks scored 8-12 High	Risks scored 15+ Extreme	Totals by directorate
Adult Services	9	0	9
Children's Services	6	0	6
Specialist Services	7	0	7
Operational Support Services	2	0	2
Corporate & HQ functions	6	0	6
Totals by risk severity	**30**	**0**	**30**

8.0 Current risks scoring 8 or above by theme

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

8.2 Themes within the current risk register are as follows:

- Eight risks concern vacancies, including staff retention and difficulties recruiting staff to posts
- Four risks are related to staff capacity due to an increase in service demand
- Four risks are about work processes and arrangements (working with others in an integrated way)
- Three risks are concerned with staff absence due to sickness and maternity leave
- Three risks are related to contractors and subcontractors
- Two risks concern IT systems
- Two risks relate to finance

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

Table 3.

Theme / BAF Risk(s)
Risk register theme: Staff sickness absence, vacancies, retention of staff BAF Risk 3.1 having suitable and sufficient staff capacity and capability RISK 3.2 the scale of sickness absence
Risk register theme: Increase in demand for services BAF Risk 2.4 retaining existing viable business and/or win new financially beneficial business tenders BAF Risk 3.1 having suitable and sufficient staff capacity and capability
Risk register theme: work processes (lack of integrated systems with other service providers, inconsistent criteria) RISK 4.2 maintaining relationships with stakeholders RISK 4.4 having sufficient capacity across the Trust to deliver the key workstreams of system change programmes Risk 4.5 ensuring there are robust agreements and clear governance arrangements for partnership arrangements

9.0 Risk profile - all risks

9.1 There are 14 open clinical risks on the Trust's risk register and 39 open non-clinical risks. The total number of risks on the risk register is currently 53. This is an increase compared to the 47 risks reported in the previous in-depth risk register report. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Table 4 Risk profile across the Trust.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	2	0	0	0	2
4 - Major	1	0	1	0	0	2
3 - Moderate	3	10	18	3	0	34
2 - Minor	0	1	8	4	2	15
1 - Negligible	0	0	0	0	0	0
Total	4	9	27	7	2	53

9.2 **Risk themes comparison by year**

Table 5 below shows the risks themes by year. It should be noted that risks do not always have a single theme, and may be interconnected with different themes, for example, a risk concerning reduced staff capacity may be also associated sickness absence or poor processes.

9.3 Over the past three years the strongest themes have been:

- Reduced staff capacity
- Processes
- Recruitment/ Vacancies
- Information Technology

It is interesting to note that Information Technology was the highest theme of 2018/19. This could indicate a higher dependence and expectation of the role that technology plays in helping LCH to meets its strategic objectives.

Table 5 risk themes

Theme	Year entered onto the register			Total of 3 years
	2016/17	2017/18	2018/19	
Processes	11	10	6	**27**
Staff Capacity	13	6	5	**24**
Vacancies/Recruitment	11	3	5	**19**
Information Technology	5	4	8	**17**
Sickness	6	4	2	**12**
Finance	4	4	2	**10**
Patient safety	3	1	6	**10**
Staff Safety	4	2	2	**8**
Increased Service Demand	3	2	3	**8**
Retention	2	1	4	**7**
Competence /training	2	5	0	**7**
Working Environment	4	1	2	**7**
Governance	0	1	3	**4**
Maternity Leave	2	1	1	**4**
Legislation	1	1	2	**4**
Targets and Objectives	3	1	0	**4**

9.4 Numbers of risks added to the register over the last three years

Table 6 below shows the number of risks added to the register 2015/16 – 2018/19.

9.5 In 2015/16 the contents of the risk register was reviewed to ensure that the risks contained were current, relevant, and adequately described. This review resulted in 11 risks being removed from the register.

Over the past three years, the number of rejected risks has steadily declined, which may demonstrate that there is a greater understanding about what information the register should hold. It may also shows that the process of management review, prior to risks being added to the register, is more embedded.

Table 6 number of risks added to the risks register 2015/16 - 2018/19

Year	No. risks added to the risk register	Allowed Risks	No. of rejected risks
2015/16	60	49	11
2016/17	48	40	8
2017/18	34	28	6
2018/19	37	34	3

An increase in the number of risks being added in 2018/19 compared to 2017/18 may also demonstrate an increased awareness of risks and understanding of how the risk register is utilised.

10.0 Board Assurance Framework Summary

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

10.2 Definitions:

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

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

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

10.5 The BAF summary **(appendix 1)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by

committees and the Board, in line with the risk assurance levels described in **appendix 2** (BAF risk assurance levels).

10.6 Since the last BAF summary report to Trust Board in March 2019, the current level of assurance for the following BAF risks has been adjusted as follows:

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

- BAF risk 1.4 (engage patients and the public effectively) Quality Committee received reasonable assurance from a number of services within the Children's Business Unit who presented their engagement activities to the Committee in April 2019.
- BAF risk 2.4 (retain existing viable business and/or win new financially beneficial business tenders) Business Development Strategy update received substantial assurance and 0-19 Public Health Integrated Nursing Service (PHINS) presentation received reasonable assurance at Business Committee.

10.6.2 ***Negative movement (indicating a worsening situation)***
No negative movement has occurred since the last BAF report to the Board in March 2019.

10.7 **BAF risk score movement**

10.7.1 **Risk 4.1** (responding to the changes in commissioning, contracting and planning landscape (Integrated Care System) implementation) and scale and pace of change). It is suggested that the risk score should be reduced from 9 (high) to 6 (moderate), as the Trust is very much involved in the Integrated Care System therefore the likelihood of failing to benefit from any new opportunities, including pathway redesign, is reduced.

10.7.2 **Risk 4.2** (maintaining relationships with stakeholders, including commissioners and City Council) It is suggested that the risk score should be reduced from 12 (high) to 8 (high), as the Trust has built strong relationships with stakeholders and the likelihood of not being involved in new business opportunities is reduced.

11.0 Risk management activity

11.1 The Health, Safety and Risk training course has been successfully delivered to attendees of the Essential Management programme. This course ensures that managers understand their roles and responsibilities for managing risks in relation to the safety and wellbeing of their direct reports and other persons affected by LCH work activities. Sessions are fully booked, until December 2019 which has limited spaces available.

11.2 A programme of risk assessment workshops is underway, ensuring that all service held statutory risk assessments are in place and current. To date, meetings have taken place with IAPT and representatives from the Police Custody Suites. It is anticipated that this may take considerable time due to staff availability and the extent of development required.

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

11.4 The spring edition of Risky Business was published in April 2019. Articles in the spring 2019 edition included:

- Risks relating to use of multi-compartment compliance aids
- Lessons learnt from a subject access request
- How to keep your smartcard safe
- Fraudulent activities resulting in prosecution (not LCH)
- Failure of risk assessment which led to two nurses being seriously injured (not LCH)

12.0 Impact

12.1 *Quality*

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

12.1.2 There is a robust process for ensuring the risk register is effectively reviewed and kept up to date. An automated system reminds risk owners to update their risks where a review date has passed. The Risk manager produces a monthly quality assurance report and if the risk remains outstanding, further reminders are sent personally by the Risk Manager. Any risks remaining out of date by more than a month are escalated to the relevant director for intervention. Following requests for risk owners to update these risks, one risk remains overdue:

Risk ID	Risk description	Risk owner	Review Date
Risk 630	Increased falls risk within Adult Services	Clinical lead ABU	31/03/2019

12.2 Resources

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

12.3 Risk and assurance

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

13 Next steps

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

13.2 The Health, Safety and Risk training course will continue as part of the Essential Managers training programme.

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

13.4 Risk development workshops will continue to be held with services to ensure that risk assessments are suitable and sufficient.

14.0 Reporting schedule

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

14.2 **Risk register reporting schedule**

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

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

15.0 Recommendations

15.1 The Board is recommended to:

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

Board Assurance Framework (summary) 2019-20

Appendix 1

Details of strategic risks (description, ownership, scores)									Level of Assurance					
Risk		Risk ownership		Risk score										
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement		Current Level of Assurance (denoted by ◆).				Assurance - additional Information	Assurance Movement
									No	Limited	Reasonable	Substantial		
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 Audit programme 2019-20 received reasonable 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					◆		At Quality Committee, Quality Account and Operational Plan received reasonable assurance. Safe domain of performance brief received limited assurance due to grade 4 presssure ulcers reported.	
	RISK 1.4 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					◆		Quality Committee received reasonable assurance from a number of services within CBU who presented their engagement activities.	→
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					◆		e-rostering project received reasonable assurance from Business Committee	
	RISK 2.2 If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	6					◆			
	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					◆			
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12					◆		Business Development Strategy update received substantial assurance. PHINS presentation received reasonable assurance at Business Committee.	→
	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					◆			
	Risk 2.6 If the Trust does not maintain the security of its IT infrastructure and increase staffs' knowledge and awareness of cyber-security, then there is a risk of being increasingly vulnerable to cyber attacks causing disruption to services, patient safety risks, information breaches, financial loss and reputational damage.	BM	AC	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						EU Exit paper to Business Committeee provided reasonable assurance	
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	4	3	12							
	RISK 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						WRES report received reasonable assurance at Business Committee.	
	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						Workforce report 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 (Integrated Care System) 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	2	3	6						Risk score - suggest this is reduced from 9 to 6.	
	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	2	4	8						Risk score - suggest this is reduced from 12 to 8.	
	Risk 4.3 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						Service support session at Business Committee which described steps taken to better manage subcontractor received reasonable assurance.	
	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							

Appendix 2

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.

AGENDA ITEM 2019-20 (15b)

Leeds Community Healthcare NHS Trust

Annual Report and Accounts 2018/19

Annual Report and Accounts 2018/19

Welcome from Chief Executive and Chair

Welcome from our Chief Executive and Chair

We're delighted to share our annual report with you and we hope it will give you a flavour of our activities and finances in the previous financial year.

Our healthcare teams improve the lives of people in our local communities often supporting the city's most vulnerable people and those with the most complex needs. This year has seen our teams going the extra mile, in often challenging circumstances, to deliver great care.

We are pleased to report that, once again, we have high levels of patient satisfaction and that we achieved our main performance and financial targets. Our colleagues should be proud of these achievements and you will see many examples of their hard work and commitment included in this report.

We know that an engaged and happy workforce is directly linked to the provision of good patient outcomes - this is one of the main reasons we have continued our commitment to supporting the health and wellbeing of our staff teams this year. We are particularly proud that our 2018 staff survey indicated a 9% increase from 2017 in the amount of staff feeling recognised and valued at work and a 10% increase in staff feeling that senior managers try and involve staff in important decisions. We have been working hard to make sure that our leaders (both managerial and clinical) understand the value of involving people. Our results show we continue to improve year on year and that the confidence of colleagues to recommend LCH as both an employer and provider of services is growing.

To further enhance our support to staff this year we have started conversations about creating the best environment possible to support each other with our mental wellbeing. We have created open spaces for staff to talk about mental health and have committed to training 15 staff to become Mental Health First Aiders.

We pride ourselves too on being an organisation that promotes diversity and inclusion. We are delighted that our Black and Minority Ethic (BAME) reverse mentoring has started here at LCH. This has seen BAME colleagues mentoring senior managers, providing an opportunity for our BAME staff to make connections and share their lived experiences first hand. This two-way approach echoes the values of our organisation - we always seek to treat everyone as an individual, whether this is patient or colleague, and partnerships such as this can only strengthen this resolve. Both of us were part of the first cohort, not least because we want this organisation to be one in which everyone is offered the opportunity to flourish and is encouraged to thrive.

Our services too are constantly growing and developing as we deliver new pathways of care for more people in the community. Quality Improvement is at the forefront of this work and we support staff to make continuous improvements to deliver care and services which are safer, more effective and more efficient. Quality Improvement (QI) programmes undertaken in the year are helping to improve both patient outcomes and staff experience.

With demand growing for services and a relentless focus on quality it is important that we continue to work well with all partners across the city. We must work in this way, bringing our collective expertise together, if we are to provide the best possible care for all citizens of Leeds now and in the future. With this firmly in mind, we continue to build on our partnership work with the local authority and with other NHS and voluntary sector organisations, in order to reduce health inequalities and contribute fully to the health and social care agenda for this city. We also continue to work much more closely with our partners in primary care.

This work is already starting to reap benefits; improved communication between teams, less duplication of work, and providing seamless packages of care for some of the most vulnerable in our communities. Together we have also built our resilience across Leeds to respond to all year round pressures. Winter was a key example of this, across the city we were able to support people 24 hours a day, making sure patients received the care they needed in their own homes, or as close to their own home as possible. If a hospital stay was required, our teams played an important role in making sure people returned home safely, with a package of care in place as soon as possible.

We are extremely proud to be an 'anchor institute' for the city, working together with some of its biggest organisations to deliver better outcomes for people, drawing on the talents of and benefitting people in all our communities.

Our achievements this year are very much the result of our outstanding colleagues both clinical and non-clinical. We must continue to celebrate and acknowledge their achievements and we hope that this annual report gives you a real sense of just how important the role of our teams are in supporting the health and social care needs of the people of Leeds.

We hope you enjoy reading our annual report and we look forward to another successful year in 2019/20.

Neil, Thea

Design note: Signatures and pictures to be included of Neil and Thea

Design note:
Contents page will be added in final graphic design layout

Who we are and what we do

Leeds Community Healthcare NHS Trust (LCH) provides a range of community healthcare services to the people of Leeds. Care is always provided in, or as near to a person's home as is possible.

Our services are organised into three groups: Adult Services, Specialist Services, Children and Families.

Adult Services	Specialist Services	Children and Families
• 13 Neighbourhood Teams (NTs) • Neighbourhood Nights • End of Life • Health Case Management Leeds Integrated Discharge Service (LIDS) • Community Care Beds and Community Bed Bureau • Single Point of Urgent Referral (SPUR) • Wound Prevention and Management • Continence, Urology and Colorectal Service • Community Falls Service • Community Geriatricians	• Improving Access to Psychological Therapies (IAPT) • Podiatry (foot health) • Musculoskeletal Services • Nutrition and Dietetics • Specialist Dental Services • Prison Health (Young Offenders Institute, Wetherby and Adel Beck Secure Children's Home) • Healthcare services for police custody suites across Yorkshire and the Humber • Community Intravenous Antibiotics Service (CIVAS) • Tuberculosis (TB) • Homeless Admissions Leeds Pathway (HALP) • Neurology • Stroke Team • Rehabilitation Unit • Speech and Language Therapy Services • Cardiac, respiratory and Diabetes Services • Leeds Sexual Health • Community gynaecology	**Integrated Services for Children with Additional Needs (ICAN) including:** • Child Development Centres • Paediatric Neurodisability clinics and children's outpatient clinics • Specialist child protection medical services • Community Eye service • Audiology and New Born Hearing • Physiotherapy • Occupational Therapy • Nutrition and Dietetic Services • Day time wetting service **Child and Adolescent Mental Health Services (CAMHS) including;** • Specialist Community service • In-patients service at Little Woodhouse Hall • Infant mental health • Criminal Justice service • Mindmate Single Point of Access (SPA) • Eating Disorders Team • Child and Adolescent Mental Health Services (CAMHS) in schools **Community Nursing Services:** • Continuing Care Nursing Team • Inclusion nursing • Hannah House **Speech and Language Therapy including;**

		• Community service • Feeding and swallowing • Communication Aids **Public Health Integrated Nursing Service (0-19)** • Health Visiting • School Nursing • Sickle cell and Thalassaemia • Watch-It weight management

For more detailed information about any of our services, please visit our website: **www.leedscommunityhealthcare.nhs.uk**

When providing care, our vision is simple:

'We want to provide the best possible care to every community we serve'.

To do this, we make sure we live our values every day:

- 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.

Quality priorities

To help us achieve our vision, we worked with patients, carers and members of the public throughout 2018/19 to develop our quality priorities. They told us that we could improve in the following four key areas:

- Prevention, proactive care and self-management
- Patient experience
- New models of care
- Our workforce

You can find out about how we are doing against our quality priorities in our Quality Account 2018/19.

Design note: Add quality Account Thumbnail

Visit: www.leedscommunityhealthcare.nhs.uk

Performance Report
(How we're meeting our goals)

Alongside our quality priorities, we've been working hard against four key goals for the people of Leeds this year.

Our Four Key Goals:

1: Provide high quality services.
2: Recruit, develop and retain the staff we need now and for the future.
3: Work with health and social care partners to deliver joined up care close to home.
4: Services are fit for purpose now and in the future.

Goal 1 – Provide high quality services

We deliver care to around 5,000 people every day. From April 2018 to March 2019 we delivered 1.5 million episodes of care to people across Leeds and (in some specialist cases) beyond. We always aim to provide high quality patient care.

To achieve high quality patient care, we assess how well we are doing by using the same questions the Care Quality Commission (CQC) uses in its inspections:

During 2018-19 we asked ourselves: Are services **Safe**, **Caring**, **Responsive**, **Effective** and **Well-led?**

Safe:

- No cases of infections such as MRSA or Clostridium Difficile were acquired by patients in our care.
- With the exception of 1 case, all incidents applicable for Duty of Candour were dealt with appropriately.
- We achieved more than a 50% reduction against the target for the number of avoidable category 3 pressure ulcers.
- During 2018-19 we have had two cases of avoidable category 4 pressure ulcers. We continue to focus on training in order to reduce this.

To help monitor the safety of our services, our Board uses key performance indicators (KPIs) and information gained from:

- Listening and talking to patients, carers and families
- Visiting services
- Meeting with staff as they deliver care

Design note: Include some LCH postcard thumbnails

Saying Sorry (also known as Duty of Candour)

If a person suffers harm as a result of an error or omission in the care we deliver, we are committed to being open and honest. We will say:

- what happened,
- what we are doing to put things right,
- what actions we are taking to reduce the likelihood of a similar incident happening again
- we say Sorry.

We have a 'Being Open with Patients' and 'Duty of Candour' policy and procedure. This is to make sure all staff understand their responsibilities. We deliver briefing sessions at service and team meetings and the 'Being Open with Patients' and 'Duty of Candour' policies feature in:

- The Trust's induction day for all new starters.
- The serious incident investigators training.

Our compliance with Saying Sorry (Duty of Candour Regulations) is monitored on a monthly basis by our Quality Committee.

Caring:

Friends and Family Test (FFT)

The Friends and Family Test (FFT) supports the principle that everyone who accesses NHS services should have the opportunity to provide feedback on their experience. (**NHS England)**

The FFT question asks if people would recommend the NHS services they have used to their family and friends and offers a range of responses from Extremely Likely to Extremely Unlikely.

By the end of 2018/2019, the Friends and Family Test shows that more than 95% of our patients would recommend both our inpatient care and the care we deliver in the community.

You can find more detailed information about our FFT responses and how we collect and use this data in the Trust's Quality Account.

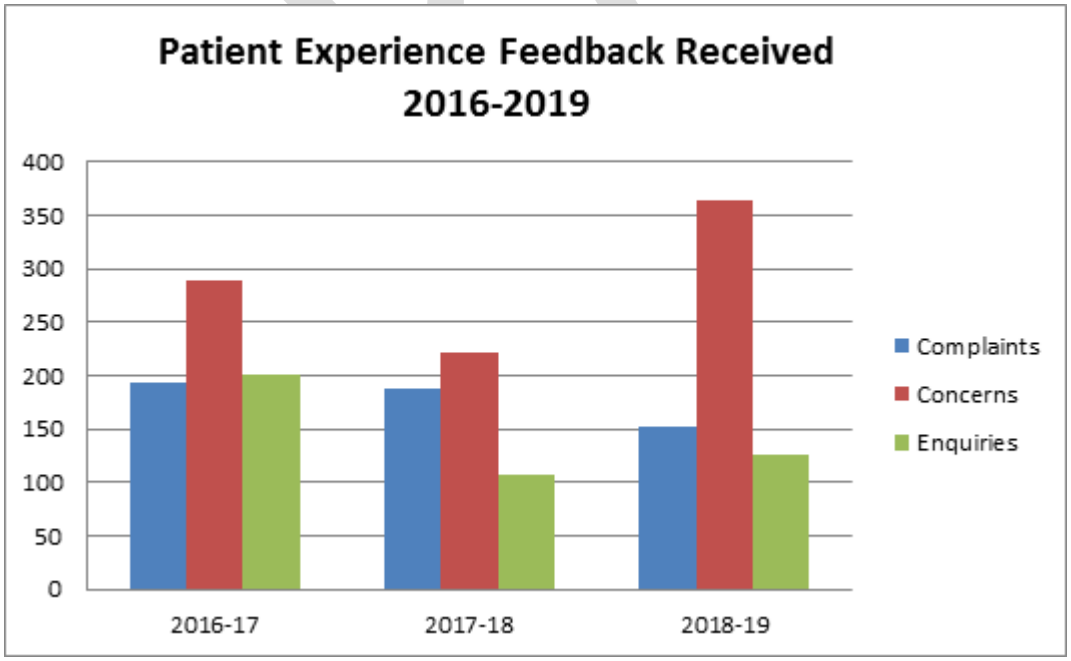
Visit: www.leedscommunityhealthcare.nhs.uk

Learning from Patient Experience (Queries, Concerns and Complaints)

We believe strongly in listening to our patients and really hearing what they have to say. This is even more important when something has gone wrong or when we are dealing with patients who have had a poor experience.

Our Patient Experience Team is here to help those who have a question or want to tell us something about our services. The team is also here as an alternative at approaching a service directly. The Patient Experience team works with all services in the trust and with other health and social care partners in the city. They ensure a 'no wrong door policy', an approach agreed with *Healthwatch Leeds. This means that no matter which health or social care organisation in the city a person contacts in the first instance, the receiving organisation will pass the right information on. This is to make sure a person with a complaint, concern or question is not faced with having to tell their story to lots of different people.

During 2018/19 we received 152 complaints about the services we provide. During the year two people asked the Trust to re-open their complaints to look at issues again**.** Two referrals were made to the Parliamentary and Health Services Ombudsman but we have received no further contact from the Ombudsman. There were also 365 concerns received and a total of 126 enquiries recorded. We also received 1472 compliments



*Healthwatch Leeds helps local people get the best out of their local health and care services by bringing their voice to those who plan and deliver services.

Of the complaints we received, we upheld either part, or all, of 43% of them. We answered more than half of the complaints we received within our target response time of 40 working days or less.

The table above shows the number of complaints, concerns and enquires received by the Patient Experience Team over the past three years.

The top five themes for complaints in 2018/19 were:

1. Clinical judgement/treatment
2. Appointment (for example, the waiting time, being unable to get an appointment or the failure or delay in a referral process).
3. Attitude, conduct, cultural and dignity issues
4. Communications issues with the patient
5. Access and availability (for example, availability of home visits, issues with the entrance to health centres or car parking facilities).

More detailed information can be found in our Quality Account available on our website: **www.leedscommunityhealthcare.nhs.uk**

Responsive

- We meet all nationally reportable and internal targets for waiting times.
- At year end the Trust was seeing more than 95% of patients on consultant-led pathways within 18 weeks.
- No patients have waited more than 52 weeks in our consultant led services
- During 2018/2019, a joint proposal with NHS Leeds CCG was agreed to reduce the ‘activity profile’ within Adult Neighbourhood Teams. This has allowed our staff to spend much more time with patients when it is needed and has enhanced the quality of care.
- At the year-end 100% of patients were waiting less than 6 weeks for diagnostic tests.
- More than 99% of patients were treated within 18 weeks of referral to Improving Access to Psychological Therapies (IAPT).

Effective

- We achieved the 80% target for clinical supervision throughout the year

- During 2018/19 **Five (5)** national clinical audits and one (1) national confidential enquiry covered the NHS services that LCH provides. During that period LCH participated in **80%** of national clinical audits and **100%** of national confidential enquiries which it was eligible to participate in.
- The reports of **106** local clinical audits were completed by LCH in 2018-19
- In February 2018 we updated our NICE Guidance Policy and now allow ourselves two years to put in place complex care pathways with our patients.
- During 2018/19, Services continued to review NICE guidance as it was published, and put in place changes to care pathways as required. Of the 38 pieces of guidance issued by NICE during 2016/17, we were able to fully put in place all relevant recommendations for 35 (92%) within our two year timeframe. This means that patients and their families were able to receive evidence-based care and treatment.
- Learning is shared at our strategic mortality surveillance group. It is also shared within business units and more widely across the whole organisation if required.

Well-led

We have continued to identify challenges and make progress in meeting them as our performance assessment shows:

- Good progress continues to be made in reducing our staff turnover rate, which continues to be below the Trust's target of 15%, and remains below other benchmark community provider trusts. Our overall stability index meets our target of 85.5%
- We recognise the importance of annual appraisal for all staff and have consistently had overall monthly Trust appraisal rates above 80% across the year, but we are missing the target of 95%
- Our total sickness absence rate across the year has varied seasonally as we would expect with year-end position below the trust target of 5.8%
- Our statutory and mandatory training percentage has consistently been at or above 90% across the year and we continue to look for new ways to support staff accessing and completing this important requirement.
- We continue to work hard to meet all requirements of the Equality Act 2010 Public Sector Equality duties.

- We currently hold an overall NHS Equality Delivery System2 (EDS2) grading of 'achieving' and have made progress in two agreed equality objectives:
  - Disability Confident Leaders accreditation
  - Workforce Disability Equality Standards (WDES)

- We continue to work with the local authority, other NHS and voluntary organisations in Leeds to reduce health inequalities.

Goal 2 – Recruit, develop and retain the staff we need now and for the future.

We want to make sure that our Trust is able to deliver the best possible care in all our communities. In order to do this we need a workforce that can adapt and respond to current and future requirements, challenges and opportunities, both inside and outside of the organisation.

With this firmly in mind, a Workforce strategy has been developed which sets out our key workforce priorities.

Design note: Thumbnail of the front of the Workforce strategy

Our workforce priorities are:

Leadership and Skills: We will support the development of our leaders to make sure that every individual experiences good or excellent leadership and has access to the right level of training and development, regardless of where in the organisation they work. One example is our new leadership development offer:

Design note: Thumbnail of the Leading by example poster

Resourcing: We will recruit the right people with the right skills and deploy them to deliver the best possible care in all our communities now and in the future. Once we have attracted the best staff, we want to keep them engaged and motivated to remain with us and have a range of initiatives in place to support this.

Integration and Partnership: We continue to work effectively with primary care, the city of Leeds and the Integrated Care System (ICS) in our area on workforce and human resources (HR) strategies, systems and plans. We're doing this in order to deliver benefits to our patients and communities. We're working with our health and care partners to promote career opportunities available across the city and we have trained ambassadors who continue our efforts to attract a future workforce.

Proactive Analytics: Our workforce systems have been improved with a newly-created Systems and Intelligence function. This delivers sophisticated workforce data and analytics to help us make the right business decisions. Our new e-rostering

solution is also making sure we have the right staff, in the right place at the right time.

Wellbeing: We place equal importance on mental health and wellbeing and physical health and wellbeing. Our Health and Wellbeing Group drives this work forward. Some examples include:

- Open conversations with staff about their mental health
- Training for staff to become Mental Health First Aiders
- Regular displays at Trust HQ of artwork produced by a colleague who uses painting to help with her mental wellbeing.
- Wellbeing in the Workplace workshops

Regardless of service area or geographical location, our workforce is more likely to be well at work and more engaged with work than in 2017-18.

Diversity and Inclusion: In line with the Trust values we want to make sure that every colleague is treated as an individual. One example of how we're doing this is through our newly established Reverse Mentoring Scheme. The scheme sees a black or minority ethnic (BAME) staff member act as a mentor to a B not from a BAME background. The aim is to begin new conversations about issues affecting BAME staff in the workplace.

Design note: Include Temba/Thea selfie or Bryan and his mentor with caption

In March the Trust held a 'Race for Equality' event at Elland Road in Leeds which welcomed more than 100 delegates. The aim was to increase leaders and managers understanding of the Workforce Race Equality Scheme and to increase awareness of the issues facing BAME colleagues.

Design note: Include pledge pictures from Twitter – Jenny and then Neil with delegates

NHS National Staff Survey 2018

Every year we take part in the NHS National Staff Survey. This year more than half our staff (52%) completed the survey. This compares well with the national average of 43%. In this year's survey, which is a year on year comparison, 46 of the 66 questions had positive changes from 2017:

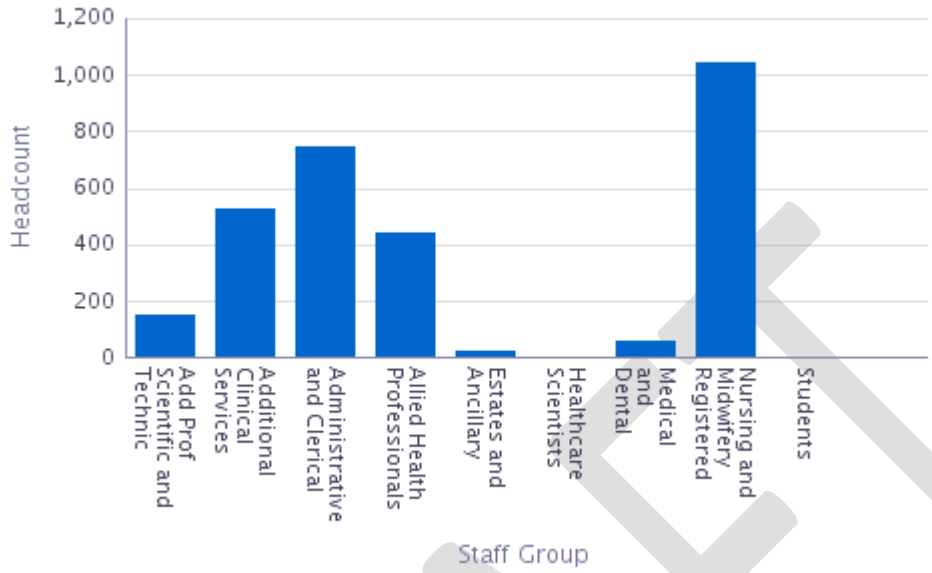
Design note: Include the Staff Survey Result 2018 graphic here:

Some areas for development:

- Staff ability to make suggestions to improve their working environment
- Continue to explore opportunities for career development
- Continue to work on team development to ensure people feel supported within their teams and by their teams.

Workforce Profile

Our workforce is organised into the following staff groups:



The table below shows the number of people we employ in each staff group. FTE stands for full-time equivalent.

Staff Group	Headcount	FTE
Add Prof Scientific and Technic	150	124.02
Additional Clinical Services	525	436.02
Administrative and Clerical	745	643.11
Allied Health Professionals	441	353.16
Estates and Ancillary	26	23.91
Healthcare Scientists	6	4.50
Medical and Dental	61	49.19
Nursing and Midwifery Registered	1,037	902.95
Students	5	4.80
	2	
Grand Total	**2,998**	**2,541.66**

Staff flu campaign

Led by Infection Prevention and Control (IPC) Nurse, Jeanette Wood, with support from the IPC team, our 2018 flu immunisation campaign was endorsed by the Trust's now famous flu mascots 'Flo' and 'Frankie'- who helped vaccinate 75% of colleagues. This season, due to the mild weather, we saw lower levels of flu generally circulating through Leeds. But we know that flu is still a huge risk to the people we serve.

Design note: Photos of Flo and Frankie with staff in annual report file.

Speaking Up

Every NHS Trust has a Freedom to Speak up Guardian (FSUG). The role was developed nationally, in response to the needs set out by Sir Robert Francis, in his Freedom to Speak Up review. The aim is to promote a more open and supportive culture that encourages NHS colleagues to speak up about any issues of patient care, quality or safety.

Our current FSUG regularly attends Trust Board meetings, for the Board to check they are adequately supported in their role.

Our current Freedom to Speak up Guardian is John Walsh.
Design note: Include FTSUG poster thumbnail

Alongside our Freedom to Speak up Guardian, the Trust has a number of ways for colleagues to tell us about their experiences. These include; direct line managers, Ask Thea (anonymous email to the Chief Executive), Human Resources (HR) team, Staffside team, direct access to directors, board member visits to services and Anti Bullying Officers.

We're Proud of… Our innovative approach to recruitment - we showcased the work of our neighbourhood teams to potential new recruits on a fun and informative bus tour. Our approach was recognised by NHS Employers.

We're Proud of…Our approach to upskilling our workforce. We're using our apprentice levy and we've introduced a New Nursing Associate role to our workforce.

Design note: Include a small picture and a testimonial for the Nursing Associate role.

We're proud of…our organisation's work to lead the national development of a district nursing apprenticeship

We're proud of…our place in the Inclusive Top 50 employers list
Design note: Inclusive Top 50 UK employers' logo

We're Proud of…our Communications Team who won a *national industry award, in the Best Event category. The acknowledgement was for the Trust's staff recognition schemes: 'Thanks a Bunch' and 'Thank You Event.

*Communicate magazine's Internal Communications & Engagement Awards.

Goal 3 - Work with health and social care partners to deliver joined up care close to home.

Our care is organised into three service areas:

- Children and Families
- Adult
- Specialist

Here's how we've been working to achieve Goal 3 across our different services.

Children and Families

Our vision is to work with children, young people and their families and with other colleagues across the Trust and the city (for example, teachers and commissioners) to make Leeds the best city for children to grow up in. Our children's and families strategy, which sets out our commitment to this vision, was launched in May 2018. Some of the developments we're making to help us achieve this vision are highlighted below.

Design note: Thumbnail of the strategy cover

Children and Young People Service Developments for 2018/19 include:

Child Health Hubs

Across all areas of Leeds, we've been looking at how we can work in a better way with primary care (you might know this as your family doctor or GP) to meet the needs of children, young people and families.

Since April 2018, we've been working with commissioners and GP colleagues on three pilot Child Health Hubs based in the community:

- Pudsey (focus on complex care)
- Harehills (focus on 0-19 and safeguarding)
- Beeston and Middleton (focus on young people's mental health)

The aim is to deliver better outcomes and reduce demand on services on the children's services that are provided in a hospital setting.

Changes to our 0-19 Healthy Child Pathway/ Early Start Service
In November 2018, we were successful in winning the tender to deliver a refreshed and more innovative service for children and young people aged 0-19 years, or up to the age of 25 for those with additional needs.

Commissioned by Leeds City Council the 0-19 Public Health Integrated Nursing Service went live on April 1 2019. A result of extensive consultation with over 800 children, young people, parents/carers and professionals, the refreshed servicewill be better for children and families in the following innovative ways:

- **One Team Approach** - brings together into six citywide teams Health Visitors, School Nurses, Nursery Nurses and Healthcare Support Workers. This will make sure that families see the right practitioner, at the right time, in the right place. It will provide the opportunity for families to continue to work with the same health practitioner over a longer period of time.
- **Located in Children's Centres in the community** - We are working towards bringing together the 0-19 Public Health Integrated Nursing Team within Children's Centres as part of Early Start Teams. This is an ambitious goal and will be achieved in a phased approach, the first step towards this will be each of the six teams re-locating to health centres in the local community.
- **ChatHealth for Children and Young People (11-19)** – a confidential text messaging service for children and young people in Leeds to send questions to a School Nurse. They will receive a reply that may include some brief advice, an offer of direct support from the service or signposting to other services.
- **Flexible and accessible service** – increased flexibility and accessibility to the service. Clinical staff will be available 8.00am – 8.00pm on weekdays Elements of the service will be delivered within these extended hours to better meet the needs of families.

Design note: Photography from the 0-19 photo shoot and graphic elements from our promo collateral

You can view our 0-19 video that explains the service on our website.

Gold Award for our Specialist Public Health Nurses (Health Visitors)
In October 2018, our 0-19 team was amongst a very small number of services to be awarded the UNICEF Baby Friendly Initiative Gold Award. The award is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support the best health and development.

New care model for Child and Adolescent Mental Health Services (CAMHS)
2018/19 was the first full year of our pilot new care model for Child and Adolescent Mental Health Services. The main aim of the pilot is to reduce the number of unnecessary admissions for West Yorkshire children and young people to in-patient beds. Where an in-patient stay is necessary we aim to achieve this much closer to home in a modern, fit for purpose space. We have had good success in reducing in-patient days and have started to reinvest the money saved into community services to better support children and young people across West Yorkshire where they live. Together with the development of the new Unit which will be built in Leeds there will have been a real transformation in CAMHS across West Yorkshire.

Progress towards a new community inpatients unit for young people
Since the announcement that new mental health unit would be built in Leeds, to serve the children and young people of West Yorkshire, we've been busy asking young people staff and local people what they would like to see in the design of the building and services. The purpose built facility will be located in the grounds of St Mary's Hospital in Armley.

Speech and Language Therapy – Better Booking
In April 2018, we piloted a centralised appointments booking system to help drive down waiting times and improve how clinical time was used. Clinicians released control of their electronic diaries to our admin team to plan and book clinic or school appointments directly from waiting lists. This great partnership working has seen waiting times reduced from above 18 weeks (with some outlying long waits of 42 weeks) to an average wait time of between 9 and 13 weeks. Centralised booking is now being rolled out across other teams.

A Smoother Journey into Adulthood; Transitions Conference

In October 2018, we hosted a conference. The conference: *a Smoother Journey into Adulthood,* was aimed at helping delegates gain a better understanding of:

- Children's and Adult Health Services
- Empowering young people to become adults of the future - able to access Adult Health Services and support effectively

The conference was well attended by partner organisations in Leeds as well as by colleagues from across our service areas.

Improving Engagement with Children and Young People
In the last year, we have been busy developing a young people's forum and our Youth Board will begin meeting soon.

Young people have also been involved in reviewing our training session for young volunteers who take part in our recruitment panels. This is to make sure that training is appropriate and that it helps to prepare young people wishing to take part.

We're Proud of…

…Rebecca Fellows, Assistant Psychologist, from our Infant Mental Health service. Her passion for service user participation saw her take the lead in organising a hugely successful conference for practitioners to look at the importance of supporting dads to be involved in the lives of their young children.

.

…The Children's Community Nursing Team, they deliver an emotionally and physically demanding service, helping children and families lead lives that are as normal as possible by providing care - including dressings, wound care and chemotherapy - to the children of Leeds in their own homes.

… Lorraine Ingram, Health Visitor in the Infant Mental Health Team and all other staff involved in the Early Attachment Observation (EAO) assessment tool project. This ground-breaking area of practice has introduced a structured way for health visitors to talk to parents about how their baby is experiencing the world and their relationship with their parent. The project has become an important part of our Universal offer – which sees every child in Leeds have access to five key visits between the age of 0 and 5 from our expert team.

Adult Services

Within our Neighbourhood Teams we continue our work to bring together adult services to provide multidisciplinary, nursing and therapy care for frail and elderly people and those with long term conditions.

This work has been guided by feedback that the people of Leeds, patients, carers and our staff told us what they want:

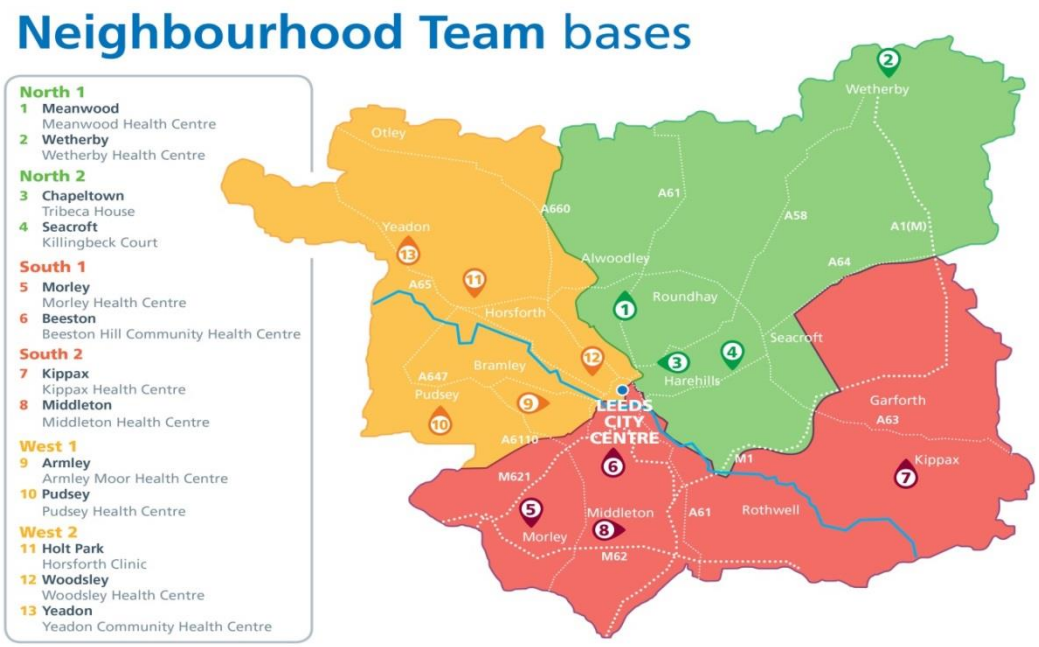
> "Support that is about me, my life, where services work closer together by sharing trusted information and focusing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect."

We have worked in partnership with primary care, adult social care, mental health and hospital providers to jointly understand local needs and improve our joined up response.

How a Neighbourhood Team Works:

- Our Neighbourhood Teams provide 24 hours a day care, 365 days a year.

- Team members who were previously district nurses, intermediate care nurses, community matrons and adult domiciliary physiotherapists work together as one team across 13 neighbourhoods.
- We work together with colleagues from adult social care to provide seamless care.
- We have 13 Neighbourhood Teams across the city. These are based around GP registered practices.
- Each team works in caseload clusters which cover one or more practices within an area. This is to make sure care is consistent and that we work with other health and care professionals to deliver proactive joined up care to people and their families.
- Teams really get to know their community and are able to respond in a timely way.



We also provide support through a range of teams who work alongside our Neighbourhood Teams.

These teams are:

- **Health Case Management:** specialist city-wide case management for people aged 18 years and over who are eligible for NHS Fast Track and Continuing Healthcare funding.

- **Leeds Integrated Discharge Service:** supports people who need extra help to plan for leaving hospital. We work with; Leeds Teaching Hospitals Trust, Adult Social Care and Age UK.

- **City-wide Services:** support for continence, wound prevention and management, falls and end of life.

- **Nursing and Therapy:** We offer this for some patients in our Community Care Beds

- **City-wide Bed Bureau:** matches people requiring community bed provision with available beds.

- **Single Point of Urgent Referral (SPUR):** manages patient referrals from community and hospital settings into a range of community services.

Adult Services Developments for 2018/19 include:

Dementia, Delirium and Depression Guidance
Neighbourhood Team colleagues have been provided with a Clinical Care Framework (best practice guidance) for Dementia, Delirium and Depression (the 3Ds).

Safety Huddles
We have introduced safety huddles in Neighbourhood Teams and Community Care Beds services. These are the first safety huddles in NHS community settings to be recognised nationally by the NHS Improvement Academy. A safety huddle is a short multidisciplinary briefing, held at the same time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.

Design note: we have photos of this

Local Care Partnerships
This is where health and care services come together to understand and jointly respond to people's needs. We are working more closely with colleagues in primary care (family doctors, GPs), third sector, social care and other local partners to put in place Local Care Partnerships. This includes working together on 'Population Health Management Programme' approaches as one of four national pilot sites.

Other ways we are working more closely with primary care and/ or third sector partners include the development of leg clubs, wound care hubs and a pilot project which sees our occupational therapists being based in GP practices.

Self-Management/Self Care
We know that people have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management or self-care is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with services provided by health and social care services.

We have developed our approach to self-management or self-care with a focus on 'working with' people rather than 'doing to' people.

Breakout boxes:

We're Proud of…

…Fiona Allport, Clinical Pathway Lead for Self-Management and Rehabilitation and Marie Boul, Self-Management Team Lead, for their self-management project. This has had great outcomes for patients in our Neighbourhood Teams, improving patient independence and allowing more time for teams to focus on patients unable to self-manage.

…Claire Morris, Neighbourhood Team Administrator. Claire often goes above and beyond in her role to support palliative patient's last wishes.

…Michelle Platt, District Nurse, for her outstanding end of life care and the support she provides to some of our most vulnerable patients and their families.

…Stewart Miller, Neighbourhood Clinical Trainer. His days are spent out and about in our 13 Neighbourhood Teams, upskilling frontline clinicians in areas where training and development is needed.

Specialist Services

It has been another busy year for Specialist Services. Our ambition at the start of the year was to:

- **Maintain and improve**
- **Grow and develop**
- **Gain new business where appropriate**

Here are just some of the ways we have done this throughout 2018/19

Maintain and Improve:

- **Providing the best possible care outside of a hospital setting:** We have continued our work with key partners within the West Yorkshire and Harrogate Health and Care Partnership and within the city of Leeds. Our aim is to make sure that admissions to hospital are reduced and that discharges out of hospital are managed quickly and well, with appropriate packages of care wrapped around the patient.

- **Police Custody:** In January 2018 we were awarded a new regional four year contract, with a possible further extension to provide custodial care across Yorkshire and the Humber. This builds on the success of our previous contract and includes more investment in staffing and the introduction of a

new resilience team. The new contract started in April 2018 following a major, and highly successful, recruitment drive.

- **Dental Service:** We were awarded a contract which came into effect from November 2018. Commissioners are working closely with service providers across the region to develop a new regional service model and set regional standards. We will be supported to develop and deliver the new service throughout 2019.

- **Improving Access to Psychological Therapies (IAPT)** This service is subject to an upcoming tender process. Our IAPT team has been working hard over the last six months to develop a joint bid with Leeds and York Partnership Foundation Trust, third sector organisations and the GP Confederation and we are awaiting the outcome. We will continue to improve access for patients, between now and the award of the new contract, with the introduction of more staff and new investment in the service.

Grow and Develop:

A number of services have had significant investment over the past year;

- **Stroke Service:** working closely with Leeds Teaching Hospitals Trust we have refreshed the way the service is delivered. This sees patients discharged earlier from hospital to receive rehabilitation at home.

- **First Contact Physio:** we have started working with Primary Care (you may know this as your family doctor or GP) to put in place this pilot service. The service allows patients direct access to a physio appointment at their surgery without the need for a GP appointment first. In 2018 the service has been working in the LS8/9 and LS25/26 postcodes. The ambition is to achieve a citywide service offer in the next 2 years.

- **The Leeds Programme:** a tailor-made structured education programme for people with Type 2 Diabetes. Further investment was also targeted to our podiatry team (foot health) to introduce a Foot Protection Service for people living with diabetes.

- **Diabetes Service:** we are actively involved in work to develop the Diabetes Strategy for the city. Talks are underway with a wide range of stakeholders to plan for the introduction of a single point of access which will be introduced in 2019.

- **Virtual Ward:** The aim of the Virtual Ward is to promote and support an early discharge for medically fit patients who wish to return home rather than remain in hospital. Care needs are met at home by community nurses and therapists which often enhances the rate of recovery. In addition, hospital beds are released for the use of patients with acute healthcare needs. We introduced this service for people experiencing the serious effects of Chronic Obstructive Pulmonary Disorder (COPD) in Seacroft and Chapeltown and

later extended to Armley and Middleton. Additional funding will be available for 2019/20 to extend the service across the city.

- **Secure Stairs:** Is part of a national framework that looks at the needs of some very vulnerable children and young people whose particular mental healthcare requirements can be hard to meet through conventional services. Secure Stairs sets out a psychologically informed therapeutic approach for children and young people in secure settings. It looks in a joined up way at assessment, sentence/ intervention planning and care and makes sure that teams have the right skills to support these often high risk, high harm, high vulnerability children and young people. This approach was put in in place at Adel Beck Secure Children's Home in 2018/19 and will be introduced to Wetherby Young Offenders Institute in 2019.

Gain new business where appropriate:

We were successful in being awarded two new contracts from April 2019:

- **Liaison and Diversion Service:** this will operate in the Hull & Humber region, closely aligned to Hull & Humber Police Custody. The service will work with people to reduce re-offending and support their health and wellbeing.

- **Tier 3 Weight Management Service:** will fill a current gap in service for people needing/awaiting bariatric surgery. We will be the lead provider and work alongside partners at Leeds Teaching Hospitals Trust (LTHT).

Specialist Service Developments for 2018/19 also include:

A number of services have been working closely with Leeds Teaching Hospitals Trust (LTHT) to deliver 'joined up' healthcare for patients who are between hospital and community care. The services involved include:

- Community Intravenous Antibiotics (CIVAS)
- Community Neurology Team
- Parkinson's disease
- Long Term Conditions
- Community Gynaecology

To do this, we've improved the way we work together to deliver services in the best way possible for patients, for example we:

- Provide joint training and development
- Have integrated our nursing service for people with Parkinson's disease to make sure there is equal access for patients across Leeds (begins 1 April 2019)
- Introduced a single point of access and triage in Community Gynaecology to reduce duplication, improve access to appointments and reduce the number of appointments for patients.

We're proud of…

…Dr Christine Comer: awarded a clinical lectureship in the field of Spinal Stenosis. Christine will focus on expanding Allied Health Professional led clinical research, and be looking at how we put in place a long term plan for improving community based musculoskeletal care (the care of muscles and bones) across Leeds.

…Mark Simpson and the Dietetics service who won a national award for the development of their e- referral system.

…Liz Keat, Outreach Nurse Gypsy/Traveller community. Liz received the Queen's Nurse Award for her work to support the Gypsy and Traveller community living in Leeds.

…Alex Hammond, Business Development Manager. Alex stepped up to lead a project at a time of strained capacity, developing a large, strategic piece of work within very tight timescales.

…Lee Maloney, Clinical Advisor (Informatics). Working in partnership, Lee overhauled an important Police Custody clinical system - a huge project that has improved the way we work.

…Leeds Sexual Health Service. The team made significant improvements in response to patient feedback. This included changing clinic times to better meet patient need and developing its staff training and development.

…Post-Traumatic Stress Disorder (PTSD) team. They made improvements in childhood trauma patient care; including introducing PTSD champions across a number of services.

…Gail Fort, Podiatry Service Manager. With over 30 years' experience of working in community care, Gail is a passionate, committed and enthusiastic service manager who looks after a happy, fulfilled workforce.

Goal 4 – Services are fit for purpose now and in the future.

To make sure our services are fit for purpose we aim to make sure we are:

- **Working in partnership**

- **Involving people in our plans**
- **Meeting our legal obligations**
- **Providing value for money**

Working in partnership

The NHS isn't a single service; it's a collection of separate organisations providing all the health care that people need to keep them as well as possible from the birth until the end of life.

In the past, separate organisations haven't worked together as well as they could have done and that hasn't helped our patients. Now there's a real determination to work together in partnership so that we can offer the people of Leeds, West Yorkshire and, in some specialist cases, beyond care that meet their needs.

We share, we learn from each other and we make sure that we are providing the services people need in places they can easily get to. It's complicated, and things don't always happen as quickly as we'd like, but there is a genuine will to make the NHS the best it can be and to spend the money that's available as wisely as we can.

We're a proud partner to the following organisations:

West Yorkshire and Harrogate Health and Care Partnership
West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) brings together all health and care organisations in our six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield to meet the needs of people as close to home as possible.

You can find out more at: www.wyhpartnership.co.uk/next-steps or ask us for a printed copy.

Leeds Academic Health Partnership (LAHP)

As a founding partner in what is one of the biggest partnerships of its kind in the UK, we work with other LAHP partners to bring together research, evidence and experts to secure a healthy future for Leeds.

Other LAHP partners are three of the universities in Leeds, the city's other two NHS trusts, NHS Leeds Clinical Commissioning Group and the City Council. Its wider membership includes the Yorkshire and Humber Academic Health Science Network, Yorkshire Cancer Research, St Gemma's Hospice and Leeds City College.

You can find out more at: www.leedsacademichealthpartnership.org/

(Design note: Logo needed) GP Confederation

The Leeds GP Confederation was established in March 2018. Its purpose is to improve the quality and sustainability of General Practice whilst developing integrated models of care for the populations it serves: www.leedsgpconfederation.org.uk

Our other NHS partners in Leeds are:

- NHS Leeds Clinical Commissioning Group: www.leedsccg.nhs.uk
- Leeds Teaching Hospitals NHS Foundation Trust: www.leedsth.nhs.uk/
- Leeds and York Partnership NHS Foundation Trust: www.leedsandyorkpft.nhs.uk

But the NHS only makes up part of the health and social care jigsaw. Services and support are offered by charity and voluntary groups, which the NHS refers to as 'the third sector'. Sometimes these are 'commissioned' – which means there is a contract which sets out the quality and quantity of services to be provided and the amount paid for them; sometimes they are provided on a voluntary basis and no money changes hands.

Local councils also have responsibility for public health and for providing social care – this means care that isn't considered to be nursing. You can find out more about Leeds City Council's health and social care here: www.leeds.gov.uk/residents/health-and-social-care

Involving people in our plans

To make sure that we provide the best possible care to every community in Leeds and, in some specialist cases, beyond we continually review what's working well, what isn't and where we can make improvements. As a result we sometimes propose changes to our services. This can include anything from changing the time of a clinic and extending surgery times, to asking people to attend appointments at a different health centre. Gaining feedback on our plans from patients, carers,

partners, the public and staff is essential if we are to get things right and make the right decisions.

Here is one of the ways we have involved and engaged patients, carers and the public in our work this year:

New Child Mental Health Unit

It is very important to the Trust that the voice of young people, families, staff and the local community has a strong presence in the development of the new CAMHS in-unit to be built in Leeds and we will continue to work together to make sure we get it right.

So far, we have held two engagement sessions with young people and one session with parents and carers. The sessions have helped us to understand what is important to people in the design of the new building and how we improve both patient and visiting experience at the new unit. We have also asked for feedback on plans developed so far.

We have also held a drop-in information session for members of the public to view and comment on initial plans. Our staff, construction and design representatives were all on hand to answer any questions about the unit.

We will continue to involve young people, their families and carers, member of the public, staff and our partners throughout the project.

Meeting our Legal Obligations

We recognise the legal obligations we have as a provider of NHS funded healthcare. We take care to uphold these responsibilities in order to work as efficiently as possible with our partners and within our local community.

Here are some examples of how we do this:

Emergency Preparedness and Resilience
We continue to fulfil our requirements set out in the Civil Contingencies Act 2004. The requirements make sure that we are able to respond in the best way possible to any form of disruption to normal service or a major incident. This includes:

- **Major incident plan:** regularly updated to ensure it is fit for purpose
- **Management on call:** a dedicated and trained on-call team who lead our response to a significant event (This Major Incident Plan and the on-call team are regularly tested through desk-top, situation-based training sessions and communications tests)
- **Emergency Team:** members take part in regular multi-agency exercises and events to strengthen and reinforce our ability to contribute as part of a wider multi-agency response to a major incident.

- **Business Continuity plans:** are in place to protect against the impact of a wide range of emergency situations which may affect normal service delivery.
- **Operational Pressures Escalation Levels (OPEL) plans**: these plans have been introduced to detail the triggers which would prompt escalation (inside our organisation and across the local health economy) and the actions required to mitigate and manage an incident. These plans have been developed with, and are aligned to, the OPEL plans of our partner organisations.
- **Local, regional and national exercises:** we work closely with partners in key areas to make sure our plans work well within the wider health economy.
- **Local Health Resilience Partnership:** as an active member we take part in a number of associated forums and groups along with more local planning-based task groups.
- **Emergency planning functions:** full plans are put in place to deal with national issues that may affect service delivery. Most recently, planning has involved national issues relating to clinical waste and Brexit.

Health and Safety

We are committed to maintaining an environment where the health and safety of staff, patients, visitors, contractors and the public is assured. This is in line with Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999).

Health and Safety in our Trust is overseen by a Health and Safety Group. The group meets every three months and is chaired by the Executive Director of Finance and Resources. The group's membership includes staff-side representatives.

Our Trust Board has approved a Health and Safety Policy, which works alongside our corporate governance processes.

The following people work together to make sure we meet safety standards:

- Health and Safety Officer
- Risk Manager
- Security Officer
- Infection Prevention and Control Team
- Estates Team

The team does
this by completing a programme of inspections and assessments of all the buildings we own or occupy and by providing suitable training, advice and support to staff.

Health and safety data, in particular Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) reports following serious incidents, show a declining number of serious health and safety incidents occurring and reported to the Health and Safety Executive (HSE) in 2018/19.

There were five events that met the criteria for reporting to the HSE under RIDDOR Regulations.

In 2018/19, the HSE did not issue our Trust with any statutory enforcement notices. A statutory enforcement notice would see an employer having to take immediate action to improve health and safety risks for its employees.

Fraud
We have a zero tolerance to fraud and we work hard to prevent, deter, detect and investigate it. Our counter fraud work is undertaken by a counter fraud specialist from our Internal Audit team and is overseen by the Executive Director of Finance and Resources. Our counter fraud work complies with the NHS Standards for Providers of NHS services.

Modern Slavery Act 2015
We meet our responsibilities under this act, as our suppliers are subject to standard NHS terms and conditions.

Disclosure of personal data related incidents
The General Data Protection Regulations (GDPR) were introduced as part of a new UK Data Protection Act 2018 (DPA), which repealed and replaced the 1998 Act.

The new legislation strengthens the rights of data subjects, while increasing the responsibilities of organisations to process personal data in a lawful and transparent manner. This means that:

- Incidents calculated as externally reportable ***must*** be reported to the Information Commissioner's Office (ICO), through NHS Digital's Data Security and Protection Toolkit (DSPT)
- The approach to the management of personal data related incidents has been revised and a different reporting and escalation criteria was produced by NHS Digital in September 2018 - Guide to the Notification of Data Security and Protection Incidents.

Risks to data security are managed by making sure that all colleagues with access to patient-identifiable data have the required access permissions and have completed their compulsory information governance training. All IT equipment is fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

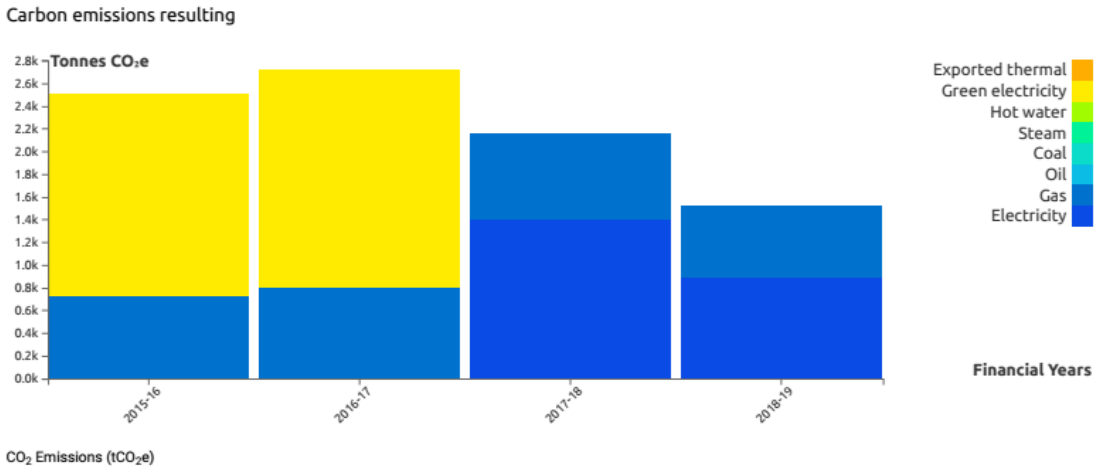
The Trust made a self-assessment against the Data Security & Protection Toolkit (DSPT) of all data security standards have been met as at 31 March 2019.

Sustainability Performance

Since the 2007 baseline year, the NHS has undergone, and continues to undergo, significant restructuring. The services provided by Leeds Community Healthcare have been provided by different organisations since 2007. Where information is available, this section reports on our sustainability performance.

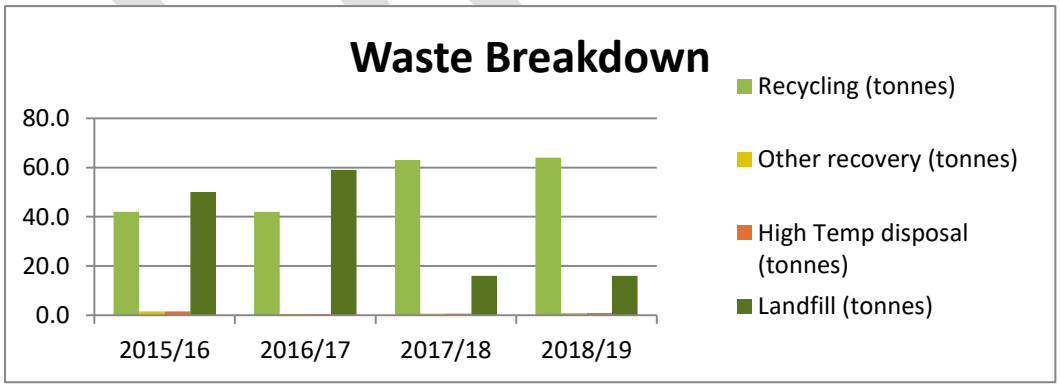
Energy

2018/19 saw a significant reduction in our carbon emissions as a result of the mild winter. Our electricty generating fuels mix currently has 40% renewables.



Waste

Waste volumes in 2018/19 were consistent with the previous year. During the year we introduced segrator bins to pre-sort waste. Landfill disposal is minimised. Clinical waste tonnages have had to be estimated because the Trust'specialist waste contrator ceased providing services during the year with a subsequent loss of data.



Travel

Many of our services are provided to people in their own homes or in facilities located in their community. Whilst this reduces the need for patients to travel to receive care it does mean that the number of miles travelled by staff (business travel

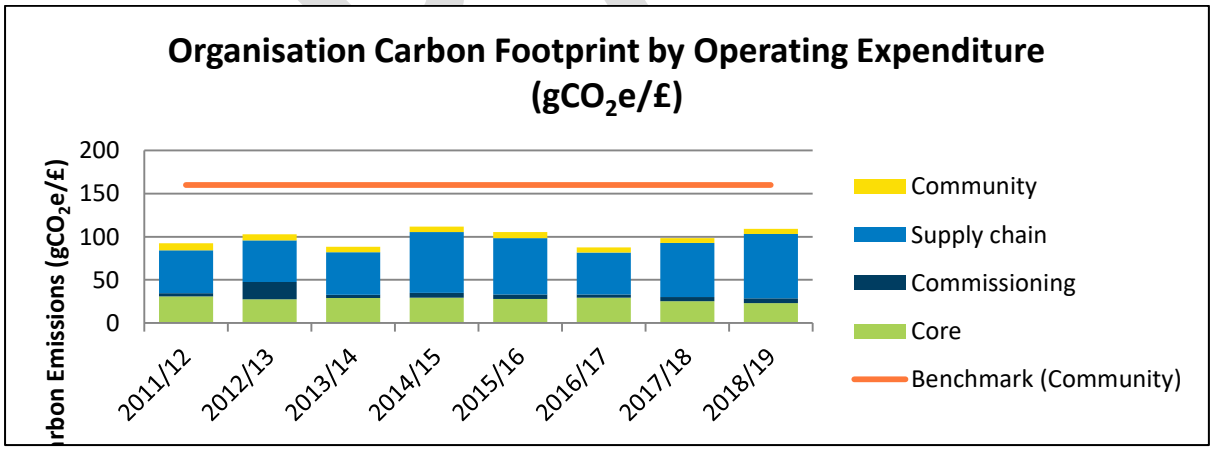
and fleet in the table) to deliver care is high. The figures are increasing due to the increased range of services we provide and the intention to provide more care locally. However, we recognise that we need to do more to provide high quality, local care whilst minimising the impact of the resultant carbon emissions.

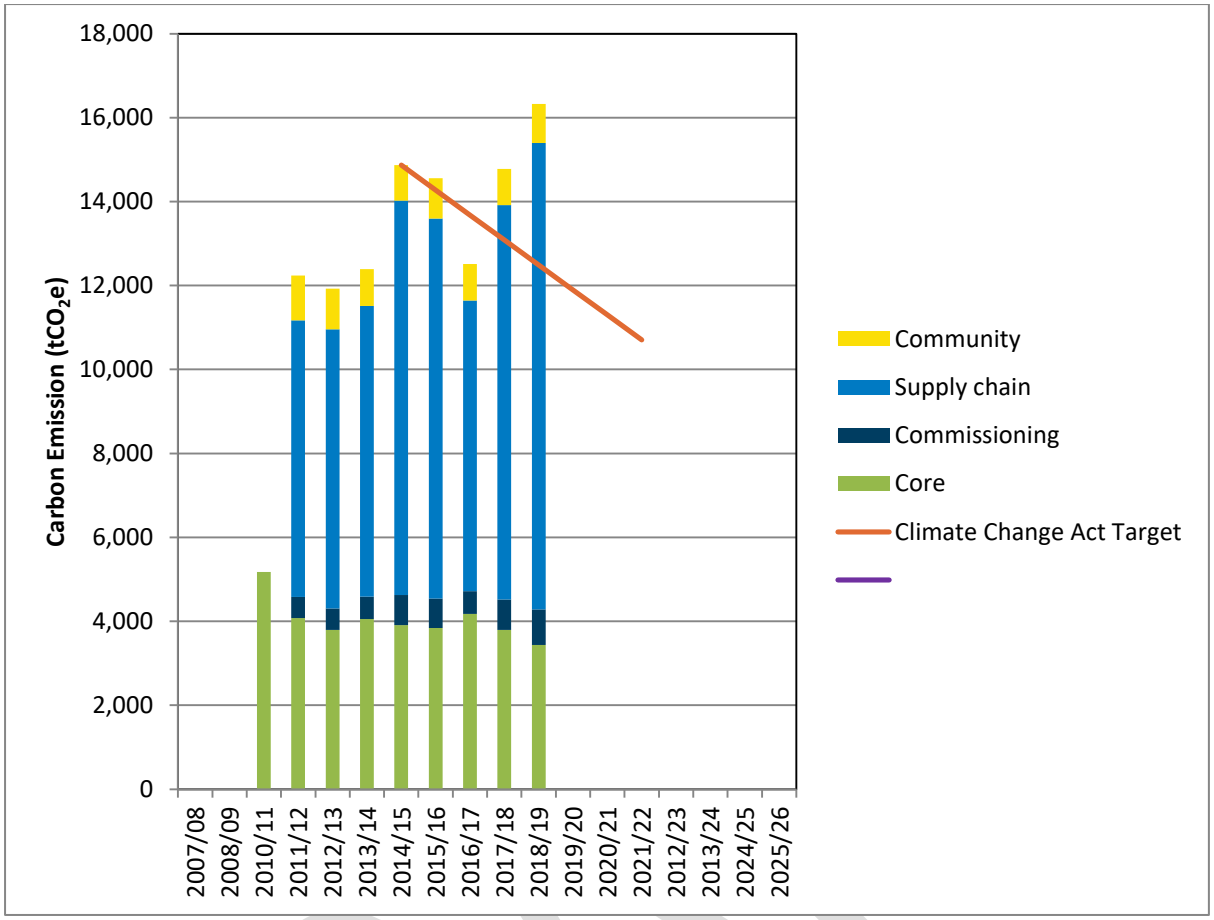
Category	Mode	2015/16	2016/17	2017/18	2018/19
Staff commute*	miles	2,609,998	2,393,859	2,386,163	2,618,643
	tCO_2e	958.99	865.70	862.38	933.09
Business travel and fleet	miles	3,043,042	3,472,501	3,742,745	3,843,610
	tCO_2e	1,118.10	1,255.78	1,352.67	1,369.56
Active & public transport	miles	n/a	n/a	n/a	30,267
	tCO2e	n/a	n/a	n/a	5.48
Total cost of business travel	£	1,380,000	1,427,910	1,411,240	1,523,722

* Calculated using national travel survey data

Overall summary of carbon

Whilst the Trust benchmarls well against similar organisations for our carbon footprint per pound of operationg expenditure, the increase in total carbon emissions is a reflection of the value of supply chain carbon which has increased because the non pay spend of the Trust has also increased in 2018/19.





The Trust continues to take its sustainability obligations seriously. For example, we are planning to use our buildings more efficiently which should reduce the amount of space we need to heat and light. In 2018/19 we reduced the building floor space we used despite an increase in staff providing new services. We aim to go further in 2019/20.

Context info	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Floor Space (m^2)	39,504	40,558	37,454	36,043
Number of Staff	2,717	2,492	2,483	2,726

Providing Value for Money (Financial Performance Summary)

Value for Money - Financial performance summary

Once again the Trust has met its financial targets and once again, my thanks are due to everyone who has played their part in that achievement. Over eight years now, Leeds Community Healthcare staff have successfully balanced the need to deliver high quality care whilst living within our financial resources. That is not always easy and they deserve great credit for managing that in what is clearly recognised as a very challenging financial environment for the NHS .

In past years a number of our services have faced the challenge of competitive tendering. During 2018/19, the Trust was required by commissioners to bid to retain services. The funding available for services that are being tendered usually provides a challenge in terms of reducing the Trust's cost base. However that is a challenge that we continue to meet through innovative new service models. As you will read elsewhere in this Annual Report, in 2018/19 we were successful in retaining and winning new services which provides a stable financial basis for the future.

In line with a general trend in the NHS, the Trust will increasingly work in partnership with commissioners and other service providers to design new ways of delivering services. This will require the Trust to manage its finances more flexibly with our partners and across health and social system. We have a stable, successful financial foundation on which to build and we are excited to be at the heart of the opportunities these new ways of working will bring.

The Trust commenced 2018/19 planning to meet a control total (target income and expenditure surplus) of £2.5m including £1.3m Provider Sustainability Funding (PSF). During the year we took advantage of an opportunity offered by NHS Improvement to improve our planned surplus by £0.5m in return for £1m additional Provider Sustainability Funding. This additional PSF will be used to support the costs of the in-patient facility for children and young people with mental health needs being developed on the St Mary's Hospital site. We also received further PSF of £1.6m at the end of the financial year as part of the national share out of PSF not earned by Trusts during the year. This additional PSF is provided as cash only; it cannot be spend on day to day running costs. Our year end surplus was £5.6m, as required by our original plans and subsequent allocation of PSF.

Target	Target	Performance	Achieved
Planned surplus on income & expenditure	£5,656k	£5,656k	☑
Remain within External Finance Limit	(£3,100k)	(£3,100k)	☑
Remain within Capital Resource Limit	£2,051k	£1,950k	☑
Capital Cost Absorption Rate	3.50%	3.50%	☑
Agency control total	£6,410k	£5,365k	☑
Use of Resources	2	1	☑
Better Payment Practice Code:			
Non NHS invoices (number & value)	95% & 95%	96% & 95%	☑☑
NHS invoices (number & value)	95% & 95%	98% & 98%	☑☑
CIP recurrent savings in year	£3,228k	£3,058k	☒
CIP non-recurrent savings in year	£1,500k	£1,670k	☑

The Trust's capital investment strategy continues to be one of aiming to invest all its internally generated capital resources and remaining within the capital resource limit agreed with NHS Improvement.

During 2017/18 the Trust spent just less than £2m on the continuing roll-out of our Electronic Patient Record, upgrading and maintaining our buildings, clinical equipment and information technology.

Planning for the new CAMHS unit continues with an expected construction start date early in the new calendar year.

In 2019/20 the Trust expects to deliver a control total surplus of £1.7m including £1.2m PSF. We have once again protected front line services from cost improvement plans for the year but will actively seek opportunities delivering care more efficiently during the year. Our financial planning has identified and budgeted for a number of risks. This Annual Report will be published a number of months into the financial year by when we will know the extent to which any further financial risks have materialised. We are proud of our reputation for providing high quality services within our financial resources; something we plan to continue.

Signed……Chief Executive

Date……

Strategic Risks

Risk management is part of the culture of the organisation from risk assessments in clinical practice to the consideration of risks which underpin the Board's decisions.

We have looked at our four strategic goals and how we are meeting them in earlier section of this report. In setting our four strategic goals we also think about the risks of not achieving them. As a Trust we have 18 strategic risks connected to our goals. These are grouped in the four following themes (these are also known as strategic risk clusters).

Design note: The following wording will be represented as a table in the final version.

Our four key goals	Risks
1: Provide high quality services.	Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
2: Recruit, develop and retain the staff we need now and for the future.	Failure to engage and empower the Trust's workforce and ability to recruit and retain and develop staff
3: Work with health and social care partners to deliver joined up care close to home.	Failure to deliver integrated care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions.
4: Services are fit for purpose now and in the future.	Failure to maintain a viable and sustainable organisation.

Risk management is considered in more detail in our Annual Governance Statement which can be found on page XX of this report.

Accountability report
Corporate governance

The Trust Board - What we do and how we do it

Along with all NHS trusts across the country, we have a Board of Directors to guide our work. The purpose of our Board is to govern effectively, and to build patient, public and stakeholder confidence that health and healthcare is in safe hands.

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services
- Accessible and responsive health services
- Public money spent in a way that is fair, efficient, effective and economic
- Being a good employer
- Patient and the public engagement in shaping health services

The Board plays a key role in:

- Shaping the strategy, vision and purpose of the Trust.
- Holding the organisation to account for the delivery of strategy
- Ensuring value for money
- Working to shape a positive culture

The Trust Board has both Executive and Non-Executive Directors. It is a unitary Board, which means that both Executive and Non-Executive Directors share the same liabilities and joint responsibility for every decision of the Board. Led by an independent chair and made up of both executive and independent non-executive members, the Board has collective responsibility for the performance of our organisation.

The Trust's Chair and Chief Executive have led these functions throughout 2018/19.

Here are the people on our Board of Directors:

Design note: Insert Board structure with photos

The Director of Workforce is a non-voting member of the Board.

Changes to the Board

Following the secondment (2 October 2017 to 31 August 2018) and subsequent retirement of Sue Ellis, Director of Workforce, the Trust recruited a job-sharing role of Director of Workforce, Organisational Development and System Development. Jenny Allen and Laura Smith joined the Trust's Management Team on 4 June 2018. Sue Ellis, Director of Workforce retired on 31 August 2018.

After a period of secondment, Marcia Perry, Executive Director of Nursing left Leeds Community Healthcare NHS Trust to take up a new substantive post on 1 April 2019. The post of Interim Director of Nursing was covered by Steph Lawrence, who then obtained the substantive post from 1 April 2019.

Dr Amanda Thomas, Executive Medical Director, retired on 16 October 2018 following a period of ill health. The role of Interim Executive Medical Director was covered by Dr Phil Ayres from 1 January 2018 to 31 May 2018 and then by Dr Ruth Burnett from 1 August 2018 to 31 March 2019. Dr Burnett was recruited to the substantive post on 1 April 2019.

Richard Gladman stepped down as non-executive director in January 2019 and was instated as an associate non-executive director.

All directors have made a declaration that they comply with the 'fit and proper person test' that was introduced from November 2014.

Board members have an annual appraisal, which is a thorough review of the assessment of their performance, reflecting on their contribution to the Trust during the year and setting objectives for the coming year.

The Board has continued with its development programme during the year. It has a programme of workshops to support Board members' development, covering such topics as quality improvement, equality and diversity, digital strategy and system planning. Both executives and non-executives attend training days and networking events to improve their knowledge base and remain up to date with current NHS matters.

Directors' Interests

Our Director's declare interests that they have in associated businesses or areas of work. These are shown in the following table:

Leeds Community Healthcare NHS Trust
Director's declarations of interests for disclosure 2018/19

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
Neil Franklin	None	None	None	Board member (acting in an advisory capacity only), Donisthorpe Hall Care Home	Donisthorpe Hall, Care Home	None	None	
Thea Stein	None	None	None	CQC Reviewer	None	None	None	None
Jane Madeley	None	None	None	Chief Financial Officer , University of Leeds	None	None	Any contracts between the University of Leeds, Leeds Faculty of Medicine and Health, Leeds Academic Health Partnership and Leeds Community Healthcare NHS Trust	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
Tony Dearden	None	None	None	Fee paid Medical Member of First Tier Tribunal (Health, Education and Social Care Chamber), i.e. mental health tribunals. Fellow, Royal College of Psychiatrists.	None	None	None	
Brodie Clark	None	None	None	Non-executive Director Compass	Compass (services for drug and alcohol misuse)	None	None	None
Richard Gladman (Associate)	None	None	None	Programme Director, Health & Social Care Information Centre (NHS Digital) Programme Director for	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
				Yorkshire and Humber Health and Care Record				
Laura Smith* (from 4 June 2018)	Director of Workforce in the GP Confederation Leeds	None	None	None	None	None	None	None
Jenny Allen (from 4 June 2018)	Director of Workforce in the GP Confederation Leeds	None	None	None	Indirect interest – husband is a partner at KPMG, which is involved in financially auditing the Trust. KPMG also bid and contract for contracts with NHS Providers. Husband is also a Trustee for Age UK Leeds.	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
Prof Ian Lewis	None	None	None	Fellow (retired) of The Royal College of Paediatrics and Child Health Trustee: Rossett School Harrogate	Occasional teaching/ facilitating for Medical Mediation Foundation	None	None	None
Bryan Machin	None	None	None	From 11 June 2018 two days per week – Director of Finance for the Est Yorkshire and Harrogate Health and Care Partnership ('Integrated Care System')	None	None	None	None
Dr Ruth Burnett (from 1 August 2018)	Medical Director Leeds GP Confederation	None	None	None	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
Dr Phil Ayres- until 31 May 2018	None	None	None	None	None	None	None	None
Sam Prince	None	None	None	None	None	None	None	None
Marcia Perry (until 31 October 2018)	None	None	None	None	None	None	None	None
Steph Lawrence (from 1 October 2018	Director of Nursing Leeds GP Confederation			I am a Trustee for Carers Resource, Bradford.	I am a Trustee for Carers resource, Bradford.			
Ann Hobson* (until 3 June 2018)	None	None	None	Husband works for West Yorkshire Police – Leeds Community Healthcare provides health input into West Yorkshire Police	None	None	None	None

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £25
				Custody Suites				

***** Non-voting Board member

]

V1 15 March 2019. Board approved 29 03 2019

V2. 10 May 2019 – Audit Committee amended – Sue Ellis and Amanda Thomas info is not relevant as they were not at LCH.

Board meetings and business in 2018/19

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally six times during the year. At these meetings, the Board takes strategic decisions and monitors the operational performance of the Trust. Any member of the public is welcome to attend the formal meetings; the dates are advertised on the Trust's website. Board meeting agendas, papers, minutes and future dates are posted on the Trust's website. A briefing document is provided to staff following each Board meeting, which provides information from the main agenda items of the meeting.

The Board has also met informally on a further six occasions. These events have taken the form of strategic workshops and have involved a wider group of senior leaders.

In addition, an annual general meeting was held in September 2018.

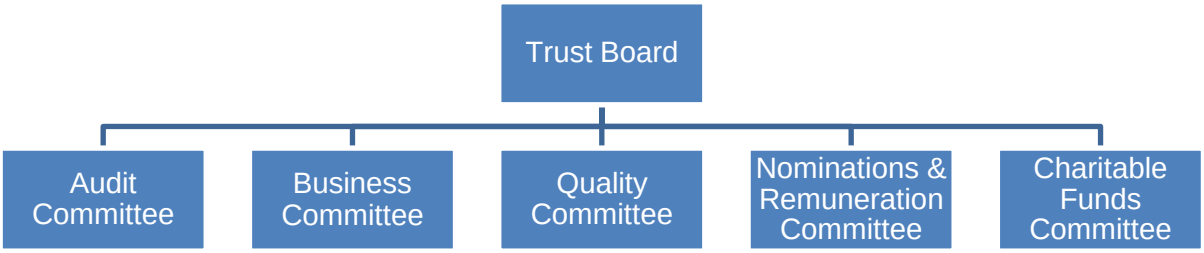
The quality of care is at the heart of all that the Trust does; the over-arching approach to quality within the Trust is captured within the quality strategy for 2018-2021. The strategy describes an overarching quality objective to strengthen the approach to quality improvement with a focus on understanding data in order to give the necessary assurances on the quality of services. Using this approach the Trust is focussing on four priority areas:

- Prevention, proactive care and self-management
- Patient experience and engagement
- New models of care
- Workforce

All actions to ensure the Trust provides high quality services are overseen closely by the Board.

The Board receives regular updates on strategic service developments and regular integrated performance reports (the report brings together quality and financial information in one document). Information in the report is aligned to the Care Quality Commission's (CQC) five domains (safe, caring, effective, responsive and well-led).This is the main way the Board assesses that we meet all national and local standards and targets for the services we provide.

The Board's committees (decision making groups)
The Trust has five committees that make sure we carry out our duties effectively, efficiently and economically. These are shown in the organisation chart below.



Details of the functions of each committee can be found in our Annual Governance Statement 2018/19.

In addition, the Trust has a 'Committees in Common' arrangements with a number of NHS organisations. A 'Committees in Common' approach allows NHS Trusts to establish their own committees, which all meet at the same time and with the same remit and common agenda. The three Committees in Common are:

- **West Yorkshire Mental Health Services Collaborative Committees in Common:** This comprises of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnerships NHS Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership NHS Foundation Trust) working together to ensure high quality, sustainable mental health services.

- **Leeds Providers' Integrated Care Collaborative, which is the four NHS healthcare providers in Leeds:** Leeds Community Healthcare NHS Trust, Leeds GP Confederation, Leeds and York Partnership NHS Foundation Trust, and Leeds Teaching Hospitals NHS Trust who have agreed to collaborate in delivering city-wide efficient and sustainable primary, community, and secondary care hospital services (including mental health services in the community and hospital) for patients.

- **Leeds Primary Healthcare Collaborative**, which is Leeds Community Healthcare NHS Trust and the Leeds GP Confederation whose aim is to jointly deliver city-wide seamless and efficient primary care and community health services for patients.

These are reflected in the Trust's current scheme of delegation.

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Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

Leeds Community Healthcare NHS Trust
Annual Governance Statement 2018/19

Scope of responsibility

'As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.'

Thea Stein

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Community Healthcare Trust NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust recognises that it is operating in a healthcare environment where patient safety, quality of care and service sustainability are paramount and are of mutual benefit to stakeholders and the organisation alike. The Trust manages clinical risks (i.e. risks to individual patients through clinical activity) and financial and business risks (i.e. risks that threaten the achievement of statutory financial duties or the safeguarding of the Trust's assets) in order to deliver its objectives in a controlled manner. Subject to controls and assurances being in place, and in line with the Trust's risk appetite statement, the Trust accepts manageable risks, but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Risk management is embedded within the culture of the organisation from risk assessment in clinical practice to the consideration of risk underpinning the Board's decisions. Risks are identified and aligned to strategic goals. Risk tolerance ie the

level at which risk is escalated, is clearly set out in the Risk Management Policy and Procedure.

The Chief Executive has overall responsibility for the Trust's management of risk. The executive team have been allocated management of risk types as follows:

- Chief Executive: Risks to staff and stakeholder engagement, integration and system change programmes
- Executive Director of Finance and Resources: Risks to efficiency, income and expenditure, IT infrastructure, partnership governance
- Executive Director of Operations: Risks to major change projects, business tenders, contracted activity
- Executive Director of Nursing and Executive Medical Director: Risks to clinical quality assessment and clinical quality improvement
- Director of Workforce: Risks to staff capacity and capability

The role of each director is to ensure that appropriate and robust arrangements are in place to:

- identify and assess risks
- eliminate or reduce risks to an acceptable level, in line with the Trust's risk appetite
- comply with policies and procedures, and statutory and external requirements
- maintain the Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively. The BAF aligns strategic risks to the revised corporate objectives identified in the Trust's operational plan. Directors regularly review strategic risks to evaluate whether the BAF strategic risk scores are appropriate and identify any additional controls or sources of assurance required.

The Trust employs an experienced risk manager who delivers risk management training, coordinated the risk register and the board assurance framework and provides support and direction in all risk management related matters.

Members of staff receive information and are briefed on risk management procedures as part of the induction process. Bespoke risk management training is provided to teams and services. Managers are trained in risk management procedures both as part of the induction process and as part of ongoing training, coaching and support. All training includes awareness of the Trust's risk appetite and how this should be applied in decision-making processes.

The Trust has a quarterly risk management newsletter to share lessons that can be learned from incidents and complaints, the latest information about risk management, training courses available and examples of good practice across the

Trust. There is a ‘lessons learned’ portal on the Trust’s intranet, for managers to share information about incidents and improvement.

There has been a targeted approach to risk management training during 2018/19 as it was identified that some services did not have suitable and sufficient health and safety risk assessments. Support, in the form of individual and group training sessions has been provided, as well as an accessible library of risk assessment templates. A training session is now being delivered to inform managers of their role and responsibilities with regards to staff health, safety and risk management, with a strong focus on risk assessment technique. This is part of the Trust’s refreshed essential management training programme which commenced in February 2019.

The risk and control framework

The Trust’s risk management policy: defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The risk management procedure: supports staff to identify, assess, manage, and monitor the risks that threaten the organisation’s ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk.

The Trust has systems in place that contribute to the identification of risk from a number of sources; the following are examples:

- Review of performance and working practice
- Clinical practice
- Legislation, national policy and guidance
- Risk assessments
- Incident reports
- Complaints
- Claims
- Audit and work place surveys
- Patient satisfaction surveys
- External/internal audits

- Regulators' inspections and reports

Any of the above can inform the risk assessment process and therefore the population of the Trust's risk register. Risks are identified in a proactive way, for example: changes or introduction of new processes, new equipment, different ways of working etc will initiate a risk assessment. In addition, individual staff may identify risks whilst carrying out their duties or risks may be identified through discussions in team meetings etc.

The risk management policy and procedure is supported by content contained in the Trust intranet in a bespoke risk management webpage, and is available to all directors, SMT, service managers, clinical leads and staff-side representatives.

The risk register is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The electronic risk management system used by this Trust to record and monitor risks is 'Datix'. The risk register contains in summary: a description of the risk, the risk owner, any controls in currently in place, actions to be completed, and the initial, current and target risk scores. Risk register extracts from Datix are frequently drawn to allow for scrutiny of risk by appropriate managers, committees and the Board.

The Trust's risk appetite is aligned with its four strategic goals. The senior management team determine the Trust's risk appetite and review this on an annual basis. The risk appetite statement is appended to the risk management policy and procedure, which is on the Trust's internal website.

Data security risk is managed through a system of general managers and heads of service that act as information asset owners and work with the Senior Information Risk Owner to manage data security and other information related risks. This process has been significantly enhanced in 2018/19 through the work required to ensure Trust compliance with the General Data Protection Regulation (GDPR).

Data security risks are also mitigated through a number IT activities which include the release of regular updates from software suppliers to ensure the Trust IT infrastructure remains protected from vulnerabilities. Typically the Trust will test any new releases on a small group of devices to ensure there are no compatibility issues before releasing the updates in line with a monthly cycle. These updates are received by desktops and laptops as they connect to the corporate IT network. Through experience of using the Electronic Patient Record, it became apparent that certain users of laptops were not connecting to the corporate network or restarting their laptops regularly enough for the updates to be effective. This has culminated in an awareness campaign in the Adult Business Unit which provides advice and guidance on how to ensure the device remains protected and up to date with the latest software.

The Trust also continues to conduct annual penetration tests using accredited third party organisations, with the latest report undertaken through the "Cyber Essentials Scheme" and received on the 14th December 2018. The resulting action plan is being co-ordinated and monitored by NHS Digital with a number of improvements have been identified for implementation before 31st May 2019.

Additional activities in 2018/19 such as the testing of Business Continuity Plans in response to a Cyber-Attack and reminding staff of the importance of protecting their smart card through the trust's risk management newsletter, have all been designed to help keep sensitive data secure and reduce the risk of unintended loss or breach.

Counter fraud measures help to protect NHS resources against fraud and ensure they are used for their intended purpose, the delivery of patient care. The Trust has a lead Counter Fraud Specialist who manages delivery of a counter fraud work plan, which is scrutinised by the Audit Committee. The Counter Fraud Specialist also presents an annual report to the Committee which summarises counter fraud activity undertaken at the organisation in the preceding year.

In April 2019, a Self-Review Toolkit was completed and submitted to the NHS Counter Fraud Authority. There are four key areas which are reviewed as part of the self-review toolkit; strategic governance, inform and involve, prevent and deter, and hold to account. The Trust has declared full compliance with 22 out of the 23 standards, with partial compliance for one standard.

Governance structures and accountability

The Board leads the Trust by undertaking three main roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the wider Trust

The Board consists of six non-executive directors (including the Chair), and five executive directors. In addition, there is one non-voting member of the Board.

There is a clear division of responsibilities between the Chair and Chief Executive. The Trust's Chair and Chief Executive have discharged their leadership functions throughout the whole of 2018/19.

The Director of Workforce is a non-voting member of the Board.

The Board has met on thirteen occasions in 2018/19; this has comprised six formal meetings held in public, six informal meetings or strategic workshops plus an annual general meeting. Attendance at Board meetings has been good and all meetings have been quorate.

The quality of services remains the Trust's first priority and, to this end, the Board's agenda features reports reflecting key quality matters. Information presented to the Board provides essential assurance. Board meetings have received papers on the Trust's quality strategy, patient experience topics and the maintenance of safe staffing levels. The Directors conduct regular visits to frontline services.

The Board has standing orders, a scheme of reservation and delegation of powers and standing financial instructions. These provide a governance framework that enables the organisation to demonstrate it is well governed and that it meets requirements of corporate governance codes of practice.

The Board has an annual work plan, which demonstrates the scheduling of required and discretionary business. The five Board committees all have terms of reference and work plans which have been reviewed during 2018/19.

The Trust's Board receives a performance brief and a suite of reports aligned to the five Care Quality Commission (CQC) domains. This is the primary mechanism for assessing compliance with national and local targets. The performance brief brings quality and financial information together in one report.

The Trust's Board receives regular updates on strategic service developments, for example work to enhance integration across primary and secondary health care and social care and the introduction of new ways of working.

The Board receives and considers extracts from the risk register and the board assurance framework at each meeting to gain assurance as to the effective management of risk in the organisation. Through these arrangements, the Board receives timely information about existing and potential risks to the Trust.

The Board also receives minutes and assurance reports from each of its committees at Board meetings.

The Board wishes to assure itself that it operates effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance, in doing so, it is mindful of the best practice contained within codes of governance.

The Trust Board and committees undertake an annual self-assessment against elements of the NHS Improvement Well-Led Framework and has drawn out a number of priorities to enhance the effectiveness of elements of the Trust's

governance. The results being reported to the Board and are contained in committees' annual reports. The committees' chairs' also meet collectively to discuss committees' effectiveness.

The Trust has a needs-based Board development programme. A feature of which is a series of Board workshops taking place every two months (six events in 2018/19); senior leaders from corporate services and business units (including clinical leads) also participate in these sessions.

The individual performance of all Board members is reviewed through a formal appraisal process and any individual development needs are identified and supported.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

The Trust's Board has appointed five committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically. These are detailed below.

Audit Committee (Chair: Jane Madeley)

The Committee comprises three non-executive directors. The Chair of the Committee is a qualified accountant and is a Chief Financial Officer in the higher education sector. The Executive Director of Finance and Resources, the Company Secretary, the Internal Auditor and the External Auditor attend on a routine basis. The Audit Committee met formally six times during 2018/19.

The Audit Committee provides an overarching governance role and reviews the work of the other committees, whose work can provide relevant assurance to the Audit Committee's own scope of work. It also has responsibility for overseeing the work of the Information Governance Group. The Committee receive minutes from this sub-group, receives papers on any matters escalated to the Committee and periodically reviews the effectiveness of the sub-group in discharging its delegated responsibilities.

During the year, the Committee has received regular reports on progress from internal audit, external audit, the local counter fraud specialist, the security management service and from information governance specialists.

The Committee has considered a range of financial control reports and a number of governance papers, and has oversight of the board assurance framework, which it reviewed twice in full during the year.

The chair of each of the Board's committees produced an annual report, which provides assurance to the Audit Committee on how each committee has met its terms of reference during the year. The committees undertake a self-assessment exercise, the results of which are included in their annual reports. The committees' chairs also met to discuss the flow of business through the committees.

Quality Committee (Chair: Professor Ian Lewis)

The Quality Committee's membership comprises the Trust's Chair, two non-executive directors, the Chief Executive and two executive directors; a number of other senior officers attend each meeting. The Committee met on 10 occasions in 2018/19.

The Committee provides assurance to the Board that high standards of care are provided by the Trust and that adequate and appropriate quality governance structures, processes and controls are in place to:

- Promote quality, in particular safety and excellence in patient care
- Identify, prioritise and manage clinical risk and assure the Board that risks and issues are being managed in a controlled and timely manner
- Ensure effective evidence-based clinical practice
- Produce the annual Quality Account and monitor progress

The Committee exercises these functions in the context of the Trust's quality strategy. The quality strategy 2018-2021 provides an overarching framework for quality within the Trust and sets out a programme of work to achieve four key objectives and seven action areas focused on patient safety, clinical effectiveness and patient experience. The Committee has received an update on a quarterly basis and has sought assurance about the implementation of specific actions.

Within that strategic framework, the Quality Committee and the Board monitors serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's incident and serious incident management policy.

Business Committee (Chair: Brodie Clark)

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives; other senior officers attend as required. The Business Committee held 10 meetings in 2018/19.

The Committee provides assurance to the Board on the financial and performance management processes within the organisation, including monitoring the delivery of the Trust's business plan and oversight of significant projects.

The Committee oversees business and commercial developments and makes investment decisions in line with the scheme of delegation and the Trust's investment policy and ensures that the Board has a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

The Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance. There has been consideration of recruitment and retention initiatives, sickness absence management and leadership approaches.

The committee has assumed an extended role in terms of oversight of the Trust's main projects. The Committee receives in-depth reports from the project leads and reports from the Change Board, which provides an overview of inter-connectivity for the main projects.

Nominations and Remuneration Committee (Chair: Neil Franklin)

The Nominations and Remuneration Committee's membership comprises the Chair and two further non-executive directors; the Committee is supported by the Director of Workforce. The Committee has met four times in 2018/19.

The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, executive directors, directors and any senior managers not covered by national Agenda for Change terms and conditions of employment.

The Committee also gives full consideration to and make plans for succession planning for the Chief Executive and other executive directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed.

It monitors and reviews any exceptional and/or significant employee relations cases of high risk to the Trust including those relating to: employment cases of high cost or of reputational significance.

The Committee ratifies and agrees any awards at the discretion of the Trust as the employer. One such duty is to review the nominations for the Clinical Excellence Awards and to encourage maximum participation from staff across the eligible consultant body. In December 2018 it was confirmed that applications received for Clinical Excellence Awards successfully demonstrated an increasing level of diversity.

Charitable Funds Committee (Chair: Brodie Clark)

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director; the Committee is supported by the Executive Director of Nursing. The Committee has held four meetings during 2018/19.

The purpose of the committee is to give assurance to the Board that the Trust's charitable activities are discharged within the law and regulations set by the Charity Commissioners for England and Wales. The Committee oversees charitable activities, approves charitable funds expenditure, agrees an investment policy for charitable funds and monitors investments on a regular basis.

Principal risks

There are eighteen strategic risks aligned to the Trust's four strategic goals, which are grouped into four strategic risk 'clusters':

- Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
- Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
- Failure to engage and empower the Trust's workforce and the ability to recruit, retain and develop staff
- Failure to maintain a viable and sustainable organisation

The board assurance framework (BAF) records: risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans have been identified and the BAF has been revised during 2018, in line with the Trust's operational plan. These risks are assigned to a lead executive to manage. Each of the strategic risks is also assigned to one of the Board's committees for oversight and scrutiny. Overall in-depth scrutiny is provided by Audit Committee. Sources of assurance are reviewed by the Board subcommittees and this information is reported at each Board meeting.

Scrutiny of risks

The Risk Review Group meets quarterly to review new risks that have been added to the risk register. They also review escalated and deescalated risks and risks that have recently been closed. The group acts as a moderator for risk grading, ensuring appropriate ownership of the risk and ensuring that effective management of the risk is being recorded. The group also maintains an oversight of the practical application of the risk management procedure.

The Board receives a significant risks and risk assurance report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures, as well as information about risks scoring 12 (high). It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The report also includes the BAF summary advising the Board of the current assurance level determined for each of the Trust's strategic risks. The Senior Management Team reviews a significant risks report on a monthly basis. The Quality Committee reviews in more detail the clinical and operational risks and the Business Committee reviews non-clinical risks, rated as high.

Assurance of risk mitigation is provided to the Board through the Senior Management Team, and through the Quality and Business Committees in relation to clinical and non-clinical risks. The Audit Committee assures the risk management process.

Together, these mechanisms allow for the appropriate identification, monitoring, control and mitigation of risks, which may have an impact on the Trust's objectives.

Incident reporting

The Trust has a strong, open incident reporting culture. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and training and regular communications. Learning from incidents is shared with staff through the Trust's quarterly risk management newsletter, at staff forums and a learning resource on the Trust's internal website for all staff to access, which has been developed to share anonymised, learning from incidents across the organisation. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Serious incidents are reported and managed in accordance with the Trust's incident and serious incident policy. The majority of managers have had serious incident investigation training and root cause analysis is carried out to ensure that systemic problems are resolved so that similar incidents do not occur.

In 2018, an internal audit review evaluated the robustness of processes in place for the identification, investigation, reporting and management of incidents and serious incidents including how lessons learned are dealt with and communicated and disseminated across the Trust. The review concluded a reasonable assurance opinion.

Safe, sustainable and effective staffing

The Trust has a range of strategies, systems and processes in place to ensure safe, sustainable and effective staffing.

The overall approach to workforce is described in the Trust's Workforce Strategy (2019-21); approved by the Board on 1 February 2019. The Workforce Strategy is aligned with LCH's strategic goals and priorities, responding to external, internal and cultural factors which are currently or anticipated to impact on our workforce requirements. Progress on delivery of the Workforce Strategy's priorities is overseen by the LCH Business Committee, a subcommittee of the Board.

The Trust's workforce plan supports the delivery of our operational business plan and is embedded in service needs as well as triangulated with finance and activity data. The plan is updated annually and receives sign off at both Business Committee and the Board; the latter at a public Board meeting.

The Board receives a twice-yearly Safe Staffing report from the Director of Nursing, in line with NQB's 2016 guidance; incorporating professional judgement and outcomes. Regular reports are also received at Board from the Guardian for Safe Working Hours.

Our services are constantly growing and developing as we deliver new pathways of care; and care for more and more people in the community. Any new service or service change is subject to a Quality Impact Assessment (QIA) and this would include where new roles mean a significant change to the way care is delivered.

Triangulation takes place both at the regular Senior Management Team meeting (SMT) and across the Board and its sub-committees, of finance, workforce and activity / performance information, to ensure comprehensive oversight of staffing and any issues arising.

A key element of this triangulation is the monthly Performance Brief, which brings together information under the Safe and Caring, Effective, Responsive , Well Led and Financial domains; together with actions being taken to address areas of concern, celebration, and learning. The Performance Brief is reviewed at SMT, Business Committee and Board.

In addition, General Managers and Clinical Leads undertake performance panels at service and business unit level, with escalations from the monthly Senior Operations Performance Panel put before SMT for consideration and further escalation if required. Discussions at these panels focus on both quantitative data and the professional judgement of the senior managerial and clinical leaders engaged in delivery of the service.

Our organisational risk register captures workforce-related risks, including any associated with resourcing / staffing challenges. The higher scoring risks are escalated and regularly scrutinised and discussed at Committees and Board.

The Trust is in the process of rolling out an e-rostering system to further improve the capability of our staffing systems. E-rostering will enable us to better monitor, analyse and plan staffing patterns and resource requirements. Implementation is taking place in a phased approach, with the first 3 services now live. The e-rostering project is overseen by the Trust's Change Board.

NHS pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has a legal obligation under the Equality Act 2010 and Public Sector Equality Duty, to provide equality in access to service provision and within employment and has a nominated Board member who champions this agenda at Board level.

The Business Committee discharges a significant role in overseeing the workforce aspects of the Trusts performance, which includes providing assurance to the Board around equality and diversity. In recognition of the importance of equality and diversity, the Business Committee receives performance information around equality and diversity mandatory training compliance and Workforce Race Equality Standard (WRES) indicator 1, on percentage of BME staff in Senior roles. On a quarterly basis the Business Committee receives more in-depth analysis and updates on a range of pro-active work around this wider agenda, which includes the delivery against the Workforce Race Equality Standard (WRES) Action Plan and shortly to receive the Workforce Disability Equality Standard (WDES) Action Plan.

Review of economy, efficiency and effectiveness of the use of resources

The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that plan is adhered to. The Trust has consistently met the financial targets set by regulators. The Business Committee also receives an annual report on the Trust's reference costs, which are an indicator of the Trust's efficiency in delivering its services. The Trust's overall reference costs for 2017/18

are 100. Delivery of cost improvement plans during 2018/19 has been good and the Trust has reported a use of resources metric of 1 being the lowest risk all year.

The Audit Committee reviews all internal audit reports and monitors the Trust's implementation of any recommendations. Annually the Trust's external auditors are required to provide a Value for Money conclusion. *For 2017/18 the auditors concluded that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2018.* The effectiveness of the Trust's services is regularly assessed by the Trust's Quality Committee and by the Board.

[Reference to 2017/18 VFM to be changed to 2018/19 to be finalised once ISA 260 received]

Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place. During 2019/20 it will be reviewed to take into account UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information governance

The Trust recognises that information is an important asset, supporting both clinical and management needs and is fully committed to ensuring that personal information is protected and used appropriately. The Trust has submitted a self-assessed score that all data security standards have been met for the Data Security & Protection Toolkit (DPST), which is the successor to the Information Governance Toolkit.

The Trust's information governance group develops relevant policies and strategies to control data security and other information related risks. As a community trust, sharing information has been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced the risk of data loss through the use of mobile devices. The Trust has demonstrated its commitment to being an accountable data controller by appointing a Data Protection Officer. The information governance group has revised the information governance policies and procedures to ensure they are robust and compliant with the General Data Protection Regulation and the Data Protection Act 2018 (in force from 25th May 2018).

In recognition of the importance of data security, there is a nationally set target of 95% of staff compliance with information governance training. Training compliance is closely monitored, and attendance is enforced where necessary.

One incident was reported to the Information Commissioner's Office (ICO) by the Trust during 2018/19. A complaint response letter was sent to an incorrect recipient

on more than once occasion due to being addressed incorrectly. The ICO required the Trust to carry out the three following actions:

- Staff members to confirm the patient's contact details prior to sending out correspondence
- Procedures to be reviewed for the updating of patient addresses and that staff read this procedure. Regular review and monitoring of the process
- Review the content of the mandatory induction data protection training and also the frequency of refresher training to ensure that sufficient practical guidance is given to staff in how to comply with the GDPR.

Data quality

The Trust reports monthly on its performance against national key performance indicators in line with NHS Improvement's Single Oversight Framework and other indicators as contained within contracts with commissioners.

The Trust works to evidence good standards of data quality and accuracy in its performance reporting and is confident that key national indicators eg waiting times are accurate.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Quality Account priorities have been developed in conjunction with stakeholders, services and senior managers to ensure that the measures can facilitate improvements in services for all communities, stakeholders and align to the Quality Strategy and business objectives. This year's Quality Account highlights some of the work that staff and partners do every day and reflects the commitment and drive to provide the best possible standards of care throughout all services.

The Trust recognises the complex needs of its community and strives to achieve consistent delivery of high quality care to maximise patient safety and experience. The Quality Account provides a balanced view of the Trust's achievements and failures and is relevant to all its communities, but also recognises the improvements it continues to make and the collaborative work with partners to make real improvements across the whole health economy.

The Trust has robust systems and processes to ensure the accuracy of data provided in the Quality Account. This includes data cleansing and data validation processes as well as oversight arrangements provided by Committees and committee subgroups.

Waiting times data is one important area where the Trust needs to ensure the information is accurate. In order to ensure this, a weekly report is downloaded by the Business Intelligence Team, which identifies any potential patient breaches. This report is reviewed and validated in the consultant-led services, where explanations are provided against any patients who are listed on the report with a waiting time over 17 weeks. The validator is required to update the patient record where an error has been made. The updated validations form the basis for the figures submitted to NHS Improvement and NHS England.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of internal auditors, the comments made by external auditors in the ISA260 report, the continuing engagement of the Audit Committee, managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. The Audit Committee undertakes a role in terms of providing assurance to the Chief Executive.

Internal audit

TIAA Limited has been the provider of internal audit services since 1 April 2015. This contract was reviewed and renewed in 2018. The Head of Internal Audit has provided an opinion that concludes that, based on the work undertaken in 2018/19, reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation’s objectives. No emerging risks have been identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

In areas reviewed by internal audit where it was assessed that the effectiveness of internal control arrangements provided less than 'substantial' assurance, recommendations were made to further strengthen the control environment. Resultant management actions, which are monitored by the Audit Committee, have been completed or are being progressed in a satisfactory manner.

Clinical audit

Clinical audit is vital to the quality and effectiveness of clinical services and is a fundamental part of the quality improvement process. It plays a pivotal role in providing assurances about the quality of services. Findings from clinical audit are used to ensure that action is taken to protect patients from risks associated with unsafe care, treatment and support.

Clinical audit is managed at service level with the support of the quality and professional development directorate. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the course of the year. The 2018/19 programme comprised of 37 mandatory audits, 51 recommended audits and a further 38 audits which had been determined locally.

CQC compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust received a CQC inspection in the fourth quarter of 2016/17 and the report arising from the inspection was received by the Trust in mid-2017. The Trust currently has an overall rating of 'Good'.

NHS Improvement oversight

NHS Improvement has assigned the Trust a segment rating of '2'; this indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

The Trust works with a range of regulators including the CQC, HM Inspectorate of Prisons, and Ofsted.

Conclusion

During 2018/19, no significant control issues have been identified by the Trust's systems of internal control.

The Trust is a well-established health care provider that has built a system of internal control based on sound foundations. The Trust has a strong safety culture and sees quality of care as the primary objective. Ongoing scrutiny enhances learning and strengthens governance.

The annual governance statement shows that the Trust has the necessary control arrangements in place to manage risks and take action when incidents occur.

Strong financial control and the achievement of statutory financial duties support the view that, clinically and financially, the Trust has effective and improving systems in place.

Signed……..

Remuneration and staff report

Policy on senior managers' contracts

The table below provides details on the contracts for each senior manager who has been employed during the year. The contracts do not make any specific provisions for compensation for early termination in addition to the notice periods.

Name and Title	Contract date	Date of Expiry	Notice period
Ann Hobson Interim Director of Workforce	2 October 2017	3 June 2018	3 months
Bryan Machin Executive Director of Finance and Resources	9 May 2011	No end date	6 months
Marcia Perry Executive Director of Nursing	10 August 2015	31 March 2019	6 months
Samantha Prince Executive Director of Operations	4 July 2011	No end date	6 months
Thea Stein Chief Executive	1 October 2014	No end date	6 months
Dr Amanda Thomas Executive Medical Director Dr Phil Ayres Interim Medical Director	5 September 2011 Internal secondment from LTHT 1 January 2018 and then employed by LCH from 9 April 2018	16 October 2018 31 May 2018	6 months
Dr Ruth Burnett Interim Medical Director Medical Director	1 August 2018 1 April 2019	31 March 2019 No end date	 6 months
Jennifer Allen Director of Workforce, OD and System Development	4 June 2018	No end date	6 months
Laura Smith Director of Workforce, OD and System Development	4 June 2018	No end date	6 months
Stephanie Lawrence Acting Executive Director of Nursing Executive Director of Nursing and Allied Health Professionals	1 October 2018 1 April 2019	31 March 2019 No end date	 6 months

Payments to past senior managers (subject to audit)

We have not made any awards to past senior managers in addition to the remuneration disclosed later in this report

The Trust can confirm:

- One senior manager received a performance related payment in 2018/19.
- There were no senior managers service contracts awarded during 2018/19.
- There were no payments to past senior managers during 2018/19.
- There were no payments for loss of office during 2018/19.
- There was no senior off-payroll engagement during 2018/19.

Number of individuals that have been deemed 'Board members, and / or senior officers with significant financial responsibility' during the financial year. This figure includes off payroll and on-payroll engagement	*16

*Please note this number has increased since previous year due to a number of interim arrangements in place

Senior managers' remuneration report (subject to audit)

	2018 / 19						2017 / 18					
Name and title	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s
Jennifer Allen - Director of Workforce, OD and System Development (from 04/06/2018)	45 - 50				100 - 102.5	145 -150						
Dr Phil Ayres - Interim Executive Medical Director (until 31/05/2018)	5 - 10					5 - 10	35 - 40					35 - 40
Ruth Burnett - Interim Medical Director (from 01/08/2018)	80 - 85	< 0.1			32.5 - 35	115 - 120						
Brodie Clark – Non-Executive Director	5 - 10	1.1				5 - 10	5 - 10	0.7				5 - 10
Dr Tony Dearden – Non-Executive Director	5 - 10	0.3				5 - 10	5 - 10	0.4				5 - 10
Susan Ellis – Director of Workforce (until 01/10/2017)							45 - 50				7.5 - 10	50 - 55
Neil Franklin – Chair	20 - 25	0.6				20 - 25	20 - 25	0.4				20 - 25
Richard Gladman - Non-Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Ann Hobson - Interim Director of Workforce (from 02/10/2017 until 03/06/2018)	15 - 20	< 0.1				15 - 20	40 - 45				40 - 42.5	80 - 85
Stephanie Lawrence -Acting Executive Director of Nursing and Allied Health Professionals (from 01/10/2018)	40 - 45				30 - 32.5	75 - 80						

	2018 / 19						2017 / 18					
Name and title	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s
Ian Lewis - Non-Executive Director (from 01/07/2017)	5 - 10					5 - 10	0 - 5					0 - 5
Bryan Machin – Executive Director of Finance and Resources	115 - 120	0.1				115 - 120	115 - 120	0.1				115 - 120
Jane Madeley – Non-Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Marcia Perry - Executive Director of Nursing (until 30/09/2018)	45 - 50	0.1				45 - 50	90 - 95	0.1			5 - 7.5	95 - 100
Samantha Prince – Executive Director of Operations	100 - 105	0.1				100 - 105	95 - 100	0.1			15 - 17.5	110 - 115
Laura Smith - Director of Workforce, OD and System Development (from 04/06/2018)	45 - 50				105 - 107.5	150 - 155						
Thea Stein – Chief Executive	140 - 145	0.1	5 - 10			145 - 150	140 - 145	0.1				140 - 145
Elaine Taylor-Whilde - Non-Executive Director (from 01/04/16 until 30/06/2017)							0 - 5					0 - 5
Dr Amanda Thomas – Executive Medical Director (until 16/10/2018)	25 - 30		35 - 40			65 - 70	95 - 100		60 - 65			155 - 160

Pension details for senior managers (subject to audit)

	2018/19						
Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2019 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2019 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000
Jennifer Allen - Director of Workforce, OD & System Development (from 04/06/2018)	2.5 - 5	10 - 12.5	15 - 20	45 - 50	174	94	301
Ruth Burnett - Interim Medical Director (from 01/08/2018)	0 - 2.5	2.5 - 5	5 - 10	20 - 25	64	23	119
Susan Ellis - Director of Workforce (to 01/10/2017)	0	0	0	0	1,039	0	0
Ann Hobson - Interim Director of Workforce (from 02/10/2017 to 03/06/2018)	0	0	25 - 30	70 - 75	527	1	562
Stephanie Lawrence - Acting Director of Nursing and Allied Health Professionals (from 01/10/2018)	0 - 2.5	2.5 - 5	20 - 25	60 - 65	337	45	450
Marcia Perry - Executive Director of Nursing (to 30/09/2018)	0 - 2.5	0 - 2.5	35 - 40	110 - 115	649	39	758
Samantha Prince - Executive Director of Operations*	0	0	0	0	613	0	0
Laura Smith - Director of Workforce, OD & System Development (from 04/06/2018)	2.5 - 5	10 - 12.5	20 - 25	55 - 60	216	100	351

* Individual ceased to be a member of the scheme before the start of the financial year

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with Statutory Instrument number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Fair pay disclosures (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director for the Trust in the financial year 2018/19 was £151,604 (2017/18, £159,144). This was 5.0 (2017/18, 5.5) times the median remuneration of the workforce, which was £30,306 (2017/18 £28,746). The multiple is the less than last year as the highest paid director has changed from being the medical director to the chief executive officer. This has seen a reduction in the remuneration of the highest paid director of 4.7% whilst the median salary has increased by 5.4% as a result of the pay award which was weighted to the lower paid in the NHS.

In 2018/19 total remuneration ranged from £17,460 to £169,326 (2017/18, £16,523 to £170,527). One medical staff employee was paid more than the highest paid director.

Total remuneration includes salary, non-consolidated performance related pay, clinical excellence awards and on-call payments and benefits-in-kind. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

Staff costs and numbers including senior officers (subject to audit)

Staff costs	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	81,251	2,758	84,009	80,490
Social security costs	7,803	0	7,803	7,353
Apprenticeship levy	390	0	390	373
Employer's contributions to NHS pensions	10,366	0	10,366	9,991
Pension cost - other	31	0	31	13
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	(690)	0	(690)	265
Temporary staff	0	5,516	5,516	6,226
Total staff costs	**99,151**	**8,274**	**107,425**	**104,711**
Of which				
Costs capitalised as part of assets	391	0	391	282

The majority of the increase in staff costs is as a result of the 2018/19 national agenda for change pay award.

Average staff numbers in post by occupation groupings.

Average number of employees (WTE basis)	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	52	27	79	81
Administration and estates	658	77	735	711
Healthcare assistants and other support staff	459	30	489	476
Nursing, midwifery and health visiting staff	890	38	928	923
Nursing, midwifery and health visiting learners	5	0	5	3
Scientific, therapeutic and technical staff	433	22	455	490
Healthcare science staff	1	0	1	1
Other	34	1	35	29
Total average numbers	**2,532**	**195**	**2,727**	**2,714**
Of which:				
Number of employees (WTE) engaged on capital proje	4	3	7	6

On average there was 13 whole time equivalent more staff in post in 2018/19. This is the net change in respect of services that were newly commissioned in year such as the Yorkshire & Humber Police Custody Service less services that were decommissioned.

Expenditure on consultancy

The Trust had no expenditure on consultancy services during 2018/19.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2019	16
Of which, the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	1
For between three and four years at the time of reporting	2
For four or more years at the time of reporting	10

All but one of the existing engagements have contractual clauses to request assurance on tax status. All but one of these appointments relates to forensic medical examiners; given the nature of their work the off-payroll contractual arrangement gives the Trust the best value for money.

For all new off-payroll engagements or those that reached six months in durations between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	2
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the year	0

Trade Union – Support to Engagement

The Trust has a track record of working positively with Staff side representatives and supports a number of employees to undertake work associated with the Joint Negotiation and Consultation Forum (JNCF), and to support individual colleagues. There are currently 12 employees that undertake the role of accredited trade union officials and are given paid time off to undertake these duties. The amount of time that they spend on this varies significantly, to meet the demands of their members.

A summary of the time off for trade union facility time is published on the Trust website.
[Ann Hobson has clarified that this is not yet available on our website but will be by the time we publish the final annual report]

Exit Packages

The figures reported here relate to exit packages agreed in year. The actual date of departure might be in a subsequent period, and the expense in relation to departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost expenditure in the accounts.

Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
£10,000 - £25,000	2	-	**2**
Total number of exit packages by type	**2**	**-**	**2**
Total cost (£)	**£24,000**	**£0**	**£24,000**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirements are met by the NHS Pensions Scheme and are not included in the table. There were no other departures during 2018/19.

Staff Sickness

The table below illustrates a total number of days lost through sickness absence across the calendar year. These figures are supplied to the Trust by the Department of Health. This is to make sure a standard approach is taken and so that figures can be compared across NHS organisations.

	Calendar 2017	Year 2018
Total days lost	32,038	31,839
Total staff years	2,485	2,503
Average working days lost	12.9	12.7

Signed ……..Chief Executive

Date……

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Financial Statements (Full accounts and notes to be appended after Audit)

AGENDA ITEM 2019-20 (15c)

Leeds Community Healthcare NHS Trust

Annual accounts for the year ended 31 March 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	145,276	142,243
Other operating income	4	10,364	7,283
Operating expenses	7,8,9	(149,282)	(144,623)
Operating surplus/(deficit) from continuing operations		**6,358**	**4,903**
Finance income	12	153	70
Finance expenses	13	-	-
PDC dividends payable		(715)	(488)
Net finance costs		**(562)**	**(418)**
Other gains/(losses)	14	(140)	(46)
Share of profit/(losses) of associates/joint arrangements	21	-	-
Gains/(losses) arising from transfers by absorption	46	-	-
Corporation tax expense		-	-
Surplus/(deficit) for the year from continuing operations		**5,656**	**4,439**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	**-**
Surplus/(deficit) for the year		**5,656**	**4,439**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(574)
Revaluations	19	-	3,428
Share of comprehensive income from associates and joint ventures	21	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	21	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset	38	-	-
Other reserve movements		-	43
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	14	-	-
Foreign exchange gains/(losses) recognised directly in OCI		-	-
Total comprehensive income/(expense) for the period		**5,656**	**7,336**
Adjusted financial performance (control total basis):			
Surplus/(deficit) for the period		5,656	4,439
Remove impact of consolidating NHS charitable fund		-	-
Remove net impairments not scoring to the Departmental Expenditure Limit		-	212
Remove (gains)/losses on transfers by absorption		-	-
Remove I&E impact of capital grants and donations		5	4
Prior period adjustments		-	-
Remove non-cash element of on-SoFP pension costs		-	-
CQUIN risk reserve adjustment (2017/18 only)		-	-
Remove 2016/17 post audit STF reallocation (2017/18 only)		-	-
Adjusted financial performance surplus/(deficit)		**5,661**	**4,655**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	30	53
Property, plant and equipment	17	29,310	29,310
Investment property	20	-	-
Investments in associates and joint ventures	21	-	-
Other investments / financial assets	22	-	-
Receivables	25	-	-
Other assets	26	-	-
Total non-current assets		**29,340**	**29,363**
Current assets			
Inventories	24	-	-
Receivables	25	9,449	8,849
Other investments / financial assets	22	-	-
Other assets	26	-	-
Non-current assets held for sale / assets in disposal groups	27	-	-
Cash and cash equivalents	28	26,483	23,244
Total current assets		**35,932**	**32,093**
Current liabilities			
Trade and other payables	29	(9,774)	(11,029)
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(580)	(1,361)
Other liabilities	31	(1,099)	(1,042)
Liabilities in disposal groups	27.1	-	-
Total current liabilities		**(11,453)**	**(13,432)**
Total assets less current liabilities		**53,819**	**48,024**
Non-current liabilities			
Trade and other payables	29	-	-
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	-	-
Other liabilities	31	-	-
Total non-current liabilities		**-**	**-**
Total assets employed		**53,819**	**48,024**
Financed by			
Public dividend capital		395	256
Revaluation reserve		12,026	12,032
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		41,398	35,736
Total taxpayers' equity		**53,819**	**48,024**

The notes on pages X to X form part of these accounts.

Name
Position
Date **0 January 1900**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Financial assets reserve*	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**256**	**12,032**	**-**	**-**	**-**	**35,736**	**48,024**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	**-**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	**-**
Surplus/(deficit) for the year	-	-	-	-	-	5,656	**5,656**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve	-	-	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	(6)	-	-	-	6	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value	-	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value	-	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	139	-	-	-	-	-	**139**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' equity at 31 March 2019	**395**	**12,026**	**-**	**-**	**-**	**41,398**	**53,819**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Available for sale investment reserve	Other reserves	Merger reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**
Prior period adjustment	-	-	-	-	-	-	**-**
Taxpayers' equity at 1 April 2017 - restated	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**
Surplus/(deficit) for the year	-	-	-	-	-	4,439	**4,439**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve	-	-	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	-	-	**-**
Impairments	-	(574)	-	-	-	-	**(574)**
Revaluations	-	3,428	-	-	-	-	**3,428**
Transfer to retained earnings on disposal of assets	-	(361)	-	-	-	361	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains/(losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Recycling gains/(losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	43	-	-	-	-	**43**
Taxpayers' equity at 31 March 2018	**256**	**12,032**	**-**	**-**	**-**	**35,736**	**48,024**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Other reserves
The Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not specifically included.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit)		6,358	4,903
Non-cash income and expense:			
Depreciation and amortisation	7.1	1,973	1,724
Net impairments	8	-	212
Income recognised in respect of capital donations	4	-	-
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		(879)	(2,331)
(Increase)/decrease in inventories		-	-
Increase/(decrease) in payables and other liabilties		(952)	1,637
Increase/(decrease) in provisions		(781)	(37)
Tax (paid)/received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	52
Net cash generated from/(used in) operating activities		**5,719**	**6,160**
Cash flows from investing activities			
Interest received		153	70
Purchase and sale of financial assets/investments		-	-
Purchase of intangible assets		-	(1)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(2,336)	(1,628)
Sales of property, plant, equipment and investment property		-	348
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from/(used in) investing activities		**(2,183)**	**(1,211)**
Cash flows from financing activities			
Public dividend capital received		139	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest on loans		-	-
Other interest		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
PDC dividend (paid)/refunded		(436)	(809)
Financing cash flows of discontinued operations		-	-
Cash flows from/(used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(297)**	**(809)**
Increase/(decrease) in cash and cash equivalents		**3,239**	**4,140**
Cash and cash equivalents at 1 April - brought forward		**23,244**	**19,104**
Cash and cash equivalents transferred under absorption accounting	46	-	-
Cash transferred to NHS foundation trust upon authorisation as FT		-	-
Cash and cash equivalents at 31 March	28	**26,483**	**23,244**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust's financial monitoring throughout 2018/19 provides evidence that financial duties and targets will be met or exceeded. The Trust has achieved the Control Total set by NHS Improvement for 2018/19; historically, the Trust has achieved all its financial duties.

The Trust's financial performance is monitored externally by NHS Improvement through monthly reporting and regular meetings. Internally, the Trust's financial performance has been monitored monthly by the Senior Management Team and the Business Committee, and by the Board at each of its meetings.

The Trust has reported a use of resources risk rating of 1 since it was introduced in October 2016. A rating of 1 represents the lowest risk rating for provider organisations.

The Trust's financial plan for 2019/20 demonstrates delivery of the Board approved surplus and Control Total required by NHS Improvement. Based on this plan the forecast use of resources risk rating for 2019/20 is 1.

The Trust has low levels of outstanding debt; the majority of the contract income is paid in month.

The Trust's liquidity remains very strong with over £26m in the bank at the year end. The financial plan for 2019/20 demonstrates the Trust has sufficient cash resources to meet its operational and capital investment commitments for 2019/20.

The Board of Directors is an experienced team. During the financial year there have been the substantive appointments of Medical Director, Director of Nursing and Allied Health Professionals and Director of Workforce. Three Non-Executive Directors, including the Chair, had their terms of office extended during 2018/19.

The Board has considered the matter of the Trust as a going concern at its meeting on 29 March 2019, and through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future. This is in line with the Group Accounting Manual 2018/19 paragraph 4.11-4.16.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The Trust provides sexual health services under a joint operation with Leeds Teaching Hospitals NHS Trust. As lead provider the contract income flows to the Trust, and Leeds Teaching Hospitals NHS Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to Leeds Teaching Hospitals NHS Trust.

The Trust provides forensic child and adolescent mental and physical health services under a joint operation with South West Yorkshire Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust, and South West Yorkshire Partnership NHS Foundation Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to South West Yorkshire Partnership NHS Foundation Trust.

Note 1.4 Revenue

Note 1.4.1 Revenue from contracts with customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard; applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

With the exception of the Provider Sustainability Fund, income payments are not dependant on the timing of satisfaction of performance obligations.

The Provider Sustainability Fund (PSF) enables NHS providers to earn income linked to the achievement of financial controls and performance targets. Access to both the general and targeted elements of PSF are unlocked as NHS providers meet their financial control totals. At each quarter, a minimum of 70% of allocated funding will be released upon achievement of the financial control total, with up to a further 30% released where a provider also meets its agreed trajectories for delivery of operational standards.

In line with IFRS 15, PSF should be accounted for as variable consideration. Paragraph 51 of the Standard identifies that consideration would be variable if a fixed amount is promised as a performance bonus.

In accordance with the Standard an entity is required to estimate the amount of consideration to which it will be entitled, in exchange for transferring promised goods or services. The Standard notes that the 'most likely amount' method of predicting consideration to which an entity will be entitled to, may be an appropriate method of estimation if there are only two possible outcomes; achieving a performance bonus or not. The method of estimation employed must be applied consistently throughout the contract.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of IFRS 15 entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner and they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from non-NHS contracts
The Trust receives revenue from contracts with non-NHS commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

Revenue from research contracts
Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

The Trust's research contract values are not considered material.

Revenue from other contracts
The Trust has no other income under IFRS 15 that is considered material.

Note 1.4.2 Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust's other income relates to rental income and lease car income.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust operates an alternative mandatory scheme, National Employment Savings Trust, for employees who do not qualify for or choose not to become a member of the NHS Pension Scheme.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
• Land and non-specialised buildings – market value for existing use
• Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:
(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
• the sale must be highly probable ie:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale', and
- the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
The Trust has no Private Finance Initiative or Local Improvement Finance Trust transactions.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	87
Dwellings	-	-
Plant & machinery	5	10
Transport equipment	-	-
Information technology	5	5
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset, and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	5	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

The Trust has no inventories.

Note 1.10 Investment properties

The Trust has no investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The Trust does not contribute to the Carbon Reduction Commitment Scheme.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services) which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, and are recognised when, and to the extent which, performance occurs ie when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as loans and receivables and are subsequently measured at amortised cost.

Financial liabilities are classified as other financial liabilities and are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts, through the expected life of the financial asset or financial liability, to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability, and is recognised in the Statement of Comprehensive Income as a financing income or expense.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Following the adoption of IFRS 9 the Trust determines the value of its credit losses using a matrix approach. The Trust has only one class of financial asset - trade receivables. The non-NHS trade receivables have been categorised by type of debt and based on historic performance the value of defaults has been assessed and a provision made for this value. Receivables with other NHS bodies are subject to the agreement of balances exercise and no credit loss is provided for.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance expenses in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control, or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated assets (including lottery funded assets)
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

Health service bodies are generally exempt from corporation tax, as they are either part of the Department of Health and Social Care or have specific exemption provided by sections 985 and 986 of the Corporation Tax Act 2010 (CTA 2010). Having reviewed these sections the Trust is satisfied it fulfils the definition of a health service body. The Trust has been established under section 25 of the National Health Service Act 2006 (as amended in 2012). This legislation states NHS trusts have been established to provide goods and services for the purposes of the health service. This is further defined as:

- the provision of goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
- the promotion and protection of public health.

Since the Trust only carries out services as described above, it has established no wholly or partially owned subsidiaries, and is therefore a health service body as defined by the Corporation Tax Act 2010, the Trust is exempt from corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction, and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to/from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

In line with IAS 16 the Trust is responsible for ensuring the carrying value of its fixed assets reported in the Statement of Financial Position is up to date. The Trust completed a full revaluation of its land and buildings in 2017/18. In 2018/19, the Trust was advised by the District Valuers Office (an independent expert body) that the estimated movement in assets values is less than 3%. As a result the Trust's Management has decided there is no material difference to the carrying values and has therefore not revalued its estate this year.

In accordance with IFRS 15 Revenue from contracts, the Trust has included the full value of the Provider Sustainability Fund income. This arrangement enables provider organisations access to income linked to achievement of financial controls and performance targets, as such it is classified as variable consideration. As the Trust has met these targets in full the total value of this income has been recognised in year.

With the introduction of IFRS 9 Financial Instruments, NHS bodies have to adopt a provisions matrix approach to determine the value of provisions in respect of all financial instruments. The only financial instrument the Trust has is its trade receivables. The Trust has had to estimate its irrecoverable debt value using the matrix for 2018/19. This has reduced the provision for bad debts by circa £30k on previous years. The prior period has not been restated; changes to the carrying amount as a result of IRFS 9 adoption are recognised as part of the opening balance of reserves and are subject to disclosure notes. The value of this is not considered to be material.

Note 1.25.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

An estimate of the redundancy and employment tribunal costs has been made and included in the Trust's expenditure for 2018/19 as required under IAS 37. The estimated value of this is £314k for redundancies and £266k for legal claims.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts Not EU-endorsed
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRIC 23 Uncertainty over Income Tax Treatments
Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating segments

All activity at Leeds Community Healthcare NHS Trust is healthcare related and the majority of the Trust's revenue is received from within UK government departments.

The main proportion of operating expenses are payroll related and are for the staff directly involved in the provision of healthcare and the indirect and overhead costs associated with that provision. It is deemed that the business activities that earn revenues for the Trust, and in turn incur the expenses, are therefore one broad provision on which it is deemed appropriate to identify as only one segment, namely healthcare.

Monthly operating results are published for assessment and review by the Trust's Chief Operating Decision Maker, which is the overall Trust Board that includes Executive and Non-Executive Directors. The financial position of the Trust to date, the Trust's Statement of Financial Position and Cash Flow and projections of future performance are assessed as a whole Trust rather than individual component parts that make up the sum total. In addition, all reporting of the position of the Trust is presented on a whole Trust basis that again implies a single operating segment under IFRS 8. As all decisions affecting the Trust's future direction and viability are made based on the overall total presented to Board, the Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Acute services		
Elective income	-	-
Non elective income	-	-
First outpatient income	-	-
Follow up outpatient income	-	-
A & E income	-	-
High cost drugs income from commissioners (excluding pass-through costs)	-	-
Other NHS clinical income	1,071	692
Mental health services		
Cost and volume contract income	-	-
Block contract income	1,598	1,621
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Community services		
Community services income from CCGs and NHS England	111,071	109,827
Income from other sources (eg local authorities)	29,676	29,822
All services		
Private patient income	-	-
Agenda for Change pay award central funding	1,546	-
Other clinical income	314	281
Total income from activities	**145,276**	**142,243**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	9,020	8,079
Clinical Commissioning Groups	104,719	104,059
Department of Health and Social Care	1,546	-
Other NHS providers	319	281
NHS other	-	-
Local authorities	28,550	28,444
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	-	-
Non NHS: other	1,122	1,380
Total income from activities	**145,276**	**142,243**
Of which:		
Related to continuing operations	145,276	142,243
Related to discontinued operations	-	-

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (16i)

Meeting Board 24 May 2019	**Category of paper** *(please tick)*	
Report title Report on Delivery of 2018/19 Operational Plan Priorities	**For approval**	
Responsible director Executive Director of Finance and Resources **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by Business Committee 24 April 2019, SMT 16 April 2019	**For information**	

Purpose of the report

This report provides an overview of delivery at the year-end of the Trust's 14 priorities for 2018/19 which drive achievement of the Trust's 4 strategic goals. Business Committee receive quarterly reports on progress and forecast delivery at year-end, the Board receive a reports at the end of quarter 2 and at year-end.

Main issues for consideration

The Board and its sub committees, through many and varied reports received, Board workshops and service visits, have been well sighted throughout 2018/19 on progress towards achieving the corporate priorities.

Year-end performance

Each priority has one or more success measures, defined in SMART terms wherever possible / appropriate. An overall RAG status is indicated which reflects an overall assessment of progress and performance in relation to the priority, not solely the component success measure RAG ratings.

At year-end:

- 10 of the 14 priorities were achieved (green)
- 3 remained on track to be achieved but not within the timescale achieved or were not fully delivered missed – timeframe, delivery requirements (amber)
- 1 was not achieved (red)

Strategic goal 1: recruit, retain and develop the staff we need now and for the future: *all 3 priorities are rated green.*

Priority 1: Improve retention
Priority 2: Improve recruitment with a particular focus on hard to recruit areas
Priority 3: Reduce sickness absence

Notable successes include:

- ✓ Retention target achieved and continues to be significantly lower than the average for community trusts.
- ✓ Our leadership and management offer has been redesigned and launched which will is central to developing effective leadership and staff engagement
- ✓ National staff survey results are greatly encouraging and endorse our approach to supporting staff health and well-being and 'creating the working life that we want'
- ✓ Good progress recruiting to hard to recruit areas: newly qualified nurses, School Nurses, Health Visitors and Police Custody AHPs

Strategic goal 2: Provide high quality services: *one of the 3 priorities is rated green:*

Priority 4: Achieve or maintain good or outstanding rating for all services

- ✓ Overall status has changed from amber in quarters 1 – 3 to green at year-end reflecting further improvement in clinical governance, operational processes and staff morale at Hannah House.

Priority 5: Develop LCH's quality improvement approach is rated amber reflecting success measures partially achieved. However, over the past 12 months we have re-established good foundations for our Trust-wide QI approach with excellent engagement across senior leadership and with services through Business Units, QI and OD and other corporate teams.

Priority 6: Provide harm-free evidence based care is rated red reflecting there being 2 Category 4 avoidable pressure ulcers in 2018/19. For the 3rd successive year, target reduction of Category 3 avoidable pressure ulcers was achieved

Strategic goal 3: Work in partnership to deliver integrated care and care closer to home: *all 4 priorities rated green*

Priority 7: Engage fully in the development and implementation of the Leeds Health and Care Plan and ICS Health and Care Partnership Plan under-pinned by an effective relationship with all partners
Priority 8: Engage fully as a key partner in the development of LCPs and ensure service responsiveness in implementing new models of care (NMoC) and pathway redesign
Priority 9: Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community
Priority 10: continue to focus on all opportunities to develop integrated working and provision between Primary Care and LCH

Notable successes include:

- ✓ LCH has continued to be fully engaged and responsive in ICS plan and Leeds Health and Care Plan development and implementation
- ✓ LCH is a key partner in multiple New Models of Care, pathway integration and redesign supporting patient flow and left shift
- ✓ Good progress in further developing integrated working, provision and governance with Primary Care including progressing integrated nursing, key senior joint appointments and establishment of the Leeds Primary Healthcare Collaborative

Strategic goal 4: Create sustainable services: *2 of 4 priorities rated green*

Priority 12: Implement year 1 of the business development strategy
Priority 13: Develop an innovative and viable model for the 0-19 pathway that meets commissioners' requirements

- ✓ 2018/19 was a very successful year for LCH business development: £13.6m of existing income was protected and retained (0-19:PHINS and Community Dental Service), and nearly £4m of additional income generated through partnership bids for new business (Humberside Liaison and Diversion service and Tier 3 Weight Management service) and business cases supporting system resilience, left shift and responding to increased demand.
- ✓ Good progress mobilising 0-19 PHINS

Two priorities were rated amber:

Priority 11: Establish a project team and implement the project plan for developing the CAMHS Tier 4 new building and service offer

- ❖ Slower progress towards agreeing an affordable capital and revenue development than planned. Building design is complete. Planning permission expected to be sought in May 2019.

Priority 14: Work on productivity within agreed services with clear expectations regarding workload and efficiency requirements

- ❖ Work on productivity has not progressed at the intended pace. An agreed work plan is in place. This remains a key focus for 2019/20.

Recommendations

The Board is asked to note progress at year-end in delivering the 2018/19 priorities

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

Priority 1:	**Improve retention**		
Overall RAG Status	**Year-end**		
Key Focuses indicated in Board approved plan • Implement retention plan • Engagement – teams / services act on staff survey, continue focus on 'creating the working life we want' and 'Building the workplace we want' • Develop Leadership and management throughout the Trust ***Other key focuses indicated in our internal delivery plan*** • Develop and promote apprenticeships that meet Trusts current and future workforce requirements		**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN**. The Trust's turnover rate was below target for Q4 at 13.5% below target in Q! & Q3, at target in Q2). Good progress on developing priorities set out in the Workforce Strategy which should contribute to a further reduction. **Retention plan**: In January 2018 the Trust joined an NHS Improvement programme aimed at improving retention rates of nursing staff and set out a retention plan to support this. Work continued throughout the year to introduce a number of initiatives to support retention. Trust turnover is much lower than other community trusts. NHSI commended the Trust on its improvement in retention: 2nd highest reduction in amongst its cohort of 19 NHS Trusts. Work will continue to create the conditions which will help us attract and retain our staff through focusing on the priorities set out in the trusts Workforce Strategy (2019/21). **Redesign of the leadership and management offer**: The redesigned offer went live during Q4. Leading LCH (3 day programme) commenced in January 2019 and three cohorts (28 leaders) have successfully completed the programme, with very positive feedback. Management Essentials went live during February 2019; 1 course has been delivered. Manager as Coach has delivered two cohorts during this quarter, engaging 88 leaders during 2018/19. Communications regarding the overall offer have been successfully developed and launched and programme dates for 2019/20 are filling rapidly. We have received interest from partners in the GP Confederation regarding access to the programme, and agreed a number of participants for the forthcoming year. The Systems Leadership component of Leading LCH is being adopted as a city-wide module by our partner organisations. **Creating positive team cultures**: 2018/19 national staff survey results received during Q4. Results show signs of significant improvement on key indicators: positive change for 46 of the 66 questions including 73% of staff feel satisfied with the support they receive from their managers, 9% increase in staff who feel respected and valued at work. Results have been fed back to teams, and engagement discussions are underway at team and service levels. A targeted approach is being offered to supporting services who benchmark below the LCH average, together with learning from those which feedback most positively	Turnover reduces to 14.5% by end of FY18/19	
	Increase in national staff survey score for staff engage-ment	
	Determine medical engage-ment	To repeat survey in 19/20

	On track		Slight under performance		Not achieved

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

Key Focuses indicated in Board approved plan • Review recruitment and selection process, systems and methodologies	**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN** reflecting good performance recruiting to identified hard to recruit areas: target exceeded. A Short Term Resourcing group worked from September 18 to March 19 to identify and implement resourcing solutions to increase capacity in services in preparation for winter pressures. To build on this group's membership and successes a Resourcing Steering Group will meet fortnightly from April 2019. **Increase in number of vacancies recruited to 1st time:** Quarter 4 was just below the target at 73.4%, but year-end position was achieved. **Improve recruitment in hard to recruit areas:** Nursing (including School nursing/health visiting) continue to be the most difficult to recruit. The Resourcing Steering Group will continue to develop the Resourcing plan. Progress at the end of the year shows the overall target being significantly over-achieved. Work continues with recruitment in progress for nurses graduating from September 2019. Two assessment centres held in February 2019: against a target of 30, 17 nurses recruited so far. Recruitment continuing; a further 16 applications submitted and to be assessed. Open day planned for May 19. **Improve time to hire:** Work progressing to align ESR and NHS Jobs systems to enable us to report on this success measure. Currently, there is no benchmark on as trusts report on different parts of the recruitment process. A West Yorkshire and Harrogate recruitment streamlining group recently formed as part of a national streamlining programme. This group will focus on improving staffs experience starting with the recruitment process**.** The group will agree standards across the region; this work will enable us to benchmark with other providers in the region/nationally. **Apprenticeships:** The Trust is supporting 25 apprentices and is currently recruiting existing staff to join the new apprentice nurse degree. Further work is required to support and promote apprentices and this will be linked to the work of the Resourcing Steering Group which will provide direction and a focus on skills shortages and how the levy can support upskilling of our workforce.	75% of vacancies recruited to 1st time: 60% fill rate for hard to recruit posts Improve time to hire	**2018 newly qualified nurses: 93%** **2019 newly qualified nurses: 56% (recruitment on track)** **School Nurses: 86%** **Health Visitors: 84%** **Police Custody HCPs: 103%** Data to be developed

	On track		Slight under performance		Not achieved

Priority 3:	Reduce sickness absence		
Overall RAG Status	**Year-end**		
Key Focus • Develop a Sickness Absence project		**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN.** Sickness absence at the year end is below target at 5.7% and is consistent with small monthly reductions in recent months. We will continue to work both on refining the sophistication of data and analysis and working with service and line managers to improve how we support staffs health and wellbeing. Sickness absence project: absence data has been stratified by the Head of Workforce Systems and Intelligence, which highlighted largest contributors of time lost due to absence. The Quality Improvement Team will investigate possible causes in Q1 19/20. The results will be fed into the HWB Steering Group for further direction. During this quarter, TIAA completed an assurance review of the sickness absence processes and concluded an assessment of "Reasonable Assurance. The recommendations included greater usage of ESR to record and manage sickness absence and more consideration on how we store our absence records. Work is progressing around these. Engagement around the Health and Wellbeing agenda continues to take place through the HWB Engagement Group. An ongoing programme of work has been identified to improve staffs health and wellbeing.		Reduction in sickness absence rate: target 5.8%	**5.7%**

	On track		Slight under performance		Not achieved

Strategic Goal: Provide high quality services

Priority 4:	**Achieve or maintain good or outstanding rating for all services (CQC and internal Quality Challenge+)**		
Overall RAG Status	**Year-end**		
Key Focuses indicated in Board approved plan • By end June '18 complete QIP actions identified from February '17 CQC inspection • Roll out refreshed Quality Challenge + by May 2018 • Implement our approach to ensure adequate focus on quality governance and ensure appropriate support to small isolated services ***Other key focuses included in our internal delivery plan*** • Share good practice identified through quality visits and self-assessments across teams and services • Ensure quality impact assessment completed prior to any service change and effective governance structures are in place to provide the necessary assurance • Progress work to ensure enabling systems such as ESR & training effective & responsive to services requirements		**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN.** The overall status has changed from amber at Q3 to green reflecting further improvement in clinical governance, operational processes and staff morale at Hannah House and SMT's belief that there is the necessary focus, support and processes to identify and address quality improvement requirements across the Trust,. • All CQC improvement actions completed by September 2018. Support for wider programme of QI and consolidation in clinical governance, operational processes and staff morale at Hannah House sustained • Pre CQC inspections of Hannah House, Little Woodhouse Hall, Sexual Health service undertaken January '19 • Well-led framework: February '19 Board agreed with SMT's overall Trust assessment: good, and ratings for the 8 KLoEs: 6 rated 'good', KLoEs 7 and 8, relating to service user engagement and continuous improvement and learning, rated 'requires improvement'. Reviewing the self-assessment and to report to Board May 2019. **Quality Challenge Plus**: • All 47 service self-assessments rated good / outstanding; includes a small number rated requires improvement which were re-assessed in-year and rated good. • 27 Quality Visits undertaken: 20 rated good, 7 rated requires improvement. Quality Challenge review completed in Q4 and revised approach approved by Quality Committee now being rolled out. The number of Quality visits (to be known as Quality Walks) will increase. They will be within service quality leads job descriptions Programme of work completed to ensure staff compliant with and accurately capturing Safeguarding training level on ESR. Progressed to next phase focussed on wider training requirements and reporting.		70% of services rate themselves good or outstanding in the QC+ self-assessment	**100%**
		80% of services visited rated good or outstanding following Quality Visit	**74%**
		Services currently rated 'requires improvement' by CQC, achieve good or outstanding rating if re-inspected	**SMT ass'ment**

	On track		Slight under performance		Not achieved

Priority 5:	Develop LCH's quality improvement approach which engages staff, service users & the public		
Overall RAG Status	**Year-end**		
Key Focuses indicated in Board approved plan • By the end of Q1 develop a clear appropriate evidence-based QI model and improvement methodology for use across the organisation • By the end of Q1 identify up to 4 QI projects at organisational and business unit level to implement in 2018/19 • Encourage QI projects to be undertaken at team / service level ***Other key focuses included in our internal delivery plan*** • Engage SMT, Board and the leadership community in understanding our QI approach and its role as a key enabler for organisational success • Successfully engage an external Improvement partner to support development & implementation of our approach • Support leaders, staff & service users involved in QI projects with access to QI training & improvement coaching • Communicate, share & spread QI work undertaken & its impact through a QI communication & engagement strategy		**Success Measures**	**Year-end RAG**
Progress update **Overall status AMBER**, reflecting success measures partially achieved. Extensive work undertaken in 2018/19 to re-establish the foundations of a Trust-wide QI approach, which will be built on in 2019/20. **Board development on QI:** 3 Board workshops in 18/19 around QI, building commitment, understanding and alignment. Board workshop in Q4 shared the learning from the 4 QI learning projects and the QI approach. **4 organisational QI learning projects:** Continuing work on the 4 QI learning projects in Q4. Staff engagement is a key focus, with use of the culture survey tool informing the work, with the potential to spread the learning from this work. Continued support from the Improvement Academy around tools and coaching to LCH Improvement Coaches. **Local QI projects:** QI resource pack to support local QI work is complete and available through the QI Hub on Elsie. Several other QI projects underway at business unit and system level e.g. Integrated Diabetes Pathway Work – rapid improvement event in February achieved significant success. The learning from this is informing other QI work. **QI Training**: 66 people participated in internal training (138 places offered), 10 accessed external training. QI training is now included in the Management Essentials training. **Alignment:** A QI Steering Group has been established to support alignment of QI work with other quality and cultural development initiatives across the Trust. A QI Strategy is pulling this work together, and aligning with the Quality & Workforce priorities. We will have 3 key priorities on which this will be based: everyone's job to 'make stuff better', good stuff is happening in LCH, Support available in terms of tools, methodology and people. **QI communications and engagement:** communications plan being developed. The QI approach is being branded as "Making Stuff Better" and is included in Induction sessions.		Able to make improve-ments and changes in their service area (national staff survey) Complete up to 4 QI projects with good outcomes and service user involvement Further 100 staff trained in QI	No change Ongoing 76

	On track		Slight under performance		Not achieved

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

Key Focuses indicated in Board approved plan	**Success Measures**	**Year-end RAG**
• Reduce the incidence of avoidable harms through implementing pressure ulcer, falls and CAUTI work plans • Further develop use of tools and provision of information supporting quality improvement to front line staff: • Further develop clinical outcomes work in line with the agreed plan ***Additional key focuses included in our internal delivery plan*** • Continue to improve compliance within 2 years with NICE guidance • Implement refreshed Research Strategy with clear focus on research relating directly to and benefits services & practice		

Progress Update

Overall status: RED reflecting that there were 2 Cat 4 avoidable pressure ulcers in FY 18/19: Cat 3 target exceeded. Good progress implementing the Pressure ulcer, falls and CAUTI work plans and in developing tools and providing information to front line staff to support quality improvement. The pace of developing clinical outcomes reporting was slower than planned, however we are confident this will be progressed at pace in 19/20 as both the CCG and LCH are investing resource.

Pressure ulcer, falls and CAUTI work plan implementation: good progress Pressure Ulcers and Falls review: investigation templates and process for review meetings revised: greater focus on sharing learning across teams. Patient information leaflets revised with a greater focus on prevention. Pressure Ulcer Prevention policy being reviewed. The citywide group is focussing initially on reviewing Cat 4 pressure ulcers to identify learning & opportunities for prevention system-wide.

Falls: revised work plan focuses on themes from falls investigations. To review assessment documentation & staff training needs CAUTI policy ratified. Catheter passport developed in partnership with LTHT. Launch events planned to share the passport, catheter product guide and new policy with staff. Systm1 catheter management templates amended so that easier for staff to use and further work being undertaken to review risk assessment tools.

Developing use of tools and provision of information supporting QI to front line staff: good progress:

- ABU safety huddles gained national accreditation
- All Specialist BU services have a Quality Board in place or are developing a virtual board. All services proactively discuss their Boards at monthly quality and performance meetings. Further work to be undertaken to support services that use Safety Crosses.
- Benchmarking information available on PIP

Develop clinical outcomes: progressed at slower pace than planned mainly due to sickness absence of the project manager. Service engagement indicated staff at all levels engaged in monitoring and improving clinical outcomes including through peer review, benchmarking and audit. The CCG and LCH are investing in 2019/20 in a programme of work for to develop central reporting of outcome data.

NICE guidelines: 31 of 38 guidelines published during 2016/17 fully implemented within the 2-year target. Actions plans in place with 7 services to implement minor outstanding recommendations.

Research and Development Strategy: refreshed strategy is nearing completion: for Board to sign off in the summer. Will be renewed focus on disseminating research output to practitioners to ensure practice based on the latest evidence.

Success Measures	Year-end RAG
Aim: 0 avoidable Cat 4 pressure ulcers. Minimum target: 50% reduction	2
20% reduction in Cat 3 pressure ulcers	43%

	On track		Slight under performance		Not achieved

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

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

Key Focuses

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

Progress Update

Overall status: GREEN. Good engagement with ICS plan and Leeds Health and Care Plan and associated governance structures.

Partnership governance:

- The Provider Committees in Common is now an established part of the city's governance architecture
- Draft internal partnership governance standards and decision-making flowchart developed (draft discussed at Audit Committee on 26 April 2019
- Population Health Management has progressed slower than planned (CCG lead). Consequently associated governance not yet being developed e.g. risk sharing, contracting and costing arrangements

Developing our relationship with primary care – see priority 10:

WY & Harrogate HCP Plan: continue to be fully engaged at Exec and senior manager level. ABU GM participated in shadow ICS Board. ICS funding to support LCP development has been allocated: will support programme management and LCP initiatives. ICS successful in bidding for funding to support digital developments across the area, including extending and joining up the Leeds Care Record with Care Records across the area.

WY CAMHS NMoC: crisis service being implemented funded from savings delivered by the NMoC. Further funding obtained from the CCG to extend the service out of hours.

Leeds Health and Care Plan development: continue to be actively engaged in developing and implementing key workstreams e.g. LCP development, involvement in citywide strategic developments for frailty, diabetes, urgent care, cancer care and stroke in the community–see priority 8. The Chief Executive is now leading LCP development. Leeds Plan refresh commenced in quarter 4

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

	On track		Slight under performance		Not achieved

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

Key Focus Work actively with partners to develop and implement Local Care Partnership plans and more integrated ways of working across all locality areas	**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN.** LCH is fully engaged and responsive in the development of LCPs, NMoC and pathway redesign. The CCG has funded additional resource to support NMoC, pathway redesign and service development in 2019/20. We have signalled to commissioners that requirements for any greater level of LCH input to development of LCPs, PHM & NMoC will require investment to fund expansion, support parallel running, backfill & / or corporate capacity **LCP development:** • Secured NHSE Funding to facilitate the development and implementation of LCP's locally. Funding split between programme resource to support development and funding to facilitate local place based work. • Leeds is 1of a number of sites nationally that has the input of an external consultancy to facilitate weekly LCP meetings. This focusses on 4 LCPs and will look at how the learning is shared across all 18: commenced Q4. • Leeds successful with a NHS England bid around population health management. • 3 Family and Child Hub pilots (childrens community care clinical MDT) operating. **NMoC and pathway redesign** • Virtual Respiratory Ward being rolled out citywide from April 2019, the learning will inform the Virtual Frailty Ward project - currently planning for some elements to go live in Autumn 2019 • Diabetes: LCH is fully involved in the commissioner led work to develop a citywide diabetes strategy. Single Point of Access for Diabetes project: developing 'Diabetes Leeds' concept where the diverse diabetes teams across the city work as one • MSK First Contact Practitioner (FCP) model: commenced provision in 2 localities in October 2018, citywide Implementation Plan developed in Q4 – roll out subject to funding agreements • Community Stroke: implementation of integrated clinical pathway started September 2018. Excellent working relationships with LTHT have enabled improvement in service delivery and outcomes - average length of stay down from 31.5 days in September 18 to 18.5 days in March '19 (national average: 21 days). • iBCF funding for Therapy Led Discharge trial to enable patients to be discharged from LTHT as early as possible • CIVAS Pathway Development: community clinics established in 2018/19s • Integrated Parkinson Disease nursing service with LTHT established, came into effect 1 April 2019. • ABU senior management fully engaged in planning for the roll-out of 5 Urgent Treatment Centres •	Active engagement and influence in all 18 LCPs New models of care (NMoC) implemented to agreed time-frames and specific-ations	

	On track		Slight under performance	Not achieved

Priority 9:	Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community		
Overall RAG Status	**Year-end**		
Key Focuses indicated in Board approved plan • Evaluation of NT self-care trial and adoption of principles into business as usual. Understand the impact of the model on staff capacity by September 18. • Embed health coaching / restorative practice approach in Children's, Specialist and Adult Business Units ***Additional key focuses included in our internal delivery plan*** • Work with LTHT to identify pathways where early intervention may result in a self-care approach • Use of Quality Improvement methodology to support culture/behaviour • Exploit use of digital technology to support self-care		**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN** reflecting NT self-management 1st stage evaluation indicating positive impact on patient experience, quality of life and health outcomes and freeing up NT capacity, 99 more staff trained in health coaching and progress in developing use of e-forms more widely across the Trust **NT self-management model**: The 2nd stage of the pilot went live 1 October '18 with the aim of embedding self-management as a function for all NT staff. Key focuses will be training NT staff (aligned to health coaching and Better Conversations) to drive culture change, identifying additional patient cohorts and maximising utilisation of self-management facilitators and exploring opportunities to work with primary and secondary care partners and strengthen links with the 3rd sector and ASC. 23 self-management facilitators recruited. Await CCG decision about funding the Self-Management project: to fund the project manager, project lead and 6 more facilitators. **Rolling-out and embedding health coaching and restorative practice**: • Health coaching training delivered to 99 staff in 2018/19: • our strategy and approach in relation to developing and embedding use of health coaching, restorative practice and better conversations, aligned with system plans to be agreed in Q1 19/20 **Exploit use of digital technology to support self-care**: • Several services are exploring the potential use of e-forms including providing a better way for patients to report information to their clinician. The Research Team is exploring its use to improve FFT and Outcome measure engagement with a view on acquiring a platform for the Trust enabling further e-forms to be developed. This has tied in with the use of e- & smart-forms in other systems. • The CCIO is now the city clinical lead for Patient Activation Management .		NT staff trained to enable roll-out and embedding of NT self-management model in line with the agreed plan Embedded self-management approach in NTs Roll-out and embed health coaching and restorative practice in services and align to the city-wide plan	

	On track		Slight under performance		Not achieved

Priority 10:	To continue to focus on all opportunities to develop integrated working and provision between Primary Care and LCH		
Overall RAG Status	**Year-end**		
Key Focuses • Develop our relationship with Primary Care with a particular focus on developing integrated nursing • Maximise the role of LCH services and corporate teams in service, pathway and new model of care development and provision by the partnership, in line with our business development strategy		**Success Measures**	**Year-end RAG**

Progress Update
Overall status: GREEN reflecting good progress. February 2019 Board received a paper describing LCH's strategy with particular focus on developing integrated working with Primary Care and describing progress to date.
 	
Developing our relationship with Primary Care
Progressing multiple initiatives across
• service provision :
  ○ Integrated Nursing projects includes progressing plans to establish wound care clinics / hubs, joint leg clubs, expanding catheter care plans
  ○ Ongoing development of a pilot home visiting service in East Leeds
  ○ Integrated projects indicated under Priority 8
• Workforce staffing, training and development:
  ○ Preceptorship & training for Practice Nurses
  ○ Primary care nurse bank
• Electronic records:
  ○ Adopted Children's Record Project
 	
Key appointments across LCH & the GP Confederation – Director of Nursing, Medical Director, Deputy Medical Director & CCIO
 	
Governance
Leeds Primary Heath Care Collaborative is well established and supports development of a strong mutual relationship between LCH & the GP Confederation.
		Board agreed change of priority focus at Q2.
		
		Integrated ways of working, service and pathway developments underpinned by robust governance
		
		Board self-assessment of progress: satisfactory	

	On track		Slight under performance		Not achieved

Strategic goal: Create sustainable services

Priority 11:	**Establish a project team and implement the project plan for developing the CAMHS Tier 4 new building and service offer**		
Overall RAG Status	**Year-end**		
Key Focused indicated in Board approved plan Ensure the capacity, skills and experience are in place to develop and implement the PID and business case for the new build ***Other key focuses included in our internal delivery plan*** • Establish robust project governance by April 2018 • Engage fully CAMHS in-patient team with corporate services to develop models for the delivery of high quality, efficient patient services		**Success Measures**	**Year-end RAG**
Progress update **Overall status**: **AMBER**. Progress towards agreeing an affordable capital and revenue development has been slower than originally envisaged. The project board has been focussed on ensuring a financially sustainable service in an affordable building which will enable the delivery of high quality care for the foreseeable future. Building design to accommodate core Tier 4 general adolescent service, PICU and S136 space and associated provisions is complete. The estimated cost is significantly in excess of the £13m Public Dividend Capital allocated. LCH and LYPFT have worked in partnership to propose a funding model. Revenue cost model remains challenging but resolvable as at 31 March 2018. Planning permission expected to be sought in June 2019.		Approvals received and work starts on site	
		Progress made on developing the service offer in line with the project implementation plan	

	On track		Slight under performance	Not achieved

Priority 12:	**Implement year 1 of the business development strategy: proactively generate income, scope opportunities to provide services in neighbouring areas and support the Leeds Primary Care Provider Partnership in developing business development propositions**		
Overall RAG Status	**Year-end**		
Key Focuses indicated in Board approved plan • In Q1 and 2 develop a corporate infrastructure that ensures we can generate income effectively, to include costing, marketing, payments processes • In Q 3 and 4 complete / refresh service annual self-assessments to support understanding about the market and service competitiveness, agree priority actions to improve competitiveness and review the service strategy		**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN** reflecting a very successful year for LCH for business development: • £13.55m of existing income protected and retained • Nearly £4m of additional income generated through bids and business cases. **Developing out of area business and growing business in Leeds**: major success story for LCH this year: won • Humberside Liaison and Diversion service in partnership with Community Links. 6 year contract worth £1.2m p/a. The service went live on 1 April '19; staff TUPE'd from existing provider NAVIGO. Still some staff to recruit so an official launch expected in quarter 2 of 19/20. • Tier 3 Adult Specialist Weight Management service in partnership with LTHT and LYPFT. 3 year contract worth £380k p/a. The service went live on 1 April '19 and will officially launch in July. The Business Development Team will be meeting with business units throughout May 2019 to confirm horizon scanning priorities for 19/20. **Business retention:** • New Community Dental Service went live October 1 October '18 • New 0-19 PHINS service went live 1 April '19 • IAPT/ PCMH bid through to 2nd stage. Contract award to successful provider expected June '19 **Providing business development expertise to the Leeds Primary Care Confederation**: Support to LCPs, PCNs and work including Urgent Treatment Centres and virtual frailty ward continues and will ramp up in 19/20 as a major focus. **Traded services**: priority projects continue to move forward: £1.1m income generated in 2018/19. Pilates and Acupuncture services fully staffed from within service: clinic organisation underway alongside marketing plan development. Eventbrite agreed as LCH traded training booking and marketing system: to roll out in Q1 2019/20 to Children's SLT and Children's Physio. Initial scoping of LEEDS Programme (Diabetes structured Education programme) to be rolled out in next financial year.		Surplus created from traded services projects – *target TBA* Number of out of area bids submitted Number of bids awarded -	Specific target not agreed but assessed as green given income level Not appropriate to RAG rate: 3 submitted Not appropriate to RAG rate: 2 of 3 won
	On track		Slight under performance		Not achieved

Priority 13:		Develop an innovative and viable model for the 0-19 pathway that meets commissioners' requirements		
Overall RAG Status	**Year-end**			
Key Focuses indicated in Board approved plan • Close working with commissioners to influence the specification • Development and implementation of engagement plan with staff, young people and other stakeholders to maximise the users voice in our submission • Establishment of bidding team with clear capacity and capability to write a winning bid ***Additional key focus included in our internal delivery plan*** • Work with mHabitat to ensure a digitally optimised submission			**Success Measures**	**Year-end RAG**
Progress update **Overall status: GREEN**. Excellent progress: having won the tender, mobilisation began October 2018, contract signed January '19 and service transitiioned to a 0-19 PHINS service on 1st April 2019. Key focuses: • Staff recruitment, retention and training: good progress with recruitment: 16 of 19 HV posts recruited, 2 SN recruited, 4 in the pipeline: target 7 - using social media and Refer a Friend initiative. Financial penalty risks largely mitigated. Developing a 0-19 recruitment and retention strategy • Co-location: Commissioners have asked LCH to propose a model that is sustainable and workable as cost of co-location may be prohibitive. We are progressing re-location of LCH staff in to 6 Health Centre Hubs • KPIs: Transition / PHINS Performance, Data & Quality development progressing well - agreeing final few KPIs with commissioners. • Establishing a Single Point of Access (SPA): recovery plan developed to resolve interface issues between the 0-19 SPA and ensure contract requirements met • Clinical Governance: May Programme Board to receive paper providing assurance that clinical governance is fit for purpose. Phase 2 QIA on specific elements of service change undertaken in Q4. • Pathway and new service developments: good progress being made however there are capacity issues re delivering the HENRY programme. Meeting with commissioners to discuss the proposed Watch It contract which we cannot deliver for the proposed contract value. • Digital patient communication innovations: good progress -Chat Health roll out and marketing comms on track			Viable response to invitation to tender within price constraints and that does not compromise quality	

	On track		Slight under performance		Not achieved

Priority 14:		Work on productivity within agreed services with clear expectations regarding workload and efficiency requirements		
Overall RAG Status	**Year-end**			
Key Focuses • Establish a working group to prioritise services and areas to be explored by May 2018 • Use of Quality Improvement methodology to support productivity gains, to include developing capability and use by services of capacity and demand tools and analysis			**Success Measures Baseline / 17-18**	**Year-end RAG**

Progress update
 	
Overall status: AMBER. Although progress has been made in the utilisation of benchmarking information to identify opportunities for productivity improvement, implementation of any changes in respect of those opportunities has been slower than expected. This remains a focus for 2019/20. The Trust once again achieved it financial targets and delivered above target activity which suggests an overall improvement of productivity albeit not a systematic and sustainable one. Hence the overall rating of amber.
 	
Workplan developed for the 1st phase of work:
• In Quarter 1 2019/20:
  ○ to review analysis of data and other intelligence in services identified as outliers across a number of productivity measures (e.g. DNA / Child Not Brought, first to follow up ratios): Podiatry, MSK (including Spinefit), Health Visiting and the Continence and Colorectal Service (CUCs) and assess the opportunity for productivity improvement.
  ○ to compare the findings of the Carter Review with performance in Neighbourhood Teams focusing on 4 key metrics.
  ○ Business Units to present analysis of reasons for outlier reference costs, high and low, which will enable identification of opportunities to improve productivity, share learning internally about effective and efficient processes and ways of working and support business cases / demonstrate efficiency to commissioners. Business Units will triangulate this with NHS Benchmarking Club data
• CAMHS pathway redesign continues: the 1st pathway, Neuro Development, has been agreed and is being implemented
• Corporate benchmarking: the Trust will use corporate benchmarking information in 2019/20 to assess the delivery of the brought forward corporate services CIP.
• Enagage staff and managers in a wider conversation about productivity/CIP approach
			Prioritised services achieve target productivity improvements – target TBA	

	On track		Slight under performance		Not achieved

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (17)

Quality Account 18-19

Delivering the best possible care to all our communities in Leeds and beyond

Contents

- Just Culture
- Patient Engagement Initiatives within service planning
- Complaints and Concerns
- Friends and Family Test (FFT)
- Patient Engagement and Experience
- New Models of Care
- Safeguarding
- Infection Prevention and Control – Shaping the Future

Appendices

Part 1: Statement of Quality

Leeds Community Healthcare Trust (LCH) provides community healthcare services across the health economy of Leeds and neighbouring areas. The Trust was last inspected by CQC in February 2017 and was rated 'good' overall.

Our purpose is to provide high quality healthcare to all. We do this by working in partnership with other organisations and groups, involving and developing our staff, and using our resources wisely to continually improve our services.

We provide a range of community-based health services across Leeds and surrounding areas and offer high quality healthcare in the most appropriate setting for our patients, whether that is in their own home, a local health centre, in-patient setting or within a health and justice setting.

We also provide health promotion and education services to improve the health and well-being of all the people across our health economy

Working closely with other organisations such as our acute hospital colleagues, the Mental Health Trust, Leeds City Council, primary care including General Practitioners and 3rd sector organisations, we make sure that if patients need to move between health and social care settings, they can do so quickly and easily.

We believe that:

- patients have the right to safe, evidence-based and innovative care
- patients should be able to access the most appropriate service for their needs in a timely fashion
- staff should have access to relevant training and development which supports them to deliver excellent care
- we work best when we work with our patients, staff and others to develop and deliver services

We also believe that quality is a core thread throughout our services, carried out by our services and staff on a daily basis. When things go wrong or we do not live up to the expectations of our service users and the public, we will review and where possible put things right. We will also learn from our mistakes and put actions in place to mitigate the risk of errors reoccurring.

This quality account looks at how far the Trust has progressed in delivering quality in 2018/19 and describes the areas and focus for LCH improvement planning and quality objectives for the coming year.

The quality account priorities set for the 2019/20 reporting period have been discussed and ratified by the Quality Committee with final agreement by the board on 24th May 2019.

We have focused on 4 main areas for the coming year to present within the Quality Account to formulate targeted key measures to ensure tangible, sustainable change and improvements which include:

- Maintain quality across all services & aim for outstanding rating – CQC & Quality Challenge+ - Looking at continuous quality improvement across services
- Strengthen organisational approach to service user engagement and experience at all stages of care delivery – reinvigoration, collaboration and wider introduction of patient engagement and experience initiatives across LCH
- Strengthen our learning mechanisms from incidents and good practice – introduction and embedding learning from across services, sharing good practice from both incidents and excellence
- Develop and implement new models of care and new ways of working including integrated pathway development, service developments, tenders and sub-contracting arrangements and working across boundaries ensure quality is maintained or improved.

We will also continue to monitor and progress the 2018/19 targets which were not fully achieved in the year. These include:

- Ongoing targeted action plans to improve and reduce the waiting times within the CAMHS service which remains a priority for 2019/20 for the Children's Business Unit and will continue to be tracked and monitored through SMT and the governance structure
- Ongoing targeted action plans to improve the access for children with additional needs (ICAN) also remains a priority for 2019/20 for the Children's Business Unit and will continue to be tracked and monitored through SMT and the governance structure
- The outcome measure and target for 2019/20 for avoidable category 4 pressure ulcers will remain at zero. This measure will be tracked within the Performance Brief domains on a monthly/quarterly basis
- The FFT equality data measure is being reviewed within the 2019/20 work plan for the Patient Experience Team with discussions taking place on how we can achieve equality of responses with a focus on the new FFT national requirements
- The Quality Challenge+ visit measures have been revised for 2019/20. The measures will be tracked within the Performance Brief domains on a monthly/quarterly basis.

Part 2: Priorities for improvement 2019/20

The Quality Priorities agreed for the 2019/20 reporting period have been devised to continue from the 2018/19 priorities and to ensure that LCH continues to strive to achieve our vision and live our values seamlessly throughout our services.

The Quality Priorities focus on ensuring our workforce is able to deliver the best possible care in all our communities and that we can continue to delivery outstanding care to all. We will ensure that we work more closely with our partners and others to ensure we can deliver integrated care with care closer to home. In addition, we always strive to ensure that we use our resources wisely and as efficiently as possible.

Priority 1: Maintain quality across all services & aim for outstanding rating – CQC & Quality Challenge+

1. Implement action plans to address improvement recommendations from external reviews to the agreed timescale
2. Define the Quality Challenge+ success measure and ensure that:
    - **a.** At least 80% of Quality Challenge+ visits are reported as good or outstanding following a peer review visit
    - **b.** Increase the number of Quality Challenge+ peer reviewers across LCH who actively engage in the Quality Challenge+ process
3. Quality Impact Assessments (QIA) undertaken on a timely basis, monitoring and escalation of impact embedded across the organisational performance process
4. Services have access to reliable outcome data to inform service development and linked to Quality Improvement

Priority 2: Strengthen organisational approach to service user engagement and experience at all stages of care delivery

1. Develop a Patient Engagement and Experience Strategy:
    a. Agree an implementation plan which has SMART objectives; to include impact measures and review timetable
    b. Agree the process and support structure to services to increase patient engagement across the organisation
    c. Agree process and support structure to help facilitate patient and/or carer involvement in incident investigations

2. Implement a Patient Experience and Engagement Framework:
    a. To establish current position across the organisation
    b. Includes chosen models for engagement
    c. Identifies key actions
    d. Directly links to the Organisations strategic priorities

3. Develop Patient experience and engagement service staff champion role and quarterly meetings:
    a. Aims, membership and Terms of Reference of the group are clearly defined
    b. There is representation from each service/team across the Organisation
    c. The group feeds into reporting structures via the Patient Experience Team

4. Organisation-wide roll out of ‘Hello my name is…’ Campaign

5. ‘Always Events’ are understood and in place across the Organisation

Priority 3: Strengthen our learning mechanisms from incidents and good practice

1. Set up a repository on ELSIE for all learning from incidents and good practice
2. Roll out FABULEEDS across LCH:
    a. Gain good practice stories from Business Units in each quarter and disseminate across services
    b. Provide an annual poster of good practice for display in services
    c. Ensure that learning from good practice is escalated to senior staff leaders through the governance reporting structure
3. Support focus events for all staff on learning from incidents and excellence to showcase good practice and learning
4. Review and strength our Patient Safety, Experience and Governance Group (PSEGG) by:
    a. focusing on learning and identification of emerging themes
    b. Discussion and dissemination of learning through services by active members of the group
    c. Wider dissemination through the governance committee’s to senior leaders of any emerging themes and trends
    d. Hold focussed workshops through the year for open discussion and sharing across services
    e. Explore how we can include service users or representatives and the wider community in PSEGG meetings and workshops

Priority 4: Develop and implement new models of care and new ways of working including integrated pathway development, service developments, tenders and sub-contracting arrangements and working across boundaries ensure quality is maintained or improved

1. Increase the number of patients who are active with self-management/care across the neighbourhood teams
2. Quality Impact Assessments consistently being completed for all new pathways/pilots/contracts etc., including post completion assessment and / or project evaluation undertaken on a timely basis.
3. Clinical governance structures fully established and functioning effectively at the commencement of delivery of services
    - Review and agree model
    - Implement model and documentation for all service and pathway developments, tenders implemented since 1 April 2019.

2.1 Quality Improvement Priorities 2018/19

The following section describes how the Trust performed against each of the quality priorities. The Trust made significant progress with the quality targets during 2018/19. There are a number of quality improvements where we will continue to make progress, and these continue to remain a target to achieve within the 2019/20 organisational priorities.

SAFE

Priority 1: Providing harm-free evidence based care
Quality Area for Action: To reduce avoidable harm • Reduce the number of avoidable pressure ulcers: 1. 50% reduction in avoidable category 4 pressure ulcers from the 17/18 figure with an overall aim of no avoidable Category 4 pressure ulcers within the Trust 2. 20% reduction in category 3 avoidable pressure ulcers from 2017/18 baseline. **Target outcome: Partially Achieved**
Progress in 2018/19: 1. There were 2 category 4 pressure ulcers identified as avoidable to the Trust in 2017/18. Two category 4 pressure ulcer was found avoidable to LCH in 2018/19 after review and investigation. The overall aim to have no category 4 pressure ulcers has not been achieved. However, a full root cause analysis of this incident has been completed with learning disseminated for future prevention across LCH. We continue to aspire to having no Category 4 pressure ulcers avoidable to the Trust. **Not Achieved** 2. The target for avoidable Category 3 pressure ulcers in 2018/19 was 10. There were 7 Category 3 pressure ulcers found to be avoidable to LCH after review and investigation. **Achieved** All pressures ulcers identified by services are reported and all are reviewed to identify where possible causation, prevention measures. Those found to be category 3 and 4 and some unstageable pressure ulcers undergo further investigation to identify any learning for the services and organisation.
Ongoing Progress in 2019/20: The issues around pressure ulcer development are complex in nature and sometimes involve patients not following healthcare advice and this can lead to pressure ulcer development. There is usually a very good reason for this, but it can cause added complexity for staff who are managing increasingly complex care in the community. The Trust has reviewed and updated the investigation and learning processes from pressure ulcers in 2018/19. This aims to make the process more conducive to learning as opposed to blame to try and ensure learning becomes embedded in order to prevent future pressure ulcers. It is hoped this approach, in addition with ensuring there is a really focus on learning from pressure ulcers at the Patient Safety and Experience Governance Proup, will really enable the Trust to achieve the 2019/20 targets as below: • Zero category 4 pressure ulcers avoidable to LCH • The target for avoidable category 3 pressure ulcers for 2019/20 has been reduced to seven. These measures will be tracked within the governance structures on a monthly and quarterly

basis.

Quality Area for Action: Achieve or maintain good or outstanding rating for all services (CQC and internal Quality Challenge+)

- Increase the number of services rating themselves as good or outstanding against the Quality Challenge+ Standards and to demonstrate improvement for services that have been rated as requiring improvement by the Care Quality Commission:
  1. 70% of services rate themselves as good or outstanding through the Quality challenge+ self-assessment
  2. 80% of services rated as good or outstanding following a (Quality Challenge+) peer Quality visit
  3. Good and outstanding services will share learning and approaches to achieving the Quality Challenge+ standards with other services. (Quality Challenge +partners)
  4. Services currently rated 'requires improvement' by CQC achieve a good or outstanding rating if re-inspected.

Target Outcome: Achieved

Progress in 2018/19:

1. All services who completed a self-assessment rated themselves as good or outstanding with an overall total of 84.4% (38/45). **Achieved**
2. There was a challenge in 2018/19 for all services to undergo a Quality Challenge+ visit due to factors including service pressures, limited visitor capacity and resources. This meant that not all services received a visit. However, where services were identified as required improvement in previous inspections or concerns were identified, all these services received an inspection. Overall 74% (20/27) of services were rated good or outstanding. **Partially Achieved**
3. Monthly reports are produced and reviewed within the Clinical Effectiveness Group and learning disseminated through the services. **Achieved**
4. Services currently rated as requires improvement produce an action plan to address the areas of concern which are monitored and tracked. These can be short term or long term initiatives. The services rated as requiring improvement will have a review visit planned to take place earlier than the annual review timetable. **Achieved**

Ongoing Progress in 2019/20:

The Quality Challenge+ measures for 2019/20 have been amended to ensure that the team members are involved in the completion of the self-assessment forms as this was one area where a number of staff had feedback that they had not been involved in the process.

There will be a targeted approach to ensure that all services are visited in and where requirements are identified also receive a follow up visit.

Quality Area for Action: Always Events

- Learning what quality care means to our patients, and working in partnership with our patients to improve their experience of LCH using the Always Events Toolkit:
  1. 200 staff within LCH to attend Always Events awareness sessions.
  2. At least two services from each of the Business Units will have identified an Always Event with their service users.

Target outcome: Achieved

Progress in 2018/19:

1. Patient engagement sessions were conducted at staff induction and the concept of Always Events were presented at a number of events throughout the year within LCH. These included within the continence service patient engagement event. **Achieved**
2. LCH will participate in the Always Event Toolkit initiative commencing in January 2019 supported by NHS England and NHS Improvements. Services have been identified to focus the NHE/I toolkit initiative. One service is currently working closely with the lead on finalising an initiative to embed an Always Event. **Achieved**

Ongoing Progress in 2019/20:

The Trust will be rolling out the 'hello my name is' campaign within the Always Event initiatives. The Trust is being supported by NHS England and NHS Improvements to identify and implement Always Events within services across the Trust to help deliver a better patient experience.

EFFECTIVE

Priority 2: Engaging staff, service users and the public to improve the quality of care

Quality Area for Action: Increase service and organisational focus on prevention, early intervention, pro-active care and self-management to keep people well in the community.

- Evaluation of self-care service currently being trialled in Neighbourhood Teams and adoption of principles into business as usual:
  1. Embed self-management approach in Neighbourhood Teams (NT) (informed by pilot evaluation)
  2. NT staff trained to enable roll-out and embedding of LCH's NT self-management model in line with the agreed plan.
- To review patient's confidence in self-care within the new Foot Protection Service within the Specialist Business Unit:
  1. Evaluate the confidence of patients in following self -management care plans within the new Foot Protection Service
- Continue to roll out and embed health coaching/restorative approach as part of asset based approaches to support better conversations and patients to be empowered to self-manage:
  1. Roll out and embedding of health coaching and restorative practice in services across the organisation in line with the agreed city-wide plan. (number to be determined for LCH)
  2. Measures put in place to evaluate the impact of better conversations and 'working with' patients.

Target outcome: **Achieved**

Progress in 2018/19:

Evaluation of self-care service currently being trialled in Neighbourhood Teams and adoption of principles into business as usual:

1. Training was completed across LCH during 2018/19. A Health Coaching Steering Group re-focused efforts on identifying staff for training, pre-training preparation and evaluation of the impact. **Achieved**

2. Qualitative information was captured from Self-Management pilot. Impact stories were collected from services using health coaching to feed into evaluation. Steering Group focussing on quantitative evaluative information via use of Patient Activation Measures (PAM), including barriers to using this tool systematically – see page 24 for further information and examples of Self-Management **Achieved**

To review patient's confidence in self-care within the new Foot Protection Service within the Specialist Business Unit:

1. The confidence questionnaires are now established within the service to evaluate patient's experience with the self-management care plans. **Achieved**

Continue to roll out and embed health coaching/restorative approach as part of asset based approaches to support better conversations and patients to be empowered to self-manage:

1. Health coaching training delivered to 99 staff in 2018/19: Better Conversations team: 3 sessions. **Achieved**
2. To agree in quarter 1 2019/20 our strategy and approach in relation to developing and embedding use of health coaching, restorative practice and better conversations, aligned with system plans. **Achieved**

Ongoing Progress in 2019/20:

- Self-Management lead roles will continue to be embedded with the self-management approach and adopted as business as usual within the Neighbourhood Team's
- The confidence questionnaire within the Foot Protection Service is now an embedded practice to evaluate the patient experience both prior to and after receiving the support from the service.
- There will be continued progress with the roll out of the use of health coaching across the Trust. Within quarter 1 2019/20 a strategy and defined approach will be developed which aligns to the system wide plans which involves partner organisations.

Quality Area for Action: Quality Improvement (QI)

- Develop a clear and appropriate QI model and methodology for use across the organisation which is evidence-based:
  1. Up to four organisation-wide QI projects to be undertaken during 2017/18 on key priority areas. In addition, a minimum of 8 projects undertaken at team / service level using the agreed QI methodology.

Target outcome: **Achieved**

Progress in 2018/19:

Four QI projects were identified and progressed throughout 2018/19. These included a project within the Children's Community Nursing Service which looked at how they can ensure that their patients and families receive a consistent, coordinated and joined up care across all care providers. The Continence, Urology and Colorectal Service (CUCS) undertook a project which looked at ensuring that patients receive the most clinically appropriate continence products at the right time. The South Leeds Recovery Hub and the council joined up to look at how they can ensure a safe transfer of patients from the service into hospital. The organisation also commenced a project which looked improving staff health and wellbeing.

The QI team also supported services with applying QI methodology in other service level projects which included an e-coli project and on the introduction of safety huddles. A QI resource pack was developed to support QI implementation locally.

Ongoing Progress in 2019/20:
An organisation Quality Improvement Strategy is being developed and will be ratified within 2019/20 which will set out our objectives of developing a culture of continuous quality improvement. The QI team will continue to roll out training on QI methodology and support services and teams with projects.

The QI will also focus on how the organisation can also increase staff feeling they are able to influence change within their service and/or the organisation. This is following the results of our recent staff survey where the Trust has remained consistently a low scorer.

Quality Area for Action: Outcome Measures

- Increase the number of services using outcome measures that are effective and meaningful and ensure that data from outcomes is extracted to ensure that outcome measures are meaningful:
  1. Implement the roll out of an outcomes programme that is clinician agreed and patient determined and in line with the Business Committee agreed plan.

Target outcome: **Partially Achieved**

Progress in 2018/19:
Within quarter 4 the Quality Committee received a report that staff are actively engaged in activities to monitor and improve clinical outcomes.

We established a self-assessment process for services to be incorporated into the quality challenge +.

We have established a baseline for the use of clinical outcomes across the organisation.
A scoping survey with all LCH services in regards to clinical outcomes achieved a 75% response rate, and of those 82% had an identified clinical outcome measure that was approved for use. It showed that those outcome measures in use, were, to a variable extent, available through the clinical system in use or LCH performance data module PIP.

Ongoing Progress in 2019/20:
SMT and Quality Committee have approved plans for next year's programme of work that will focus on reporting systems.

SMT have approved funding for a project manager and support officer to implement the roll out of the outcomes programme.

Leeds CCG have agreed to fund work that is required in business intelligence and SystmOne as part of their city wide support team.

Posts for the project manager and project support officer are currently advertised, interviews were held at the end of April and the post was successfully recruited into.

In 2019/20 the outcome programme for LCH will concentrate on ensuring that all services have business intelligence and data support required to ensure the Trust can centrally report on clinical outcome measures. The new Program Lead will oversee this programme of work and work with individual services to ensure measures are appropriate, linked to city-wide patient outcomes and utilised as part of the Trust-wide quality improvement approach to measurably improve patient outcomes.

CARING

Priority 3: Engaging Staff, Service Users and the Public to Improve the Quality of Care
Quality Area for Action: Family and Friends Test (FFT) • Increase the response rates for FFT using baseline from the end of 2017/18: 1. Increase the uptake of FFT across all Services to achieve a minimum 3% increase in response rates by the end of 2018/19 **Partially Achieved** 2. Services to share learning and 3 changes made as a result of FFT feedback from service users. **Achieved** • Ensure FFT equality data is reflective of the patient population through promotion, in order to identify and better understand health inequalities; and bring about improvements in patient care: 1. Services to improve on the equality of FFT data from the baseline developed from the 2017/18 data. **Not Achieved** **Target outcome:** **Partially Achieved**
Progress in 2018/19: Steady progress was made throughout the year on increasing the FFT returns. There was acknowledgement that some services found the increase quite difficult for a number of reasons including a high proportion of services users being longstanding patients, patients accessing a number of services leading to survey fatigue and services already receiving a high number of FFT responses. Learning is shared within services with the introduction of 'you said, we did' boards and sharing of feedback at handover, huddle meetings. The improvement of equality of FFT data has not been achieved in this reporting period due to competing priorities to progress and identify a robust and sustainable methodology.
Ongoing Progress in 2019/20: The Patient Experience Team will be reviewing the national changes to the FFT requirements for 2019/20 and will undertake targeted worked across the Business Units to reflect the national changes and ensure that we collect meaningful data to help improve services and patient experience. One of the focus areas for the Patient Experience Team in 2019/20 will be to look at how we share learning from patient experience and engagement across LCH. A Patient Experience and Engagement Strategy will be developed within 2019/20 with the support from our 3rd sector colleagues and patient groups.

RESPONSIVE

Priority 4: Access to Services
Quality Area for Action: Access to Services • Reduce internal waiting times, understand waits and agree further priority areas for intervention: **1.** Children and Adolescent Mental Health Service (CAMHS) - All first appointments will

be undertaken within 12 weeks. **Not Achieved**
2. Access for Children with Additional Needs (ICAN) - Pre-school children will be seen for ASD assessment within 12 weeks. **Not Achieved**
3. 80% of initial appointments for OT and PT should be seen within 12 weeks. **Achieved**

- To develop a pilot in one service in relation to tracking follow-up appointments. The learning from this will be used to shape a plan to develop this across services: **Achieved**
  1. Service identified
  2. Pilot plan and project established
  3. Learning will be identified
  4. Evaluation completed in relation to potential to roll out across services and business requirements to enable this.

Target outcome: **Partially Achieved**

Progression:

There are still ongoing difficulties relating to waiting times in a number of services. There is targeted approached to review the capacity and demand of the service to identify key actions to help support and reduce the waiting times for services.

The Eating disorders: Continue to offer all routine appointments within 4 weeks and all urgent within 1 week.
The Community CAMHS/crisis team: We are in the process of moving emergency assessments from Community CAMHS into Crisis with a view of this being completely removed once the newly developing Crisis team is at full capacity. We continue to offer all emergency appointments within 4 hours. All urgent referrals are seen within 1 week.
For routine referrals: the service 22.5 week wait for Neuro developmental assessments (ASD/ADHD/) and 15.6 weeks for Next Steps (previously called Consultation Clinic).
Internal waits – we have 25 internal waiting lists and 5 are over 12 weeks.

ICAN ASD Assessments within 12 weeks

Number of children seen within 12 weeks = 11.3% and number seen within 18 weeks = 88.7%.

Follow up Medical Appointment within 4 weeks

Overall 70% of children seen within 4 weeks of follow up appointment.

80% of initial appointments for ICAN OT and PT should be seen within 12 weeks

Occupational Therapy - 68.4% of children seen within 12 weeks. 80% of children seen within 13.3 weeks of referral.

Physiotherapy - Target met with continual improvement in wait times. 89.8% of children of children seen within 12 weeks. 80% of children were seen within 8.5 weeks.

Actions will continue to address the challenges with waiting times.

Ongoing Progress in 2019/20:

Further funding is being made available to support teams with recruitment into extra posts. Pathways are being reviewed to ensure a smooth and seamline care pathways are developed.

There will be focussed time to enable full development and implementation of Neuro Development pathway. This will help to prevents double waits for patients and their families and will enable a move towards a maximum 12 week wait. There will also be a significant reduction of the current waiters on the list.

Robust review of case management and management supervision procedure is taking place within teams. Training on letter and report writing is being developed to reduce clinical admin time. There will be continuing support to move all staff across to electronic diaries. Job plans continue to be revised, ensuring they reflect current need of service and to assist clinicians in offering the appropriate allocated slots. Data is being collated monthly on individual performance and discussed with Team Managers.

CAHMS staff will receive Cognitive Behavioural Therapy (CBT) training in order for them to offer group therapy to address CBT internal waits.

Text reminders have now commenced to help reduce the' did not attend' rates within services. The Standard Operating Procedure for the management of missed appointments/ did not attend is being updated.

There will be continued work to implement Emotional Disorders pathway.

A review of internal waiting lists is currently taking place with a view to move them across to pathway waiting lists, considering national data requirements are met.

WELL LED

Priority 5: Recruitment and Retention of Staff
Quality Area for Action: Leadership • Develop leadership and management throughout the Organisation through implementation of the leader development LEAD Programme and development of the senior leadership team: 1. Reporting will be timed with cohorts to the programme. We will measure the quality impact to through surveys which will assess achievement of personal learning objectives, impact on the team and feedback from line managers.to be conducted 6 months following completion of the cohort to allow for change to take place. **Target outcome: Achieved**
Progress in 2018/19: The redesigned offer went live during Q4 2018/19 after development and engagement activities throughout the year. Leading LCH (3 day programme) commenced in January 2019 and three cohorts (28 leaders) have successfully completed the programme, with very positive feedback. Management Essentials went live during February 2019; 1 course has been delivered. Manager as Coach has delivered two cohorts during this quarter, engaging 88 leaders during 2018/19. Communications regarding the overall offer have been successfully developed and launched.

Ongoing Progress in 2019/20:
A new talent management approach including tools to support staff and managers will be developed through a process of engagement. The trust will also launch the LCH Leadership Competency Framework which will underpin the future Leadership and Management Programme.

Quality Area for Action: Staff Engagement

- 'Creating the working life we want' by increasing year on year the National Staff Survey score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey*:
  1. Increase in the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey.

Target outcome: **Achieved**

Progress in 2018/19:
Staff survey results for 2018/19 were received during Q4; analysis and feedback of these has been a significant focus during this period. Results are showing signs of significant improvement on key indicators. 46 of the 66 questions have had positive changes year on year from 2017: 73% of staff feel satisfied with the support they receive from their managers, there is an increase of 9% in the number of colleagues who feel respected and valued at work. Results have been fed back to teams, and engagement discussions are underway at team and service levels. A targeted approach is being offered to supporting services who benchmark below the LCH average, together with learning from those which feedback most positively.

Ongoing Progress in 2019/20:
Although we have improved in our staff survey scores from the 2017 survey, there will continue to be a focus on the areas identified as requiring improvement. This includes employee's engagement and staff feeling supported within their role.

Services will be supported to review their individual results and help focus on developing actions plans to improve the areas identified as requiring improvement.

Quality Area for Action: Staff Retention

- To improve retention and reduce trust turnover:
  1. Reduce staff turnover to 14.5% from 14.8%
  2. Delivery against the NHS Improvement retention plan.

Target outcome: **Achieved**

Progress in 2018/19:
In January 2018 the trust was invited to join an NHS Improvement programme aimed at improving retention rates of nursing staff and set out a retention plan to support this. Work has continued throughout the year to introduce a number of initiatives to support retention. The trust is below the trust target of 14.5% and much lower than other community trusts who report over 21%.
NHS Improvement has recently recognised the trusts improvement in retention and has compared progress with other trusts involved in this programme and within the region and sector. The trust has achieved the second highest reduction in turnover amongst its cohort of 19 NHS Trusts.

Ongoing Progress in 2019/20:
Although the Trust currently has a good retention rate and achieved the second highest reduction in turnover, we will continue to progress and monitor our recruitment and retention through 2019/20 to ensure that we have a sustainable workforce to provide high quality services to all.

The Trust will develop and implement an organisational wide workforce plan and will focus recruitment and retention drives in the known 'hard to recruit' roles to help reduce vacancy rates. The Trust will also focus on apprenticeship roles ensuring that they align with workforce needs and future planning.

Although the LCH 2019/20 quality priorities have a different emphasis than the 2018/19, the outstanding priorities not yet achieved in 2018/19, still remain a focus for staff. Maintaining service improvements in these areas and evaluating outcomes are continuing to support and influence care provision across all LCH services to ensure we provide the best possible care to every community in Leeds.

2.2 Statement of Assurance from the Board

The board receives assurance for patient safety, clinical effectiveness and patient experience through the Quality Committee which receives and reviews information from the supporting sub group governance meetings.

The Quality Committee is one of five committees established as sub-committees of the Trust's Board and operates under Board approved terms of reference. The committee provides assurance to the Board that high standards of care are provided by the Trust and in particular, that adequate and appropriate quality governance structures, processes and controls are in place throughout the organisation which promotes quality. These include patient safety and excellence in care, identify, prioritise and manage quality and clinical risk and assurance. This then assures the Board that risks and issues are being managed on a controlled and timely manner. The committee also ensures effective evidence based clinical practice and produces annual quality account priorities which are monitored on a quarterly basis.

The Quality Committee promotes a culture of open and honest reporting of any situation which may threaten the quality of patient care.

LCH also continues to review and update organisational and service priorities on an annual basis to ensure that the Trust can meet the needs of the people and communities we serve. The three business units (Adult, Children's and Specialist) review and produce their individual 'plans on a page' for the coming year as well as the Trust plan. These plans look at the overall vision and direction of the organisation and the development of services.

Celebrating Success

There were many successes achieved within LCH during 2018/19 both big and small as well as the NHS celebrating 70 years. This year's celebration of the NHS at 70 allowed for reflection on how healthcare services have changed and evolved to the success story it is today and also for LCH to reflect on our journey. We have seen services lost through competitive tendering and acquired services over the years. We have progressed as an organisation and have aspirations for the future for both our services but also for our patients and local community.

Each Business Unit (Adults, Children's and Specialist Services) holds annual celebration events to showcase the excellence work of our teams and individuals.

Below is a snapshot of some of our celebrating successes from 2018/19.

Equality and Diversity

In recognition of our continued dedication to workplace diversity, LCH has been ranked 49 in The Inclusive Top 50 UK Employers List – a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within an organisation.

Announced in November the Inclusive Top 50 UK Employers is a list of companies identified as the most inclusive across the nation. There were more than 1,000 entries for the awards.

The Inclusive Top 50 UK Employers List 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. Demonstrating the promotion of all strands of diversity including age, disability, gender, LGBT, race, faith & religion; the list focuses on representation at management, senior, executive and board level.

Infant Mental Health Service

The Infant Mental Health Service have had a paper published in the journal 'Child and Family Clinical Psychology Review' about service user participation and how they involved parents in filming the 'understanding your baby' series. The 12 films are included on the Best Beginnings website and the national Baby Buddy app.

Babies, Brains and Bonding' wins national award!

The Infant Mental Health Service training programme 'Infant Mental Health: Babies, Brains and

Bonding' achieving first place for the 'Contribution to Health Visiting Education' award from the Journal of Health Visiting. The team beat off three other teams and received their award last week. The training, which has been delivered to more than 2300 practitioners in Leeds, is an integral part of the Infant Mental Health Service offer. Rebecca Fellows, Assistant Psychologist said: "Receiving this national recognition is a fantastic achievement! Health visitors play such a vital role in the infant mental health agenda across the city and to work so closely in training the health visitors has always been a priority for the service.

New Research Award

One of the Community Dietitian's won the British Dietetics Association's Research Symposium 1st prize for New Research. This was awarded for research on Iodine screening for women of childbearing age.

Dietetics' double award win!

A digital innovation from our Nutrition and Dietetics Service has had a brilliant double win at the 2018 Building Better Healthcare Awards in London.

Supported by the LCH Service Improvement Team and in collaboration with healthcare IT specialists AireLogic Ltd, the team 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.

The e-form was named winner of both the ***Best Healthcare Software – Patient Centred*** and ***Patients Choice*** awards at a ceremony held in October 2018.

Children's Services rated 'Outstanding' by Ofsted

Leeds Community Healthcare is delighted to be sharing with Leeds City Council in the fantastic news that children's services for Leeds have been rated by Ofsted as 'Outstanding'. The judgement is made all the more special as Leeds is the first major city to achieve this standard.

This highlights the outstanding work that our health visitors, school nurses and safeguarding teams carry out on a day to day basis which can often come at times of increased pressures. Children's Services across Leeds have been on a continuing journey of improvement since 2010 and all health and social colleagues involved in the inspection are being congratulated for the huge and positive difference they are making to the lives of children and families in Leeds.

Leeds has now been recognised at the highest level – and partners across the city will continue to forge ahead during 2019 towards a shared ambition to make Leeds the best city for children to grow up in.

IMPROVING HEALTH OUTCOMES

Safety Huddles

Safety huddles have been introduced within services across LCH to share information about potential or existing safety problems facing patients or staff. Safety huddles are a brief multidisciplinary meeting which is aimed to give an opportunity for all staff to understand what is happening with patients in their care and address any immediate or future care needs or risks. The huddles are aimed at increasing safety awareness among staff, allowing teams to develop action plans to address identified or potential risk for both patients and staff, and to raise a culture of safety. The Safety huddles compliment the quality boards already in use across services.

Self-Management Team

The Neighbourhood Team (NT) Self-Management Pilot was initially funded October 2017 - March 2018 as one of a series of winter initiatives to support NT capacity and outcomes.

Recruitment took place for a Self-Management Lead and four Self-Management Facilitators clinical role initially on a 6 month secondment.

The pilot initially focussed on working with the Armley and Chapeltown NT clinicians to identify a cohort of patients in order to test out the following assumption - that a proportion of patients using a different model of clinical care have the potential to self-manage.

The initial criteria for selection included patients requiring Insulin and Low Molecular Weight Heparin (LMWH) administration, stoma care, simple wound care and catheter care.

A programme of intervention has been delivered to facilitate and empower patients to manage their own health care needs based on the principles of health coaching and better conversations.

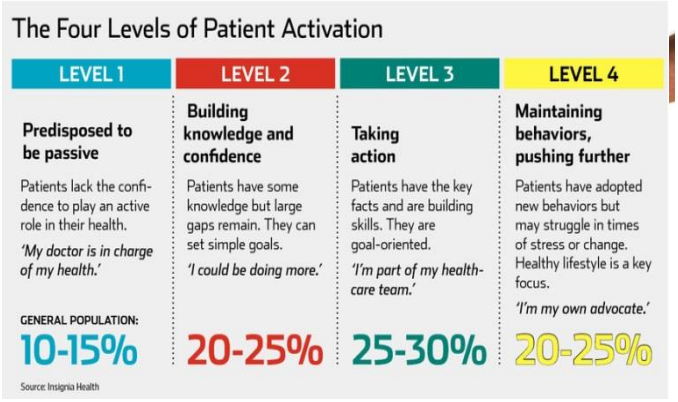
The Initial findings found that the greatest impact on capacity has been seen with patients self-managing Insulin and catheter bag changes. For example, one patient had been seen 14 times per week (3 hours 15 minutes) in order to have his Insulin administered. Post Self-Management Facilitator working with him, he is now administering his own Insulin and visits have reduced to just once weekly (15 minutes) to ensure his confidence remains high and to prevent future relapses working towards discharge to his GP's care.

There is evidence that following working with a Self- Management facilitator patients experience improved health literacy and knowledge in concerns to when their health is deteriorating. This allows them to be proactive in managing their long term conditions impacting on use of health resources i.e.

PAMs as an outcome measure – How we measure improvement

Patient Activation Measure (PAM) is a validated tool to support self-management.
It assesses the underlying knowledge, skills and confidence to enable an individual to manage their own health

The analysis of initial PAMs shows that all patients referred for Self-Management Facilitator input were at either at level 1 or 2 of activation. They therefore lacked the skills, knowledge and confidence to actively manage their long term conditions.



83% of patients following Self-Management Facilitator intervention have increased levels of activation and 62% have moved to activation level 3 or 4.

In order to maintain behavioural change the aim is for Neighbourhood Team patients would ideally to be enabled to move to activation level 3 or 4.

Although initial referral are for simple non-complex care the impact of patients' self-managing has been far wider than just the care delivered for example returning to employment as outlined in case studies. The rate of referrals was equivalent across the 2 Neighbourhood Teams giving early indication of a transferable model.

Of the patients seen by the Self-Management facilitator over 85% are self-managing elements of their care following intervention.

<u>Recommendations regarding the next steps for implementation include:</u>

There is a plan for further roll out across the Neighbourhood Teams. There has already been interest from Neighbourhood Teams after sharing of the results from the pilot highlighting an appetite to expand the project. This needs to be a consistent approach throughout all teams to ensure that the self-management function can be embedded.

Always Events

Always Events® is a national NHS initiative which is defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system. Always Events® is a co-production quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families and carers and then co-design changes to improve experience of care. Genuine partnerships between patients, service users, care providers, and clinicians are the foundation for co-designing and implementing reliable solutions that transform care experiences with the goal being an "Always Experience." The creation of an Always Events® is a practical methodology for achieving this goal by asking patients and people who use services "**What matters to you**?" in addition to "**What's the matter**?".

One of the main examples of an Always Event is the 'Hello my name is' campaign which is being rolled out across LCH in 2019.

There has been two initial quality improvement projects identified for a co –production approach including the Always Event methodology:

1. The co-ordination of care for children with complex needs, planned engagement with children and their parents and carers to ensure that the service review is developed collaboratively with them

2. The Continence, Urology and Colorectal Service (CUCS) review to ensure that the service is meeting the needs of the patients and carers. In September 2018, 259 patients and their carers attended the annual awareness day within the CUCS. Feedback from this event will help focus on some key areas which should be Always Events.

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

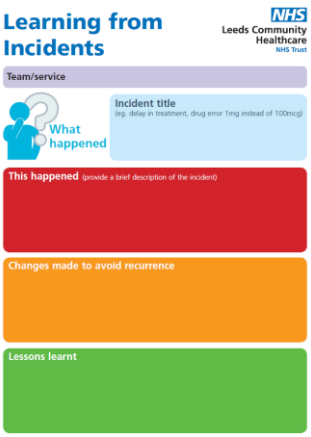
The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. Such emergencies may include death or cardiac arrest, but are not limited to those events. The process is intended to respect both patient preferences and clinical judgement. The agreed realistic clinical recommendations that are recorded include a recommendation on whether or not cardiopulmonary resuscitation (CPR) should be attempted if the person's heart and breathing stop.

ReSPECT may be used across a range of health and care settings, including the person's own home, an ambulance, a care home, a hospice or a hospital. Professionals such as ambulance crews, out-of-hours doctors, care home staff and hospital staff will be better able to make immediate decisions about a person's emergency care and treatment if they have prompt access to agreed clinical recommendations on a ReSPECT form.

Training will be disseminated across LCH within key services such as the Adult Neighbourhood teams and Children's Community Nursing Team. Evaluation of the training and how the new documentation is being used will be completed within 2019/20 across LCH.

Lessons Learnt

Learning From Incidents



Things can and do go wrong and mistakes are made. What is important that through comprehensive review, investigation and analysis that we can identify why the mistake happened, what the contributory factors were and what we can do to try to mitigate from the incident happening again. Through reviewing of trends and repeat reoccurrence of events we can help improve safety across the organisation, building a strong culture of 'Just Culture' for our staff and fair, open, transparent and inclusive investigation process for our patients.

We have reviewed our incident reporting processes in 2018/19 to build on the learning tools available within the organisation and to increase our organisational memory for sustainable learning improvements.

Anonymised learning from individual incidents across LCH is now shared and accessible to all on the Trust Intranet and disseminated to teams across LCH for wider discussion. Learning and actions are discussed with the Patient Safety and Effectiveness Group to identify area of concern or where targeted actions need to be addressed for teams or as an organisation. Workshops will take place within 2019/20 open to all staff to drop in for open discussion and learning across the organisation.

The new learning from lessons resource has been developed for the purpose of sharing learning and will allow us to improve patient and staff safety through the sharing of what went wrong and identifying what the learning is for all across the Trust.

Examples of Shared Learning

There has been a number of incidents where anticipatory palliative care medicines has been prescribed by both primary and secondary care which have not been in line with local prescribing guidelines. This has not then being checked at prescribing which has led to missed or unsuitable dosages being given.

Key messages given to staff include:

- When first transcribing palliative medicines onto the Medication Administration Record (MAR) Chart to be aware of local prescribing guidance.
- To be aware/familiarise yourself of the LCH document "Symptom Management Guidance in the Last Days of Life"
- Be particularly vigilant of use of Opioids - Morphine , Diamorphine and especially Oxycodone
- Make sure midazolam is prescribed as 5mg/ml (or equivalent 10mg/2ml) and not 5mg/5ml.

A National Patient Safety Alert was received which identified that pulse oximeters intended to be placed on fingers were being used on other body extremities including ears to test oxygen saturation. This resulted in inaccurate pulse readings. The alert message reiterating the proper use of pulse oximeters was disseminated through multiple message outlets across the organisation including through managers, team meetings, lesson learnt bulletin, staff notice boards and organisation electronic notices.

Learning from Excellence

Fabu-Leeds is a new learning concept which has been developed for teams and individuals to share good and outstanding practices for other teams and individuals to learn from. This concept is also about celebrating excellence within teams and building a culture of continual learning.

We are using the CQC fundamental standards as a framework to help showcase outstanding practices, providing a supportive network of learning and showcasing excellence.

Example of the poster produced to highlight some learning from excellence across the three Business Units

Examples of Everyday Care from Across LCH

<u>Adult Business Unit</u>

Support provided by one of the Neighbourhood Team to enable an elderly lady to remain in her own home.

Mrs A was referred initially to one of the Neighbourhood Team (NT) for care of category 2 pressure areas on both heels. Mrs A is known to suffer with Alzheimer's disease with significant impact on her daily life and poor communication with little speech. Mrs A lacks mental capacity regarding moving and handling, safety and is at risk of falling. Her husband reported long periods of immobility from a time spent in hospital. Her husband was keen to keep his wife at home in familiar surroundings.

Therapy assessment of Mrs A's mobility following a period of domiciliary rehabilitation resulted in Mrs A being able to mobilise safely with a wheeled Zimmer Frame. This enabled Mrs A to maintain her mobility and muscle strength for longer supported independent living. Mrs A demonstrated her ability to learn how to use a new walking aid and learnt to improve her centre of balance which reduced the risk of falling.

Integrated and proactive patient centred care working between the NT nurses and therapists with the family and patient The NT supported Mrs A and her husband's wish for her to remain safely at home.

The NT always ensures that they:

- Make every contact count (MECC)
- Provide Person Centred Care and ensure a Shared Decision making approach it taken whenever possible
- Consider Best Interest Decision (BIA)
- Instigate Better Conversations / Health Coaching approach
- Advocate #Homefirst

Specialist Business Unit

Pathway Redesign of the Foot Protection Service

In January 2017 a city wide group of health care professionals submitted a bid, with the support of Leeds CCG, to NHS England for monies to improve the quality of foot care for patients with diabetes in the city. In April 2017, the city was told we were successful in gaining two years funding.

A community based Foot Protection Service (FPS) was developed to provide an integrated diabetes foot pathway in the city in order to reduce the number of diabetic amputations. A new pathway was developed, agreed, communicated and delivered.

The focus was to educate patients and train health care professionals to make sure that everyone is aware of the risks of foot ulcers and even amputation to the legs and feet with having diabetes especially if it is not well controlled. The aim is to make sure that all patients understand their own risks and what they can do to help themselves. In addition, healthcare professionals to screen for early signs of complications and to give appropriate advice to the patient and make any necessary onward referrals.

Example of a Successful Outcome for a patient

72 year old patient with type 2 diabetes, hypertension and angina with generally poorly controlled diabetes since the initial diagnosis in 2014. The patient was taking two medications to try to control the diabetes.

For this patient, education was identified as the key factor for the patient to be able to lower the future risk of amputation and other complications such as stroke or heart attack.

During the assessment the podiatrist and patient agreed on three main individual goals and discussed how they would be achieved which included:

1. To understand ways of better controlling the diabetes. Patient booked an appointment to see the Specialist Diabetic Nurse
2. Patient to check their feet daily for any wounds or signs of infection, wear appropriate supportive footwear, checking it before they put them on for any foreign objects that could damage the feet.
3. Patient would apply an emollient to both feet daily, at the same time as checking her feet. Patient was given a ‘Feet In Diabetes’ leaflet.

The patient’s feedback at the 3 month review appointment ; ‘I have attended the Leeds programme and made some really good changes, my bloods have got so much better that the diabetes consultant has discharged me and they said that I no longer have to go onto the insulin which had been the plan. My feet look much better, I put the cream on and check them every day I have no concerns with them at all. I feel like I have changed my life’

Community Neurology

Community Neurology Rehabilitation Service comprises of a number of services including inpatient and outpatient rehabilitation, community based neurological, stroke rehabilitation and Parkinson’s Rehabilitation.

A review of hospital discharges in Leeds for patients who have had a stroke or traumatic brain injury highlighted the need for pathway development to improve the patient experience and accessibility to services for all patients – 'All patients should receive the right therapy in the right setting at the right time for their rehabilitation journey'.

Stroke

Achievements and developments in the Stroke Pathway include:

- Relaxation of stroke team criteria which includes the key changes of:
  - removal of the timeframe of a 6 week cut off following a stroke
  - rehabilitation provided for a period of 12 weeks rather than the previous limitation of 6 weeks
  - service now accepting patients requiring assistance of 2 to transfer or mobilise
- Following extra funding allocated for this year, the number of staff within the Community Stroke Team was increased. New roles were created including a nursing role, clinical psychologist and extra therapy assistants. This enabled the team to provide further rehabilitation appointments and widen the scope of the multi-disciplinary team.
- Relationships between community, hospital colleagues and the Stroke Association improved with better communication, increased trust and regular sharing of learning across the pathway to improve the patient experience.
- New initiatives have been identified to support integrated working and the development of knowledge and skills of the stroke pathway workforce. This has included secondment opportunities and development of cross organisation rotations.
- New ways of working have been developed to improve capacity and efficiencies within the community team
- All of the above has contributed to a shared vision and aim which is to improve patient experience and flow out of hospital and reducing length of hospital stay.

Children's Business Unit

Working Together - Successes

Connecting with Dads Conference - Understanding the nature and effect of fathers' involvement on the health and well-being of children can help to inform best practice within perinatal and infant mental health services, with the shared aim of improving family psychological and health outcomes. This is the premise upon which the Infant Mental Health service decided to organise a local conference: 'Connecting with Dads: The Importance of Fathers in the Lives of Their Babies' organised by practitioners for practitioners to share best practice on how professionals can engage fathers more and think about some of the barriers and how these could be overcome. The conference included a range of presentations from services in Leeds working across the perinatal period. This included speakers from the Community Midwifery Service, the Perinatal Mental Health Service, the Infant Mental Health Service, the Baby Steps Team, Leeds Dads, and Caring Dads as well as fathers sharing their own experiences about what worked well and what could be improved with regards to their involvement. The conference was attended by over 50 practitioners and evaluated positively. The 'Connecting with Dads' conference was successful in bringing practitioners across Leeds together to begin conversations around how we can improve engaging fathers in the whole perinatal experience with the hope of improving health outcomes for the whole family.

Feedback from dad's found that dad's often felt that they were not encouraged to take part in discussions during appointments and felt disconnected with the whole experience both before and after the birth of their child. One dad shared that he felt traumatised by the birth experience of his baby but that he had not been asked how he was managing by any health professional. He also did not feel welcomed at any clinical visits or included in any discussions. Following feedback from dad's, health professionals within services have been able to reflect on their own practices and collectively reviewed how they can better engage with dad's both before and after a child is born.

Children's Speech and Language Therapy Service (CSLT) – Orange Team Pilot Project

The aim of the project was to improve stakeholder experience of booking appointments and to optimise CSLT staff capacity in terms of clinical time for face to face contacts. This was also to ensure that benchmarking targets were being met and waiting lists continue to be effectively managed.

The Orange Team, which is one of the CSLT mainstream teams, worked with administrative team colleagues to pilot a central booking system for mainstream school appointments in a specific part of Leeds. A central booking system was already in place for clinic appointments and this was extended to school appointments. The waiting lists for school assessments and interventions in Orange team exceeded 18 weeks at the start of the pilot.

The impact of the pilot on children, young people, the team and the organisation has been to increase available clinical time for CSLT staff, benchmarking targets set by service leadership have been met. The waiting lists have met the 12 week target.

The pilot was completed and continued as standard service delivery in Orange team. From January 2019 it was rolled out in another part of the city, with a plan to extend across the whole city by the end of 2019.

Jen's Story

Jen was referred to the Integrated Children's Additional Needs (ICAN) Service as he was struggling to sleep on a night and was constantly up and down which affected the whole family. The service worked with the family to support Jen to get a better sleep routine and understand why this is important. Jen's mother was off work for some time with stress related to Jen's situation. Following involvement from the ICAN Paediatric Neurodisability (PND) service, Jen has managed to turn his whole routine around and understand the importance of good sleep and the different cycles of sleep he goes through. He now plays rugby for the elite team at school, his concentration at school has improved and he's even managed a school trip to France which was a big deal for the family. Jen's Mother is now back at work too!

Children and Adolescent Mental Health Service (CAHMS) – Transition Team

Transition's is a joint pathway with joint responsibilities between children and adult services. Adult services include statutory and 3rd sector services. Transitions is a process whereby young people are supported in identifying the most appropriate adult service for their need and

are prepared for the differences between the adult and children's services. The differences can include the nature of the involvement of family and the need for independence. A transfer of care takes place on or before the young person's 18th birthday, however transitional support may continue for 3 months post this date.

LCH has worked with our adult service partners on the joint pathway between CAMHS and adult specialist which has recently been reviewed as part of a focused pieced of work to improve the pathway between children and adult services.

Additional Gaps in service provision were identified in young persons' transitions across Leeds, which included the need for a learning disability transitions worker. This post has recently being successfully recruited into which will support the team. It was also identified that there was a requirement to review our internal referral process within LCH to ensure there was a smooth pathway into the Transition Team when a young person has been identified as meeting the criteria for transition.

There were also other identified possible changes which would support young people requiring the support from adult services which included changes to the adult eating disorders acceptance criteria, the possibility of adult NHS services lowering the thresholds to accept young people in crisis and the need for better established pathways with 3rd sector colleagues. These are to be addressed in the recent NHS Innovations Learning Collaborative that LCH is taking part in which will focus on Leeds Transitions for young people.

HENRY Programme

HENRY is a national initiative which was set up to provide a wide range of support for families in the early years of a child's development. The approach is designed to support behavioral change which helps parents gain the confidence, knowledge and skills they need to help the whole family adopt a healthier, happier lifestyle and to give their children a great start in life.

LCH in collaboration with Leeds City Council to form a 'Healthy Families Grow Up Group' to provide support to families with children of primary school age. The group is a 10 week programme which includes a support group where parents can share ideas and suggestions on maintaining a healthy family. Sessions include:

- How to build healthy routines into family life… and how to maintain them
- Ideas for family activities, healthy meals and snacks
- Coping with everyday challenges of leading a healthy family lifestyle
- Understanding children's behaviour as they grow and develop
- Peer pressure, outside influences on body image and emotional connections with food.

A parent's comment after completing the HENRY Programme "*I really learned a lot. I loved sharing with others and hearing their stories. It helped me realise I'm not the only one – it's not just me. As a family we play more games together. The children are more involved in preparing meals and we eat meals together at the table. Everybody is more aware of healthy eating and being more active".*

Statements on Quality as mandated in the Regulations

This section of the Quality Account contains all the statements that we are required to make. These statements enable our services to be compared directly with other organisations and services submitting a quality account.

Review of Services

During 2018/19 the Trust provided and/or sub-contracted 65 NHS services with £144.2m of income. The Trust has reviewed all of the data available to it on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by the Trust for the year.

In addition, the Trust also provided £1.1m of non-NHS services and the data in respect of 100% of these services was reviewed in year.

Clinical Audit

A central database of all planned annual clinical audits is held by the Clinical Audit and Effectiveness Team who monitor the progress of the annual programme. The monitoring of the audit results, summary report and improvement/action plans are reviewed within the Clinical Effectiveness Group.

All clinical audits that are planned to be undertaken within LCH **must** be registered on the clinical audit and effectiveness registration database.

National Clinical Audits

During 2018/19 **Five (5)** national clinical audits and one (1) national confidential enquiry covered the NHS services that LCH provides. During that period LCH participated in **80%** of national clinical audits and **100%** of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that LCH was eligible to participate in during 2018/19 are as follows:

Eligible National Clinical Audits
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme Sentinel Stroke National Audit Programme National Audit of Intermediate Care Learning Disability Mortality Review Programme (LeDeR) National Diabetes Audit – Diabetic Foot Care Audit
Eligible National Confidential Enquiries
Long Term Ventilation Study

The national clinical audits and national confidential enquiries that LCH participated in during 2018/19 are as follows:

National Clinical Audits participated in
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme – 2 year data collection National Audit of Intermediate Care Learning Disability Mortality Review Programme (LeDeR) – commenced March 2019 National Diabetes Audit – Diabetic Foot Care Audit – Commenced March 2019
National Confidential Enquiries participated in
Long Term Ventilation Study

The national clinical audits and national confidential enquiries that LCH participated in, and for which data collection was completed during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit	Number of cases submitted	Percentage
Chronic Obstructive Pulmonary Disease (clinical audit of pulmonary rehabilitation services)	Organisational audit – data just requested. Will be reported on during the next financial year Clinical Audit: data collection will commence during 2019	100% of all cases identified
Sentinel Stroke National Audit programme	March 2019 – no data has been submitted nationally due to a partner Trust not registering the patients for the past 12 months. Therefore Leeds Community NHS Trust has been unable to upload data. The Trust has continued with collecting data for the past 12 months, but it has not been processed or entered on the national database. Discussions have taken place with the Sentinel Stroke National Audit Programme team to request how the Trust can participate in the audit which is not possible without the acute trust.	100% of all cases identified Zero data submitted
National Audit of Intermediate Care	Organisational audit not fully submitted, however: <u>Home Base</u> 58 Service Users Questionnaires Submitted 20 PREM Questionnaire's (this is returned directly by the service user) <u>In-patient service Bed Based</u> 33 Service Users Questionnaires Submitted 16 PREM Questionnaire's (this is returned directly by the service user)	100% of all cases identified

Learning Disability Mortality Review Programme (LeDeR)	Audit commenced in March 2019 – cases will be identified within 2019/20 audit period for submission	Cases for inclusion yet to be identified
National Diabetes Audit – Diabetic Foot Care	Audit commenced in March 2019 – cases will be identified within 2019/20 audit period	Cases for inclusion yet to be identified

The reports of 6 national clinical audit(s) were reviewed by the provider in 2018-19 and LCH intends to take the following actions to improve the quality of healthcare provided:

National Audit	LCH action following review in 2018/19
Sentinel Stroke National Audit programme	This audit requires information to be inputted into the national database which LCH and partner organisation has not currently submitted any data. The results are yet to be published online for 2017-18 data submission period. Stroke is now being addressed with a city wide approach. The intention is to develop and implement a system wide action plan
Chronic Obstructive Pulmonary Disease (clinical audit of pulmonary rehabilitation services)	National report published which identifies recommendations to improve the care for patients undergoing pulmonary rehabilitation due to chronic obstructive disease (lung disease). Individual local report has been published and recommendations are currently being reviewed to identify an action plan.
Chronic Neurodisability Study – cerebral palsy	National report published which identifies recommendations to improve the care provided to patients aged 0-25 years with Chronic Neurodisability condition with cerebral palsies. Recommendations have been reviewed by the service to ensure that an action plan is produced and that the recommendations are embedded.
UK Parkinson's Audit	Individual Service Level report published April 2019. Recommendations currently being reviewed prior to Improvement plan being developed
National Audit of Intermediate Care	National report and Organisation level Report published which is currently under review. An appropriate action plan will be produced following the review.
Falls and Fragility Fractures Audit programme (FFFAP) -	National report published which identifies recommendations following the 2017-18 audit

	Local Results and recommendations identified within the report and improvement plan ongoing

Local Clinical Audit

The reports of **106** local clinical audits were completed by LCH in 2018-19 and LCH intends to take the following actions to improve the quality of healthcare provided:

- The Community Gynaecology Service completed an audit which looked at the assessment and management of women who have heavy menstrual bleeding against the National Institute for Health and Care Excellence (NICE) NG 88. The findings from the audit have ensured further discussions with other clinicians have occurred on the audit. The audit shows that all women attending the clinic received a comprehensive history recorded (100%) but improvements have been made to the template to allow for an option to record further management needs. Through the audit being undertaken, women now have their Body Mass Index recording according to treatment needs and not automatically when using the service but that the number of full blood count (blood test) taken should be increased.

- The Child and Adolescent Mental Health Service looked at how the access assessment form 1 had been completed and measured compliance against NHS England guidance and weather it had been produced in accordance with the Data Protection Act 1998. The audit showed that for many of the standards the service had achieved 100% compliance but that we could do even better for a few others. Due to this, the service has amended the form used to make it easier to use and will undertake another audit next year.

- An audit completed by the medicine management team looked at how controlled drugs are managed within a children's inpatient area. The audit has been developed using standards from the Controlled Drugs Regulations (2013) and NICE Guidance (NG46) for Safe Management of Controlled Drugs (2016). The audit shows that record keeping is in line with best practice and has been shared with staff but that unwanted or out of date drugs need to be disposed of as soon as possible.

- Wetherby Young Offender Institute participated in an audit which looked at improving antimicrobial stewardship due to the risk of becoming resistant to antibiotics. The audit used two key documents which were from the Department of Health and NICE guidance (NG15). The audit demonstrated how LCH demonstrate that we have a high standard of practice when medicines are given. The audit shows that the correct product had been used (99.1%) and showed an improvement compared to the previous audit. This has been shared with different teams within LCH, pharmacists and General Practitioners.

- The Integrated Children with Additional Needs (ICAN) Service completed an audit which looked at the use of the Canadian Occupational Performance Measure (COPM) in the pathway for children and young people aged over 5 years with mild/moderate motor impairment. The audit had four standards and showed that further learning on the pathway process was required including whether the COPM had been repeated at follow up appointments.

- The Child and Adolescent Mental Health Service looked at how information is recorded in the case notes for young people who are fed through a nasogastric tube as part of their treatment. The audit measured against different standards which included Guideline for Nasogastric Tube Management (NHS Improvement 2016), Nasogastric Tube Misplacement, Continuing Risk of Death and Severe Harm (NHS Improvement 2016). The standards set initial placement checks for nasogastric and orogastric tubes. Changes to the documents used by staff when inserting the tube, feeding care plan and feeding log have been introduced following the audit which will improve the care for young people.

- An audit has been completed which looked at how care leaver's health summaries were being offered to care leavers aged 18+ in Leeds. The audit had been identified following a visit by the Care Quality Commission and based on the Department of health document 'Promoting the health and Well-being of Looked After Children 2015. The service has now amended the template which records the information that is given to the care leavers.

During 2018/19 all services were required to participate in the annual documentation audit and produce an improvement plan to identify required improvements. Our Neighbourhood Teams within the Adult Business Unit included collection of data relating to end of life care, pressure ulcer management and falls in keeping with some of the priorities for improving patient care in the organisation.

Additionally, the Infection Prevention and Control Team undertake a range of local audits. These include; Environmental audits, PLACE audits and Essential Steps to Safe, Clean Care audits. These audits aim to reduce the risk of microbial contamination in everyday practice and to ensure our environment is managed in a way that minimises the risk of infections to patients, staff and visitors.

This table does not include audits that will be continued into 2019/20:

Local Clinical Audits completed during 2018/19 - by Business Unit	
Adult Services	
• Documentation Audit • Quality Challenge+ • Environment Audit • PLACE Audit • Holistic Assessment (all Neighbourhood Teams) • Patient satisfaction – pelvic floor dysfunction clinics	• Chronic Wound Care Assessment Audit • Health and Safety Audits • End of Life • Pressure Ulcer • Falls Audit
Children's Services	
• Documentation Audit (all services) • Quality Challenge+ • Compliance with NICE guideline for Depression for Children and Young People • Compliance with NICE guideline for Eating Disorder for Children and Young People • Re-audit Providing Assurance of Medicine	• Re-audit of Medication Review Appointments in patients on Methylphenidate • In-Patient CAMHS Length of stay and Treatment Audit • UNICEF BFI Breastfeeding Staff and Mothers Audit Gold Award

Storage
- Audit of Information Documented in Case Notes for Young People who are/have Nasogastric Feed
- Environment Audit
- PLACE Audit
- Occupational Therapy Caseload and Goal Management
- Obesity in Children
- Care Leavers Health Summaries
- Controlled Drugs Audit
- Hand Hygiene Audit
- School Screening Calibration Recording Audit
- Clinical calibration recording Audit
- Mattress Audit
- Scanning of Audiology Results
- Children community Nursing Oximeter Clinic Audit
- Audit of New Daytime Wetting Service
- Care Leavers Health Summaries
- Audit of Recurrent Respiratory Infections in Children with Downs Syndrome
- Use of the COPM in the over 5s MMP

Specialist Services

- Documentation Audit (all services)
- Heavy Menstrual Bleeding
- Making Best Use of Clinical Radiology Services Prior To Referrals Into The Community Podiatry
- Controlled Drug Audit – CNRC
- Missed and Delayed Dose Audit (Wetherby YOI)
- Missed and Delayed Dose Audit (CNRC)
- Essential Steps
- Mattress Audit
- Environment Audit
- PLACE Audit
- Informed Consent for HIS 2nd Cycle
- Hand Hygiene Audits
- Hoist Sling Audit
- Sharps Audit
- PGIC Compliance Audit
- CQUIN2 – Alcohol and Tobacco Use
- Treatment Plan In Relation To Risk and Clinical Need and Rationale for Care
- Quality Challenge+
- Prescribing Standards - CNRC
- Re-audit Transport Use Audit (Service and other Services in the BU)
- Emergency Contraception Provision UK National Audit
- Supervision Audit
- Allocation of an Up-To-Date Risk Code in the Last 18 Months
- Supervision Audit
- Use of Environmental Template on EPR-Lone Worker Risk Filter Function
- Re-audit Antimicrobial Stewardship WYOI

Clinical Research

The number of patients and staff receiving NHS services provided or sub contracted by LCH in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 776.

LCH continued to be very active in recruiting participants from across the Trust to the Yorkshire Health Study until it closed to recruitment in Sept 2018.

The use of the Trust's staff bank (CLASS) to facilitate Occupational Therapist capacity to deliver the "OTIS" falls prevention trial proved very successful with 128 Leeds residents randomised onto the study. Importantly this approach also facilitated the development of expertise amongst staff who hadn't previously been involved in clinical research delivery.

A further study commenced recruitment in 2018 supported through the use of CLASS employed staff. The Achilles Tendinopathy Management study (ATM) compares the treatment of Achilles tendinopathy with platelet rich plasma injections with a placebo.

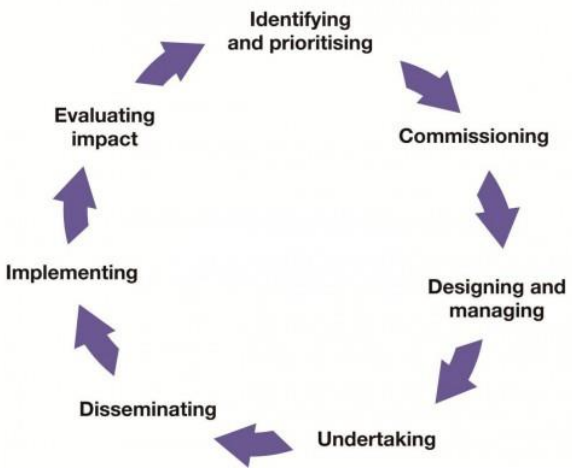
The Trust continues to host strong research collaborations in a number of services, in particular in musculoskeletal (including podiatry) and with regards to palliative care through strong links to St Gemma's Hospice.

Working alongside the University of Leeds and researchers based at St Gemma's Unit of Academic Palliative care, the Trust's research nurses has been involved in a number of different studies including "STIOC"(An observational study of diagnostic criteria, clinical features and management of opioid-induced constipation in patients with cancer pain), **"**MePFAC" (Methylphenidate versus placebo for fatigue in advanced cancer), "STEP" (Supporting Timely Engagement with Palliative Care) and "LCPA" (The Leeds Cancer Pain Assessment).

The development of research about Child and Adolescent Mental Health, hosted within Wetherby YOI and Adel Beck secure children's home specialist has continued to develop over the past year with recruitment to two significant studies planned to start imminently. These are "Using QbTest to aid the identification of Attention Deficit Hyperactivity Disorder (ADHD) in young people in the criminal justice secure estate" and the "Secure Stairs" evaluation study (Secure Stairs is the **Framework for Integrated Care for the Children and Young People in the Secure Estate).**

The research Strategy for 2019-2022 is currently been reviewed and will be developed with a stronger emphasis that LCH will become a centre of research excellence where:

- Staff are enthused about research activity and perceive it to be part of their "day job"
- Leaders understand how and why research is core NHS business
- World class research is practiced in all of the communities that it serves, which is translated



NIHR Cycle of Research

into improvements in care and clinical outcomes
- Partners in the statutory, academic, industry and voluntary sectors seek research collaboration with us as an organisation of first choice.

It is the ambition of LCH to provide opportunities to participate in world class research to its patients and their families, the findings of which are translated into improvements in care and clinical outcomes.

The Leeds Community Healthcare (LCH) Research department facilitates and manages LCH participation in projects that range from nationally funded multicentre research, to student research and local service evaluations.

Commissioning for Quality and Innovation (CQUIN)

A proportion of LCH income in 2018/19 is based on achieving quality improvement and innovation goals agreed between LCH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Commissioner	CQUIN	Description	Actual (YTD)
LEEDS CCG 1a	Improvement of staff health and wellbeing	This CQUIN requires organisations to achieve a 5 percentage point improvement in 2 of the 3 NHS annual staff survey questions on health and wellbeing, MSK and stress.	**Partial achieved 75%** (Staff survey data in)
LEEDS CCG 1c	Improving the uptake of flu vaccinations for front line staff within Providers	This CQUIN sets a target for 18/19 of 75% of staff having received the flu vaccination.	**Achieved** (Flu data in)
LEEDS CCG 2a	Provider Network	This indicator incentivises providers to contribute to the development of a formal partnership agreement or network structure across all bed bases within the Community Care Beds Service.	**The working assumption is that LCH are actively engaged in the Provider network. Anticipated to be achieved.**
LEEDS CCG 3a,b,c	Tobacco screening, brief advice, referral and medication offer	These 3 CQUINs apply to adults (18 plus) admitted to inpatient units for longer than a day. It requires monthly data submission to confirm the number of patients: • Screened for smoking (a) • Given brief advice and (b) • Referred on (c)	**Achieved**
LEEDS CCG 3d,e	Alcohol screening and brief advice or referral	These 2 CQUINs apply to adults (18 plus) admitted to inpatient units for longer than a day. It requires monthly data submission to confirm the number of patients: •Screened for drinking risk levels	**Achieved**

		(d) •Given brief advice or referred (e)	
LEEDS CCG 4	Improving the Assessment of Wounds	The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.	**Achieved.**
LEEDS CCG 5	Personalised Care and Support Planning	The aim of this CQUIN is the delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence of patients managing their long-term conditions.	**Achieved**
LEEDS CCG 6	STP & Control Total Risk Reserve	Leeds Community Healthcare NHS Trust are required to contribute to STP/ ICS transformation initiatives and demonstrate to the STP / ICS governance arrangements how it is supporting and engaging in the local STP initiatives.	**The Trust has a nominated representative and is actively engaged in the STP plan. Anticipated to be Achieved.**
LEEDS CCG 11	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	This CQUIN aims to improve the experience and outcomes for young people when they transition out of Children and Young People's Mental Health Services (CYPMHS) on the basis of their age.	**Achieved.**
NHS E H&J 8a	Staff Health and Wellbeing	This CQUIN requires an improvement in staff health and wellbeing across the service. 1a Improvement of health and wellbeing of NHS staff, 1b, Healthy Food for NHS staff, visitors and patients, 1c Improving the uptake of Flu Vaccinations for front line staff within providers.	**Achieved**
NHS E H&J 8b	Personalised Discharge and Transition Planning Wetherby YOI and Adel Beck	Early planning for release is crucial, with early confirmation of the resettlement arrangements that will be in place when the young person leaves the institution. This is so interventions are able to start promptly on release and the young person has an opportunity to prepare themselves for where they are likely to be living and what they are likely to be doing.	**Achieved**
NHS E H&J 8c	Escort and Bed watch	The Escort and Bed watch CQUIN aims to look at alternative ways to manage healthcare within the Prison setting and in turn reduce the amount of hospital transfers and bed watches taking place.	**Achieved**
NHSE Public Health	Reduce Health inequalities by	The Provider should be able to demonstrate how they identify and address any health inequalities in the	**Achieved**

9	improving uptake Screening and Immunisation Programmes	S7a Services they deliver; evidencing procedures they have in place to identify and support those persons who are not accessing the service (including those with protected characteristics, mental health conditions and learning disabilities), those considered vulnerable/find services hard to reach and take proportionate and appropriate actions.	
NHSE 10	CAMHS Transitions	This CQUIN will improve transition/transfer/discharge planning, improve patient and carer involvement, and improve experience and outcomes with regard to transition between services.	**Achieved**

Care Quality Commission

LCH is required to register with the Care Quality Commission and its current registration status is full registration without conditions.

The Care Quality Commission has not taken enforcement action against LCH during 2018/19.

In August 2017 the CQC published the final reports on its announced inspection, 31 January – 2 February 2017, and unannounced inspections of Hannah House, Leeds Sexual Health and the Single Point of Urgent Referral. The CQC rated the Trust overall as **'Good'**. Most of the CQC improvement actions were completed in 2017/18, the remaining improvement actions were completed in the first half of 2018.

Hannah House completed all CQC improvement actions in 2017/18 but maintained focus throughout 2018/19 on embedding and sustaining those actions along with a wider programme of quality improvement and staff engagement and development.

The Children and Young People's CAMHS In-Patient service at Little Woodhouse Hall successfully completed the two outstanding must-do actions which related to ensuring staff compliance with statutory mandatory training ensuring timely completion of the outstanding action from the Mental Health Act inspection relating to personal search training. The Personal Search Management policy has been refreshed to reflect best practice and staff have been trained in the new approach.

Leeds Sexual Health service completed the outstanding actions which related to ensuring staff compliance with the appropriate level of safeguarding training and other statutory mandatory training, ensuring clinical supervision standards are consistently achieved, providing effective support for all staff groups and displaying waiting times in clinics.

Community Neuro Rehabilitation Unit completed actions related to providing appropriate dementia training for staff and addressing recommendations of a Legionella Risk Assessment.

Adult services completed actions relating to clarifying in training records the required level of safeguarding training and ensuring dementia awareness is incorporated into mandatory training. Staff compliance is monitored through service and business unit performance management processes.

The requirement to ensure systems for monitoring environmental issues in community clinics are consistent was completed through doing IPC, Health and Safety and fire risk assessments at the same time to enable an overarching understanding of environmental risks and triangulation of assessment information.

Senior Management Team (SMT) and Quality Committee received assurance through reporting regarding progress with implementing and embedding the CQC action plan. The Director of Nursing and Medical Director have quarterly engagement meetings with the CQC to review progress in implementation of the action plan and wider quality performance and management.

To support preparation for the next inspection by CQC, which will include the new CQC Well-Led Review, the Trust instigated a peer Well Led review by Cambridgeshire Community Health Services NHS Trust. Many of the findings of the peer review reflected development requirements already identified and being progressed, however there were a few additional development areas identified which we have incorporated into our plans.

LCH has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

- **Review of Care for People over 65**

The Care Quality Commission (CQC) visited Leeds in October 2018 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 found a number of positive reflections on the work of LCH teams including:

- Leeds has a strong embedded neighbourhood model which is considered a real strength
- The frontline has a positive approach (with particular shout-outs to Single Point of Urgent Referral (SPUR) and the Recovery Hubs)
- There is good Occupational Therapy (OT) 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

LCH intends to take the following action to address the conclusions and requirements reported by the CQC:

A cross partnership Task and Finish Group of senior quality and practice leads established to support the Leeds partnerships through the CQC local system review developed a joint action plan to address the CQC recommendations. The actions were informed by the December 2018 Summit and further by a Health and Wellbeing Board convened meeting in January 2019

in which members of the Partnership Executive Group (PEG), Integrated Executive Group (ICE), Leeds Provider Committees in Common (LPICC) and System Resilience and Assurance Board (SRAB) were represented. This ensured full senior partnership agreement and ownership. Accountability for progress will be via Leeds Health and Wellbeing Board with regular reporting to the Board. LCH is supporting implementation of the action plan: several actions require a system response and implementation by all partners. None of the actions relate solely to LCH.

Actions that require a system response and therefore LCH engagement are:

- strengthening the focus on people's experiences across their journeys / pathways of care
- embedding the culture of 'home first' and moving people away from hospital throughout the system, especially in the hospital setting
- development and implementation of a population health management (PHM) approach to enable identification and tailoring provision to support members of communities who are most at risk.
- ensuring robust evaluation and clear exit plans for pilot schemes to develop and improve provision in the community.
- work to reduce hospital admissions as higher than the England average.
- rolling out patient choice policy as a priority
- development of a workforce strategy for Leeds

Secondary Uses and Hospital Episode Data

LCH submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- that included the patients valid NHS Number was 100% for admitted care and was 99.98% for outpatient care
- that included the patient's valid General Medical Practice Code was 98.1% for admitted care and 99.88% for outpatient care

**The above confirms data available for 1 April 2018 to 28 February 2019; the submission timetable for data does not require data for 2018/19 (to 31 March2019) to be submitted until May 2018.*

Information Governance

LCH Data Security & Protection Toolkit overall score for 2018/19 was 'Standards Met'. The mandatory 32 assertions have been achieved.

The Trust recognises that information is an important asset, supporting both clinical and management needs and is fully committed to ensuring that personal information is protected and used appropriately. The Trust has submitted a self-assessed score that **all data security standards have been met** for the Data Security & Protection Toolkit (DPST), which is the successor to the Information Governance Toolkit.

The Trust's information governance group develops relevant policies and strategies to control data security and other information related risks. As a community trust, sharing information has

been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced the risk of data loss through the use of mobile devices. The Trust has demonstrated its commitment to being an accountable data controller by appointing a Data Protection Officer. The information governance group has revised the information governance policies and procedures to ensure they are robust and compliant with the General Data Protection Regulation and the Data Protection Act 2018 (in force from 25th May 2018).
In recognition of the importance of data security, the Trust has a target of 95% of staff compliance with information governance training. Training compliance is fully monitored, and attendance is enforced where necessary.

Disclosure of personal data related incidents

The General Data Protection Regulations (GDPR) was introduced as part of a new UK Data Protection Act 2018 (DPA), which repealed and replaced the 1998 Act. The new legislation strengthens the rights of data subjects, while increasing the responsibilities of organisations to process personal data in a lawful and transparent manner.

- Incidents calculated as externally reportable ***must*** be reported to the Information Commissioner's Office (ICO), through NHS Digital's Data Security and Protection Toolkit (DSPT)
- The approach to the management of personal data related incidents has been revised and a different reporting and escalation criteria was produced by NHS Digital in September 2018 - Guide to the Notification of Data Security and Protection Incidents.

One incident has been reported to the Information Commissioner's Office (ICO) under the mandatory reporting requirements. The incident related to the disclosure of personal data to an incorrect recipient via the postal service.

A fact-find has been undertaken in the wake of the incident and process improvements have been actioned, where appropriate, to prevent recurrence.

We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken at source. Low level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support Information Governance (IG) training through the national e-learning programme and ensure staff takes part in annual Information Governance training.

The Trust has a highly developed IG function and framework. It maintains effective links with the Trust's clinical teams through directorate and clinician representative delegates at the Information Governance Group meetings. The Trust's Senior Information Risk Owner (SIRO) (Executive Director of Finance and Resources), Caldicott Guardian (Executive Medical Director) and the Data Protection Officer are members of this group. The group is a sub-group of the Audit Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. The group monitors IG breach incidents, maintaining oversight of breaches, as well as triggering appropriate responses to clusters of low-level incidents.

Risks to data security are managed by ensuring that all staff with access to patient-identifiable data have the requisite access permissions and have completed their compulsory information

governance training. All IT equipment is fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

The Trust made a self-assessment against the Data Security & Protection Toolkit (DSPT) of all data security standards have been met as at 31 March 2019.

Payment by Results

LCH was not subject to the Payments by Results clinical coding audit during 2018/19 by the audit commission.

Freedom to Speak Up Guardian

Speaking Up at LCH is a practice not a position. We have many ways for staff to speak up (managers, Ask Thea, Human Resources (HR), Staffside, easy direct access to directors, Anti Bullying and Harassment Officers, the Freedom To Speak Up Guardian). We encourage all staff to speak up about what matters to them, their colleagues and the care we offer. This work seeks to embed speaking up as a practice and culture across our organisation.

We offer a programme of pastoral support to all staff who speak up. This includes regular phone calls, texts, emails and face to face meetings. We offer meetings with the Chief Executive and the directors where required.

We feedback as things unfold to the staff who have shared concerns. Sometimes other issues arise too and we work with the staff member to ensure they have links to the relevant Trust departments on these areas.

We would address any concern about detriment through speaking up by working with the Chief Executive and board members to investigate. We also have a Non-Executive Director (NED) responsible for speaking up.

The Freedom To Speak Up work has continued to build on the foundations we have created as a Trust. We see the Freedom to Speak Up work as a practice not a person. We have many mechanisms for this to happen so that this practice spreads and becomes culture.

We have assurance measures aligned to the Freedom to Speak Up Guardian role. We are reporting quarterly to the National Office as required. The guardian role has worked with staff from across the organisation. Staff from within different occupational groups have approached the Freedom Guardian during the last year including nurses, admin, Healthcare Assistants (HCA's), medical staff, managers and Allied Health Professions (AHP's) such as physiotherapists and occupational therapists.

The Freedom to Speak Up Guardian role is involved with change work in the Trust including the admin review and Public health integrated nursing service work and works with teams facing challenges.

A joint piece of work looking at a guardian role in General Practice in Leeds is taking place in December 2019 to explore the best model for the city with the Clinical Commissioning Group

(CCG), General Practitioner (GP) Confederation, LCH, Royal College of General Practitioners (RCGP)and local practices supported by input from the National FTSU Office.

There was a peer review in January with Locala and LCH to look at each other's work on Freedom To Speak Up. This involved interviews with Chief Executive Officer (CEO), Non-Executive Director (NED), Freedom to Speak Up Guardian, a staff member who has used the service and others from across the organisation.

We are developing learning from the role and feeding this into the strategic programmes and plans of the Trust.

The role is strongly supported by the Chief Executive, Board and across the organisation. Feedback from staff is positive and supports retention, culture change, good culture / leadership and further staff involvement.

Learning from Deaths

All **adult patients** who die whilst receiving care from LCH are reviewed but are not always reported as an incident through the Datix reporting system. All deaths undergo an initial level 1 mortality assessment and where triggered on assessment, a deeper level 2 investigation will be completed. Following a level 2 investigations, a number of cases will receive a further review through the Mortality Surveillance Group to help identify key learning points and explore for any trends. Where identified, deaths which fall within the serious incident category are reviewed following the serious incident progress.

The highest number of deaths reported within LCH is within the Adult Business Unit which can experience fluctuations in the number of fast track patients on caseloads and therefore variations in the number of expected deaths.

Not all deaths of patients who are under the care of Specialist Business Unit require a review. There are a number of services in the SBU which are exceptions to the review process. This decision was taken following the guidance from; National Guidance on Learning from Deaths. A Framework for NHS Trusts and NHS Foundation Trusts on identifying, Reporting, Investigating and Learning from Deaths in Care First edition.

All patients who die whilst under the care of the Specialist Business Unit where a review is required are heard within the Adult Business Unit process.

Review/Investigation	*Qtr1	Qtr2	Qtr3	Qtr4	Total
Level 1 Mortality Review (Adult)	168	234	314	295	1011
Level 2 Mortality Review (Adult)	36 (21%)	39 (17%)	60 (19%)	54 (18%)	189 (19%)
Level 2 proceeding to Mortality Surveillance Group Review	6 (17%)	7 (18%)	9 (15%)	12 (22%)	34 (18%)
Death proceeding to SI	0	0	1	1	2

Good practice and learning gained from the Adult Mortality Reviews:

- A mortality case reviewed at Level 1 (did not trigger a Level 2 investigation) was escalated by the Clinical Pathway Lead as requiring further review and reflection, as a multi-agency case, due to concerns around communication and management of the fast track discharge. This resulted in a meeting between representatives from the Acute Trust Ward's leadership team, the Neighbourhood Team and the Health Case Management Team to reflect upon ways of improving communication and management of highly complex patients in order to achieve preferred place of death (PPD).
- Positive feedback from the mortality case reviews relating to the compassionate and sensitive case management of end of life patients by the Neighbourhood Teams
- A theme related to the prescribing and transcribing of anticipatory medications has been identified. These are predominantly no harm incidents and are investigated and lessons shared locally and across the ABU. Any relating to controlled drugs are also reported and investigated in conjunction with the LCH Medicines Management Team and included within the quarterly report.

Where a death has occurred and a SI investigation has been undertaken, these cases are now reviewed within the ABU Mortality Governance Review meeting (this could be a case review or lessons learnt summary). The group are vigilant to any emerging themes.

Accuracy of ABU reporting continues to improve with completion of the Level 1 and 2 reviews and a more informed understanding of a normal range of data.

A number of learning points were identified within the Specialist Business Unit (SBU) from the review meetings including:

- The importance of maintaining effective and regular communication between all disciplines involved in patient care particularly where care is complex.
- The importance of thorough case management through caseload reviews by the Neighbourhood team.
- The importance of reading patients case notes prior to rescheduling patient visits to identify any changes in the patient's care or condition.

The Quality Lead for the SBU has met with the lead for the respiratory service to review their process for reporting deaths and ensure compliance with the "Mortality Review and Responding to Deaths Policy". There have been a number of conversations between the Quality lead and service lead for clarification on process and to discuss reported deaths to identify if level 1 mortality assessment is required.

In January 2019 the SBU hosted a workshop on Mortality Review and sharing the learning from the past year.

Child Deaths (Expected and Unexpected)

All **children's** deaths (0 -18 years of age) are reviewed by the statutory Leeds Child Death Overview Panel (CDOP) in order to identify whether there is any learning to influence better outcomes for children and young people at both local and national level.

All unexpected deaths are further scrutinised by the Sudden Unexpected Death in Childhood (SUDIC) process, as part of CDOP. LCH is commissioned to lead the SUDIC process on behalf of the Leeds Safeguarding Children Partnership (LSCP). The SUDIC process aims to understand the reasons for the child's death, address the possible needs of other children and family members in the household and also consider any lessons to be learnt to safeguard and promote children's welfare in the future. The decision of whether a child's death meets the SUDIC criteria is made by the Designated Paediatrician for SUDIC and throughout the process the child remains under the jurisdiction of HM Coroner.

Review/Investigation	Qtr1	Qtr2	Qtr3	Qtr4	Total
Expected Death CDOP Review only (Child)	5	0	2	4	11
Unexpected Death SUDIC (Child)	3	5	6	5	19

Good practice and learning gained from the Children's Mortality Reviews:

Learning from the CDOP and SUDIC processes are shared and discussed at the LCH Safeguarding Committee as well as the Children's Mortality Governance Group.

All the expected deaths in 2018/19 have been in a place of the families choosing with support from the Children's Community Nursing Services as identified in their care plan

LCH Level 2 reviews have been completed to share good practice and identify possible improvements

Good practice:

- Support for staff involved via formal supervision and informal support from peers and colleagues from hospice and other services
- Good relationships with children's palliative care team

Areas for improvement:

- Communication to children's services of a child's death, especially if this occurs in hospital. There have been a couple of occasions when this has been delayed which causes the family and staff additional stress. Action taken: Discussions with Children's Hospital to improve communication pathways facilitated by Team Leader, Children's Nursing.

The newly formed Children's Mortality Governance Group meeting commenced in January 2019 chaired by a Consultant Child & Adolescent Psychiatrist. LCH CDOP representatives are part of the group and will be updating on investigation findings and possible outcome alongside SUDIC team.

Reported Incident Deaths (Adult & Child)

During 2018/19, there were 263 reported deaths within LCH through the Datix incident reporting system. This comprises the following number of deaths which occurred in each quarter of that reporting period:

Qtr1	Qtr2	Qtr3	Qtr4	Total
72	57	67	67	**263**

A recent case heard by the coroner highlighted communication failure between the multi agencies involved and with the patient and family. LCH with our partner organisation have identified key learning and actions to help mitigate the risk of this tragic event happening again. LCH has acknowledged that improvements are needed in our communication processes which includes updating our internal processes and working with our partner organisation on pathway redesign. This will ensure that there is a clear pathway and clear areas of responsibilities within the service.

2.3 Reporting Against Core Indicators

All Trusts are required to report performance against a set of core indicators using data made available to them by the Health and Social Care Information Centre. Many of the core indicators are not relevant to community services. Those that are applicable to LCH are shown below.

Prescribed Information

21. The percentage of staff employed by, or under contract to the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The table below shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends*, as reported on the NHS National Staff Survey**. This includes comparison with previous years.

**current definition: "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"*
***definition has changed since Quality Account guidance was issued*

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National Average (Community Trusts)	Highest/Lowest
2013/14	2970	60%	67%	76%-60%
2014/15	2960	64%	70%	83%-62%
2015/16	2672	69%	73%	82%-67%
2016/17	2790	65%	73%	86%-65%
2017/18	2781	70%	73%	83% - 65%
2018/19	2833	75%	53%	83% - 37%

LCH considers that this data is as described for the reasons: Gaining staff opinion on LCH as an organisation and how we work together is very important to LCH. Levels of engagement at LCH have increased. For the key engagement indication of 'staff recommendation of LCH as a place to work', LCH achieved a +9.4% year-on-year difference scoring 63.6% (4.2% above national average).
The Trust has seen a statistically significant improvement (meaning that there has definitely

been an improvement in those areas since 2017) in four of the key Nationally-reported themes:

- Health and wellbeing
- Immediate manager support
- Safe environment from violence and
- Staff engagement.
  - There has not been a decline in any of the key themes since 2017
  - LCH scored at most 5.1% below the average whereas the highest response above the mean had a difference of +11.2%.

Most significant improvements year-on-year in local question scores (with larger changes of between +6% and +10% year-on-year compared with changes experienced between 2016 and 2017) relate to senior manager communication, immediate manager support and employee engagement measures of 'recommendation as a place to work and receive treatment', all areas of focus for engagement work in 2018.

The Trust intends to take the following actions to improve this indicator: There is a structured support programme in place to identify and work with those services which experienced particularly negative feedback or low levels of engagement with the National Staff Survey. All Business Units are required to report into the Performance Panel on their broad and local engagement initiatives throughout the year. Furthermore, the Staff FFT (Friends & Family Test) has recently been modified to more closely reflect National Staff Survey content and thereby acts as a pulse for the three quarters between National Survey.

We use a broad range of methods and platforms to listen, share information and engage throughout the organisation. Particularly impactful examples include, but are not limited to, our "50 Voices" engagement group; and our Leaders Network sessions where participants are invited to "call a conversation" on any topic.

Linked to this are our well-embedded Vision, Values and Behaviours, "Our Eleven" – we hold each other to account using these, and they are an important part of our organisational and cultural identity.

Prescribed Information

22. The trust's 'Patient experience of community mental health services' indicator score with regards to a patients experience of contact with a health or social care worker during the reporting period

Satisfaction within the Improving Access to Psychological Services (IAPT) is collected and recorded as part of a national dataset.

Reporting Year	% satisfaction all of the time
2013/14	77.0 %
2014/15	83.5 %
2015/16	84.2 %
2016/17	83.5 %
2017/18	83.4%
2018/19	88.8%

LCH considers that this data is as described for the reasons: Patient experience data collection is a national requirement of all IAPT services with satisfaction a measured post screening and at the end of treatment. Audits are carried out on a quarterly basis to review the outcomes to identify any learning or trends.

The Trust intends to take the following actions to improve this indicator: Continue to work with key partners in secondary care mental health to help improve the mental health pathways and service user experience. Continue to improve access and increase capacity within the service. Ensuring services users are kept up to date of waiting times and provide those who are waiting information on how to keep themselves safe and where they can obtain help and advice from other services or support groups.

Improving Access to psychological therapies (IAPT):

a) Proportion of people completing treatment who move to recovery – 50.4%
b) Waiting times to begin treatment:
    1. 72.7% within 6 weeks of referral (Target 75%)
       The service has experienced a significant number of increased referrals above capacity levels around 12% higher than the previous year. There has been a number staff vacancy's which has impacted on waiting times with a recognised local and national shortage of Psychological Wellbeing Practitioners. The waiting list has been managed through a range of service initiatives.
    2. 99.8% within 18 weeks of referral (Target 95%)

Prescribed Information

25. The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Reporting year	Number of all patient safety incidents	Number (and %) of PSIs that occurred within LCH care	Number of PSIs resulted in severe harm or death (caused directly by the PSI)	Number as a percentage of all patient safety incidents
2015/16	4207	3215 (76.4%)	49 (47 severe harms + 2 deaths – LCH care)	1.2% (LCH PSI incidents)
2016/17	4189	3156 (75.3%)	61 (60 severe harm + 1 death – LCH care)	1.93% (LCH PSI incidents)
2017/18	4759	3250 (68.3%)	63 Severe harm 9 (14%) avoidable 54 (83%) unavoidable *1 avoidable death to LCH	1.9% (LCH PSI incidents)
218/19	4201	2921 (69.5%)	77 Severe harm 6 (8%) avoidable 65 (84%) unavoidable 6 (8%) ongoing *1 avoidable death to LCH	2.6% (LCH PSI incidents)

*****Defined as avoidable to LCH through the SI process due to a falls risk assessment not being completed whilst under LCH care. In 2018/19 LCH has reviewed the falls risk assessment criteria to ensure that where there is a risk of a patient falling that early review and risk reduction interventions are implemented.

LCH considers that this data is as described for the reasons: LCH has a strong reporting culture with staff encouraged to be open when something has occurred. LCH continue to report all incidents that affect our patients including those that occur in other organisations such as care homes or hospitals. An example of this would be a pressure ulcer obtained in hospital with treatment being provided by our Neighbourhood Team after discharge.
The Trust intends to take the following actions to improve this indicator: In 2018/19 we have continued to provide incident training across the organisation and provide support to staff in incident review and investigations. We have updated our serious incident, Falls and Pressure Ulcer investigation documentation. Comparative Data: Within the NRLS (National Reporting and learning Systems) dataset LCH is within the top quartile of reporting, however with the difference of services that community organisations manage direct data comparison is not feasible.

Part 3 An Overview of Quality of Care

This section of the Quality Account provides information of the quality of care based on performance in 2018/19 against quality and performance indicators agreed by the LCH board and also performance against other relevant indicators set out by regulators.
Greater detail will be provided on:

- NHS Staff Survey
- Work Relations Equality Standard
- Leadership
- Patient Engagement in Service Planning/Provision
- Learning from Patient Experience
- Friends and Family Test (FFT)
- Patient Engagement and Involvement
- New models of Care
- Safeguarding
- Infection Prevention and Control

Staff Satisfaction (NHS Staff Survey)

The way the staff survey results are analysed nationally before we receive them locally has changed in 2018 – there are no key findings this year. From the benchmarking report:
"Key Findings have been replaced by themes. The themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. Please note that you cannot directly compare Key Finding results to theme results."

Examples of how LCH scored against key themes

"Safe environment – Bullying & harassment" the results out of 10 are as follows;

	2015	2016	2017	2018
Best	8.8	8.7	8.7	8.8
LCH	7.9	8.5	8.5	8.5
Average	8.3	8.4	8.4	8.4
Worst	7.9	8.0	8.0	7.1

"Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?". Percentage of people who responded yes:

	2014	2015	2016	2017	2018
Best	95.2%	94.8%	92.3%	92.4%	93.8%
LCH	90.7%	89.3%	92.2%	89.6%	89.6%
Average	91.2%	90.0%	89.8%	88.5%	89.2%
Worst	82.1%	82.6%	81.6%	80.0%	73.7%

Errors/ near misses/ incidents:

- Questions involving errors, near misses and incidents have also shown a positive change since 2017
- In questions 16a and 16b which involve witnessing errors, near misses and incidents LCH is now above average.
- Question 17c “When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again” has been steadily increasing in positive response and LCH now has the best score

Immediate Manager Support:

- Immediate manager questions had a dramatic dip in 2017, with LCH showing the worst response of all comparable trusts in several questions but response appears to have recovered and LCH is now scoring at National average for these measures.

Resourcing (Staff):

- For question - there are enough staff at this organisation for me to do my job properly LCH response has risen to 7.8% and is now above average which is a significant improvement from previous years

LCH will be working with our staff to ensure that actions plans are devised for any areas that require attention. We will also be striving to continue to improve our position of the key indicators that have remained static and those which have also seen a rise with a hope to improve the position even further.

Work Relations Equality Standard (WRES)

If we are to realise the vision of delivering the best possible care to all communities, it is essential that our workforce is as diverse as the community we provide services to. To this end, during the last year we have continued work to build knowledge, skills and behaviours within the healthcare community. In common with other public service organisations we have policies to guide us in achieving this aim; however, it is the way we implement our policies that makes a difference.

At LCH we continue to raise awareness of equality issues, in particular we continue to resource & support the LCH Black, Asian Minority Ethnic (BAME) staff network creating an inclusive environment for patients and staff.

The NHS Workforce Race Equality Standard (WRES) was introduced in 2015 with the aim of ensuring that employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

LCH continues to make progress, agreeing the WRES action plan with additional resource and launching the Reverse Mentoring programme between BME staff and Trust Board members.
To work towards reducing the numbers of staff experiencing inequality of opportunity or treatment, we continue to provide opportunities for all staff to access face to face 'Unconscious Bias' awareness sessions and is included in the 2 day Recruitment & Selection Managers course.

In 2019 LCH was included in the Inclusive Top 50 UK Employers, a definitive list of UK based organisations that promote inclusion across all protected characteristics, throughout each level of employment within their organisation.

In 2014 LCH received the 'Disability Confident' - employer accreditation, and have commenced work to achieve a 'Disability Confident' – leader accreditation in 2020.

The first phase of the WRES focused on supporting the system to understand the nature of the challenge of workforce race equality and for leaders to recognise that it was their responsibility to help make the necessary changes.

The next phase of the WRES will focus on enabling people to work comfortably with race equality. Through communications and engagement we will work to change the deep rooted cultures of race inequality in the system, learn more about the importance of equity, to build capacity and capability to work with race.

LCH is working hard to ensure the WRES action plan is integrated throughout the organisation.

Leadership

At LCH we are committed to developing our staff and ensuring we have strong leadership and management throughout the organisation.

We are building on our strong Leadership & Management foundations to enable managers and aspiring managers from across the organisation to access Leadership & Management development. We are considering options to scale up the development offer to reach more people both within LCH and across Primary Care; and we are working closely with the Leeds Health and Care Academy on the development of their System Leadership module.

We are embedding a Leadership Competency Framework (LCF), based on the LCH values and behaviours as well as engagement with stakeholders. It is envisaged this will support constructive discussions about leadership potential and development needs, linked with appraisal processes and the emerging LCH Talent Management approach.

We are identifying our critical roles within the organisation, and engage services in the development of an improved talent management approach, linked with appraisal processes.

Just Culture

Mistakes can occur and therefore errors in the workplace will certainly happen. It is often the way we handle the mistaken that can dictate their resolution. By establishing a 'just culture' organisations can learn to avoid the risks of unnecessarily and harshly blaming employees which can lead to distrust, lower workplace morale and further incidents. A 'Just Culture' is a culture in which individuals are not punished for actions, omissions or decisions taken by them which are appropriate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated.

A 'Just Culture' ensures that staff involved in a patient safety incident are treated fairly, and which supports a culture of openness and transparency to ensure opportunities to learn from mistakes are maximized.

LCH is committed to supporting staff through incident management and learning when things go wrong. We want to ensure that we have robust support structures in place and are able to have open and honest conversations without apportioning blame. Staff can often feel responsible when things go wrong and on occasions can feel an essence of blame from patients or families which can be difficult.

LCH is considering how we can include patients, carers and other service users in our investigation process with the aim for a more collaborative approach to help with learning, exploring root cause and where required system change.

Patient Engagement Initiatives within Service Planning/Provision

New Child Mental Health Unit - It is very important to the Trust that the voice of young people, families, staff and the local community has a strong presence in the development of the new CAMHS in-unit to be built in Leeds and we will continue to work together to make sure we get it right.

So far, we have held two engagement sessions with young people and one session with parents and carers. The sessions have helped us to understand what is important to people in the design of the new building and how we improve both patient and visiting experience at the new unit. We have also asked for feedback on our plans developed so far.

We have also held a drop-in information session for members of the public to view and comment on initial plans. Our staff, construction and design representatives were all on hand to answer any questions about the unit.

We will continue to involve young people, their families and carers, member of the public, staff and our partners throughout the project.

Child Development Centre Relocation - We want to ensure our services are provided in the very best facilities. Over time it became apparent that the building, which housed the Child Development Centre, was no longer suitable. During June to September 2017 we asked for

your feedback on plans to relocate the Child Development Centre from the St James' Hospital site to the Reginald Centre. Overall, engagement has shown that the proposals to move was positively received. We invited people to come and hear about the outcomes of engagement for our proposals to relocate the child development centre. We held two information sessions to talk to people about our plans, ask any questions and be shown where the service would be delivered from. In moving to the Reginald Centre children are now seen in a modern, fit for purpose community environment which is providing an improved care environment and facilities for patients and staff.

Friends of LCH - We asked for feedback about changing the term 'members' to 'Friends of LCH' to describe people's relationship with us and how people can continue to be involved in the work of the Trust. 75% of people that responded said they were supportive of the name change. Those not in support were concerned that members have a stronger influence than friends. We are confident that changing the name will not change the relationship people have with us or the impact they can have.

Staff thank you awards - We invite 'Friends of LCH' and involve people in judging the Trust staff 'Thank You' awards based on our 'How we work' behaviours.

Complaints & Concerns

This year we have reviewed our processes following an internal audit of our feedback policy to ensure that all complaints are initially risk assessed to identify any immediate patient safety risks and highlight any immediate learning or areas for improvement. Staff support has also increased to provide comprehensive and individualised responses to complaints and to also aim to resolve any complaints or concerns as soon as we can.

To help us to achieve this:

- Clinical Leads risk assess the complaint as soon as this is logged on our Datix system to identify any immediate patient safety risks or learning
- The Service Lead reviews all completed investigations, draft responses and recommended learning and action plans prior to the response being sent for Executive review and CEO (Chief Executive Officer) review/sign off.
- Actions and learning and identified themes are reviewed and discussed and shared across the organisation through the clinical governance structure
- Compliments and outcomes of concern and complaint investigations are discussed with named practitioners as part of individual appraisal or supervision and with service teams

In the last year the Trust has seen the amount of patient feedback received by traditional channels continue to reduce. During 2018/19 we received 152 complaints relating to services LCH provides. Of the complaints we received, the Trust upheld either in part or fully 43%. Two complainants asked the Trust to re-open their complaints to look at issues again. Two referrals were made to the Parliamentary and Health Services Ombudsman but we received no further contact from the Ombudsman during the reporting period. There were 365 concerns raised and a total of 126 enquiries recorded. We also received 1472 compliments.

The top themes for complaints in 2018/19 as categorised within our Datix reporting system were:

1. Clinical Judgement / Treatment

2. Appointment
3. Attitude, conduct, cultural and dignity issues.
4. Confidentiality of information
5. Access and availability

In the reporting period we looked for any trends in relation to the themes and categories. The reviewed included any correlation with service pressures, trends within any particular service or individual staff or teams. We found that a number of complaints received in relation to appointments/access and availability were received from areas within LCH where the services were experiencing high levels of demand. Both services have undergone a review of capacity and demand and implemented actions to improve patient flow ensuring that patients are kept informed and updated at peak demand levels, providing alternatives or support as appropriate. This has reduced the number of complaints received relating to these themes.

Friends and Family Test (FFT)

The Friends and Family Test (FFT) supports the fundamental principle that everyone who accesses NHS services should have the opportunity to provide feedback on their experience.

The FFT question asks if people would recommend the NHS services they have used to their family and friends and offers a range of responses from Extremely Likely to Extremely Unlikely. Some surveys used across LCH also ask service-specific questions alongside the FFT question, to try and obtain more detailed feedback and this is captured using the national Membership Engagement System (MES) database. This feedback allows us to see what is working well and what could be changed or improved, helping us to continuously shape the design and delivery of our services.

Leeds Community Healthcare remains compliant with the requirement to collect data and reports results regularly both internally and externally to NHS England via NHS Digital. The Trust target for FFT response rate in 2018/19 is 6.8%.

During 2018/19, 15,093 FFT responses were received giving a 5.94% response rate across all services, with 95.9% of respondents saying they would recommend our services to their friends and family. We received 93 overall responses from our Community Inpatient services; a response rate of 40.9%, with 95.7% of respondents saying they would recommend our services to friends and family.

NHS England announced plans to improve some of the ways the FFT operates and plan to produce refreshed guidance in April 2019. Some key areas for development include;

- Explore a more effective question
- Supporting services to make the most of what it can give them as a local service improvement tool
- Removing the burden in meeting some of the specifics in the guidance (such as the 48 hour rule for acute trusts and the fixed “touchpoints” across maternity care)
- Supporting the best possible use of the data.

The Patient Experience Team, are starting to review the Trust's use of FFT comments and how we can make better use of the information received. Services are also being encouraged to access MES to pull service specific reports and share this data at team meetings to explore new ways of gathering feedback from service users and using feedback proactively to improve the experience of service users.

Patient Engagement and Involvement

LCH is committed to listening to our service users, carers and the public to ensure our services meets the needs of the community. We are committed to hearing patient stories throughout the organisation to hear what really matters. Board members hear direct from patients or a family member the impact of both a positive and negative experience. Members of the board also commit to participate in service visits to gain a better insight into services from both staff and patients.

We aim to significantly improve our Organisational offer for Patient Experience and Engagement over the next 12 months and hope to continue to continue to develop this as a main priority. This will ensure that our services are continuously improving and are reflective of the needs of the Communities serve.

The Organisation has committed to this development and has recently recruited to 2 new job roles to lead and drive this work; we now have a Patient Experience and Engagement Lead and a Patient Engagement, Experience & Participation Officer in post.

Our starting point for this improvement is the commissioning of Healthwatch Leeds to complete a report outlining our current position; this will involve semi-structured interviews with staff across the Organisation to establish a baseline across all services. This report, along with in-house fact finding and reviews, will provide recommendations on how we move forward within Patient Experience and Engagement.

We will implement a framework to establish and measure our progress; this will likely take the form of the NHS Improvement 'Patient Experience and Improvement Framework' to aim towards achieving good and outstanding ratings within CQC standards.

We aim to create a Patient Experience and Engagement Strategy in collaboration with Patients, staff, Carers and families. To support the strategy we will implement a delivery plan including impact measures and a review timetable. This will ensure there are robust procedures in place to measure progress and effectiveness.

We will implement process that will be shared and accessible to provide guidance on Patient and family engagement to allow for services to take the lead on engagement activities with support from the Patient Experience Team. We will engage staff to reinvent the 'Experience/Engagement Champion' roles and to have staff representation at quarterly

meetings from all services/teams. We will review the use of 'Engagement standards' in line with our framework and strategy.

We aim to work with our partners in Leeds to develop a city-wide engagement network allowing for learning to be shared and for a more consistent experience of engagement to be embedded across the City. We are a member of the Leeds People's Voices Group and are on the working group for the Big Leeds Chat 2019; the 2nd annual event of its' type in Leeds to bring together members of the public and key decision makers across Health, Primary and Secondary Care and the Voluntary Sector. We will work with our partners to create an engagement space for the people of Leeds to tell us what they want and need from health care services, and give the opportunity for the public to discuss key issues with decision makers within these organisations.

We will support the role out of the 'Hello, My name is' campaign in September 2019 and will work with Communications and Workforce to embed the initiative within all staff levels. We will support the implementation of the 12 month forward plan from July 19 to maintain momentum post roll-out in September. A mobilisation plan is in place for Q1-Q2.

We will continue our work with listening to patients experience through the Friends and Family Test and also from feedback from complaints and concerns to help drive our service improvements.

New Models of Care

Mental Health Support for Children and Young People - Thanks to closer working relationships between South West Yorkshire Partnership NHS Trust; Leeds and York Partnership NHS Foundation Trust; Bradford District Care NHS Foundation Trust and Leeds Community Healthcare NHS Trust and the introduction in April 2018 of the New Care Model (national pilot) for children and adolescent mental health services (CAMHS) progress is being made to support more children and young people with mental health problems closer to home.

Evidence shows that care provided closer to home has better health outcomes than most hospital admissions and is importantly better for families and carers - reducing travel time and unnecessary anxiety.

LCH is leading the work for new care models for the Partnership. Information collected to date, shows that by adopting a shared approach across West Yorkshire and Harrogate the number and length of hospital bed days for children and young people across the area has reduced in the last six months from 708 occupied days in April 2018 to 536 in September 2018. The money saved means funding is available to organisations across the area with £500k worth of investment in community services - ensuring more children and young people are cared for closer to home.

Through the introduction of the new care navigator role twenty one children and young people were also supported locally in the last six months without hospital admission.

However, children and mental health services remain poor in terms of assessment waiting times and providing timely access and meeting increasing demand. More must be done.

Working in partnership with other organisations, including the police, local authorities and community organisations is critical to further improving care for children and young people in communities. You can see a good example of this in the work of Bradford's safer spaces for children and young people in mental health crisis. This provides an alternative to hospital bed days whilst reducing unnecessary A&E attendance. It has the potential to be rolled out across other Partnership areas.

The Partnership's work is also supported by a £13m capital investment from NHS England to build a new Children and Adolescent Mental Health Unit in Leeds. Led by Leeds Community Health Care NHS Trust on behalf of the Partnership, the new purpose built specialist CAMHS unit is due to be completed in the next 2 years. It will support young people suffering complex mental illness. Importantly this means they will receive care locally if and when they need specialist hospital care. There are currently eight general adolescent beds for patients across West Yorkshire which are provided by Leeds Community NHS Healthcare Trust in Leeds. This new unit will bring a significant increase in capacity and provide 18 specialist places and four psychiatric intensive care unit (PICU) beds. These 'extra' beds are in part due to reallocating hospital beds across the country so that young people get specialised inpatient care nearer to where they live.

Safeguarding

LCH ensures there are systems and processes in place to promote the safeguarding and wellbeing of the people of Leeds. Safeguarding is about working closely with families and partner agencies in health and social care to respect to the rights of everyone to live life free from abuse, neglect or emotional harm.

The LCH Safeguarding Team exists to guide and support staff, managers and service leaders in fulfilment of their safeguarding duties; including, as part of our corporate function, working with our Contracting and Business Development Team to ensure LCH's commitment to safeguarding is reflected in our tendering and contracting processes such as delivery of Custody Suite and 0-19 years Healthy Child services. During 2018/19 we have built on our commitment to safeguarding:

- Reviewing the safeguarding training compliance status of staff across the Trust and reconfiguring our Electronic Staff Record system to accurately reflect the level of training required for each role. All departments and teams in the Trust have responded the challenge of ensuring we are equipped with relevant knowledge to safeguarding the people of Leeds and each other in line with "Safeguarding children and young people: roles and competences for health care staff" (Intercollegiate Document March 2014)

- Working closely with strategic partners in the Leeds Safeguarding Children Partnership to respond to the systems and process changes arising from the publication of "Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children" (July 2018); which seeks to strengthen local partnership working and the robustness of processes for child safeguarding practice reviews and child death reviews
- Working closely with strategic partners in the Leeds Safeguarding Adults Board to revise the safeguarding adult procedures; developing the "Leeds Approach"; clearly and firmly placing service users at the heart of safeguarding practice. 2019 will see the embedding of the "Citizen-Led Multi-Agency Safeguarding Adults Procedure: Talk to me, hear my voice".

- The LCH safeguarding team were integral to the planning and delivery of a highly successful self-neglect conference promoted under the “Talk to me, hear my voice” banner and scheduled to be repeated in May 2019

External scrutiny of safeguarding children practice has been a strong feature of 2018/19. A CQC Review of health services for Children Looked After and Safeguarding in Leeds in June identified practices across Health Visiting, School Nursing, Leeds Sexual Health Service, CAMHS and the Children Looked After health service of which we can be proud whilst remaining committed to continuous improvement and development.

The CQC findings were reinforced by Ofsted’s Inspection of Children’s Social Care Services in October/November of 2018 which found that “Children are placed at the centre of work within the city and strong multi-agency strategic partnerships are promoting effective practice…”. Their judgement was that children’s services in Leeds are outstanding.

2019/20 will be another challenging and exciting year as we look to continuously strengthen, develop and integrate our safeguarding practice with that of our colleagues in NHS Leeds CCG, Leeds Teaching Hospitals Trust, Leeds and York Partnership Foundation Trust, Leeds Safeguarding Children Partnership, Safer Leeds, The Leeds Safeguarding Adults Board and the Leeds GP Confederation.

Infection Prevention and Control – Shaping the Future

Throughout the year the Infection Prevention Team have continued to address the challenges faced through the changing landscape of the NHS and the enhanced vulnerabilities of some of the people we care for. LCH continues to place infection prevention and basic hygiene at the heart of safe care and clinical practice, and we are committed to a “zero tolerance” approach to preventable healthcare associated infection.

Over the past year the Infection Prevention team have worked closely with care delivery staff both working within LCH and the wider health economy to promote a clear message emphasising the importance of safe infection prevention practice. Central to this has been the work around the national reduction of the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli) through upstream approaches to public health and health promotion. In addition LCH has achieved the local and national targets for reportable infections: Clostridium difficile (CDI) and MRSA bacteraemia.

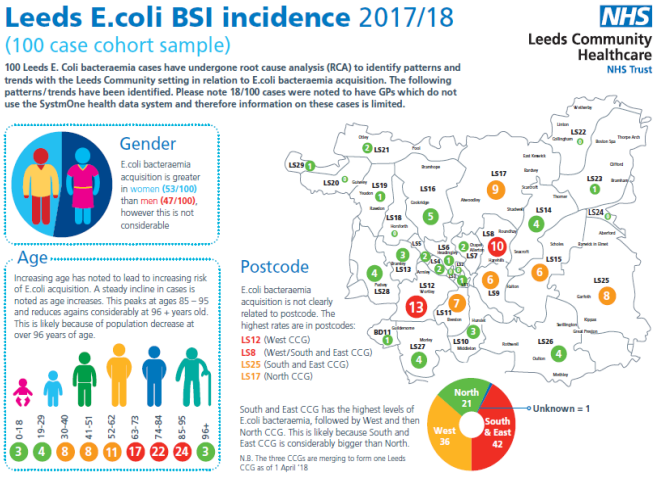
- **NO** cases of MRSA bacteraemia have been assigned to LCH within 2018/19

Throughout 2018 the Infection Prevention Team have coordinated various awareness campaigns at a variety of venues and engaged with LCH staff groups and the wider community.

Throughout this we have worked towards the following objectives:

- Raise the profile of Infection Prevention Control
- Hydration Awareness
- Sepsis Awareness
- Promote the I-Spy E.coli Campaign
- Address seasonally important issues such as influenza, Norovirus, hand hygiene
- Highlight sharps safety compliance, both organisationally and with the general public
- Reinforce that IPC is “everyone's responsibility” across the healthcare economy

The Infection prevention Team began work to reduce E. coli bacteraemia burden in Leeds by 10% yearly leading to a 50% reduction in 2020 as set out by the Department of Health. Focusing on the elements of education, hydration and UTI's. Partnership work has taken place across the city including hydration awareness days, a television advert on the Leeds TV Chanel and public campaigns in the city centre.



A significant highlight of 2018/19 is our success in vaccinating LCH staff through the Flu Vaccination Campaign. The Infection Prevention team were challenged with a requirement to vaccinate 75% of our frontline staff before the end of January 2019.

Going forward throughout the year LCH views the prevention of Healthcare Acquired Infection as a key priority. We will continue to hold this at the forefront our commitment to deliver safe, clean care to the people within the Leeds Healthcare Economy and to continue working collaboratively with all key stakeholders, and keeping the patient at the centre of healthcare delivery.

Appendix 1: Healthwatch Leeds, NHS Leeds Clinical Commissioning Group

Appendix 2: **Statement of directors' responsibilities in respect of the Quality Account**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the Regulations and supporting guidance.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from Leeds Clinical Commissioning Group on xxxxxx and Healthwatch Leeds received on xxxxx
  - the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints (England) Regulations 2009
  - the national staff survey Autumn 2018
  - the Head of Internal Audit's annual opinion of the trust's control environment dated xxxxx
  - CQC inspection report dated 29/08/2017
  - the Quality Report presents a balanced picture of the Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Signed..... Date.....

Neil Franklin, Chair

Signed..... Date.....

Thea Stein, Chief Executive

Acknowledgement

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2018/19 Quality Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, the Senior Management Team and the Board of Directors.

This Quality Account provides an insight into how we are working to realise our vision, values and strategic objectives, and our Quality Strategy. Quality is at the heart of everything we do; we hope we have demonstrated within this document how quality is created, embedded, developed and improved within LCH through sharing examples of initiatives underway to help us achieve these aims.

In line with other NHS organisations, we produce an Annual Reports and Accounts to outline our financial and other key performance measures. These can be found on our website at www.leedscommunityhealthcare.nhs.uk

How to comment on the Quality Account

If you would like to comment on this document you may do so:

- By e-mail to lch.comms@nhs.net
  Please ensure you place the phrase “Quality Account 2018/19 Feedback” as the subject of your e-mail.
- In writing to:

The Clinical Governance Manager
Quality Account 2018/19 Feedback
Clinical Governance Team
Leeds Community Healthcare NHS Trust
1st Floor, Stockdale House
Headingley Office Park
Victoria Road
Leeds
LS6 1PF

Glossary

Audit: a review or examination and verification of accounts and records (including clinical records)
Children and Adolescent Mental Health Services (CAHMS): a service specifically designed to look at the needs of children with mental health problems
Care Quality Commission (CQC): Health and Social Care regulator for England
Clinical Audit: a review or examination and verification of accounts and records (including clinical records)
Clinical coding: an electronic coded format that describes the condition and treatment given to a patient.
Commissioners: organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation)
Clostridium difficile (Cdiff): an infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics
CQUIN (Commissioning for Quality and Innovation): a financial incentive encouraging Trusts to improve the quality of care provided
Datix: an electronic risk management system (database) used to record incidents, complaints and risks for example
Friends and Family Test (FFT): a measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family
Information governance: the rules and guidance that organisations follow to ensure accurate record keeping and secure information storage
Innovation and Research Council: This is an independent body which brings together the seven Research Councils, Innovate UK and Research England
Inquest: a judicial inquiry to ascertain the facts relating to an incident
SUDIC: A review of progress of unexpected child death
Leeds Safeguarding Children's Board (LSCB): a statutory body (independently chaired) consisting of senior representatives of all the principal agencies and organisations working together to safeguard and promote the welfare of children and young people in the City
(LGBT) a collect term for a community of people who identify themselves as Lesbian, Gay, Bisexual or Transgender
Medicines management: processes and guidelines which ensure that medicines are managed and used appropriately and safely
Methodology: a system of methods used in a particular area of study or activity
NHS England (NHSE): the central organisation that leads the NHS in England and sets the priorities and direction of the NHS
NHS Improvement (NHSI): an NHS organisation that supports us to provide consistently safe, high quality, compassionate care
NHS Digital: is the national information and technology partner to the health and social care system. Looking at how digital technology can transform the NHS and social care
NCEPOD: reviews clinical practice and identifies potentially remediable factors
National Institute for Health and Care Excellence (NICE): an organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services
National NHS staff survey: a survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS

National Reporting and Learning System (NRLS): a central database of patient safety incident reports

OFSTED: Is the Office for Standards in Education, Children's Services and Skills, who inspect services providing education and skills for learners of all ages and also inspect and regulate services that care for children and young people.

Outcome Measures: a measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue

PAM: is a tool that enables healthcare professionals to understand a patient's activation level, or their level of knowledge, skills and understanding to help support them in their own health and care

Patient Experience Team: a service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible

Patient experience: feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment

Patient Engagement: methods for patients to take part in service improvement and service reviews

Patient satisfaction: a measurement of how satisfied a person felt about their care or treatment

Payment by results: the system applied to some services whereby NHS providers are paid in accordance with the work they complete

Pressure ulcer: damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing

Public Health England: an organisation that works to protect and improve national health and wellbeing, and reduce health inequalities

ReSPECT: is a process that creates a plan with a patient on what they would like to happen if they were unable to express their wishes in an emergency situation. It provides health and care professionals responding to an emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment

Risk Assessment: a process to identify risks and analyse what could happen as a result of them

Root Cause Analysis (RCA): a method of investigating and analysing a problem that has occurred to establish the root cause

Safety Huddle: a mechanism of route discussions held within teams and across multi-professionals to discuss current patients to help reduce harm and risk and improve patient safety

Serious Incident (SI) – these are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response

Strategy: the overall plan an organisation has to achieve its goals over a period of time

Trust Board: the team of executives and non-executives that are responsible for the day to day running of an organisation

WRES: Workforce Race Equity Standard

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (18)

Meeting Trust Board 24 May 2019	**Category of paper**	
Report title Healthwatch review of patient engagement activity	**For approval**	√
Responsible director Executive Director of Nursing and Allied Health Professionals **Report author** Executive Director of Nursing and Allied Health Professionals	**For assurance**	
Previously considered by Not applicable	**For information**	√

PURPOSE OF THE REPORT

This paper is to highlight the work undertaken by Healthwatch Leeds for the Trust to scope its current approach to patient engagement and experience and to make recommendations for the future.

MAIN ISSUES FOR CONSIDERATION

The report highlights the key findings of the Healthwatch Leeds report and the recommendations from them. The report is very clear on what is working well now within the Trust and highlights some examples of excellent work in relation to patient engagement and experience and then makes recommendations in relation to how this can be embedded across the whole Trust.

It goes on to explain the work currently being undertaken in the Trust in relation to patient engagement and experience and finally gives an overview of the timeline for development of a patient engagement and experience strategy and framework for use across the Trust.

A hard copy of the report will be available at the Board meeting on 24 May 2019.

RECOMMENDATIONS

The Board is recommended to:

- Acknowledge the work undertaken by Healthwatch Leeds and the subsequent report
- Agree the suggested timeline for development of the strategy and framework for the Trust

Patient Engagement and Experience Report

1.0 Background

1.1 SMT asked Healthwatch Leeds to undertake a piece of scoping work to look at patient engagement within the Trust as it was felt there were pockets of great practice but the focus from a central perspective wasn't there.

1.2 A new team was recruited for patient engagement and experience in the Trust and this consists of a patient engagement/experience lead and a patient engagement/experience officer.

1.3 In addition a new structure in the Director of Nursing and AHP's directorate will ensure there is strategic oversight of patient engagement/experience from the level of an Assistant Director.

2.0 Highlights from the Healthwatch Leeds Report

2.1 A hard copy of the full report will be available at the meeting; however, the headlines are shown below:

- Excellent senior level commitment to developing engagement.
- Good staff understanding of the benefits of engaging people.
- A variety of engagement activity happening across LCH, and pockets of good practice predominantly where resources have been allocated, however this was ad-hoc and not consistent across the Trust.
- A particular area of strength was involvement of people in their own care, which seems to be well on the way to becoming embedded in the Trust.
- There is some reliance in LCH on the Friends and Family Test which due to the nature of the question asked, only provides limited data, much of which once collected isn't systematically reviewed or acted on.
- A gap in the resourcing of engagement over the last couple of years which has resulted in a lack of good systems and co-ordination of engagement activity.
- There is also no formal strategy or plan in place around engagement which means that there is a risk of it dropping off the agenda- the majority of the people 'doing' the engagement work are clinicians whose first priority will always be their caseload.
- Staff have lots of good ideas but time, resources and expertise as key barriers to putting these into action.
- Recognition that more could be done to engage with people from diverse groups.
- A clear need to make sure that engagement is accessible to all users of LCH services, and in particular those with disabilities, cognitive and communication impairments, those that are housebound and in receipt of end of life care and people whose first language isn't English.

3.0 Key Recommendations

3.1 There are a number of recommendations emerging from the report and these are highlighted below:

- Vision and Leadership - The approach of putting people at the centre of LCH services is adopted at all levels, linking in with hearing the staff voice. We need to look at how we hear these voices at Board level to make this more meaningful and accessible.
- Culture - How do we make engagement everybody's business? This should link explicitly to the Trust's behaviours and should include developing ways of sharing and celebrating good practice, as well as how we communicate more widely around engagement activity and messages.
- Process, systems and infrastructure - Using a framework (such as the NHS Improvement patient experience improvement framework self-assessment tool or similar) to agree areas for action and review which should inform the development of an overarching Engagement Strategy. This should include ways that the infrastructure and systems in LCH can enable all strands of patient experience to tie up. This should include complaints and compliments, FFT, service level engagement work and public consultation around service change.
- Resource - The central PET is now in post. Continued and future resource will be need to be considered; both centrally and locally. Budgets for engagement reimbursement will need to be allocated, with updated policy to support this. Consider developing volunteers within the Trust.
- Skills and expertise - Development resource bank of tools, develop training, dedicated staff time and resources.
- Diversity of voices - Improve access for involvement, develop how we hear the voices of the most underrepresented groups.
- Working with others - Build and strengthen links with our partners across the City and Nationally. Develop more creative ways to work with the more challenging services and groups (to gather feedback).
- Monitoring and reporting impact - FFT, website, outcomes-based reporting mechanisms, QI systems.

4.0 Update on internal key pieces of work

4.1 There are a number of internal pieces of work in relation to patient engagement already ongoing in the Trust and these are highlighted below:

- 'Hello, My Name is….' - This will be rolled out organisation-wide in the months leading up to September; all staff will have the new lanyards, email signatures will be updated, the Patient Engagement and Experience Team (PET) will attend staff meetings to share the message, we will be collating patient stories around why the initiative is so important. We will celebrate this at the AGM in September where hopefully we will have a contribution from Chris Pointon, co-founder of the campaign.

- Always Events - Working within the NHS England guidance we aim to support the Always Events to be developed across all business units. Progress so far: 3 conference calls with other Trusts in our cohort, coaching call with our buddy, identified subject area within CUCS- to be developed by attending team meeting on 9th, Initial meeting with CBU to identify area of focus.
- Children's service Quality Improvement project (with Improvement academy) - Working with the Improvement academy to gather feedback from families that access all services within the Children Nursing service. We will invite families to meet with us and give us their feedback, using tools from the Yorkshire Patient Experience Toolkit.
- Experience of Care week 19 - An example of a National event that showcases the feedback our services receive from patients, carers, staff and others. The feedback we received was great, and we hope to build on this across other events throughout the year.
- Big Leeds Chat - Date to be confirmed but will take place at the Leeds Market in autumn; with key decision makers across Leeds Health and Care systems involved to speak to the people of Leeds.
- Patient Experience Champions - second staff champion group took place on 9 May 2019 with 25 staff members attending. This meeting will now formally feed into PSEGG.
- Friends and Family Test (FFT) - Review how we use FFT to make the data it provides more meaningful, and input process to learn from this and improve services as a result.

5.0 Strategy Development

5.1 The Trust now needs to develop a patient engagement/experience strategy and the timeline for the development of this is set out below. It will include the recommendations from the Healthwatch Leeds report and from engagement work.

- May 2019 - Develop Working group; Staff, Patients, Carers, Healthwatch Leeds, Partners
- May/June 2019 - Strategy and framework development
- 24th June 2019 - Quality Committee Workshop - Draft Strategy for feedback
- 2nd August 2019 - Sign off at Board

Leeds Community Healthcare NHS Trust

Agenda Item 2019-20 (19)

Meeting: Trust Board May 2019	**Category of paper**	
Report title: Annual Patient Safety and Engagement Report	**For approval**	
Responsible director Executive Director of Nursing and Allied Health Professionals **Report author:** Patient Experience and Engagement Lead, Incident and Risk Assurance Manager	**For assurance**	√
Previously considered by Quality Committee	**For information**	

PURPOSE OF THE REPORT

This report provides the annual update of Patient Experience and the management of Patient Safety Incidents within Leeds Community Healthcare NHS Trust (LCH).

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 and concerns, the Friends and Family Test, Individual service patient surveys, Engagement initiatives such as the Always Events.

The report summarises the outcomes, themes, actions and learning from Patient Safety & Serious Incident investigations closed within the organisation during 1st April 18 to 31st March 2019; as well as progress against action plans.

MAIN ISSUES FOR CONSIDERATION

The report provides a review of Complaints and concerns, Serious Incidents, feedback via the Friends and Family Test, and wider feedback for 2018/19; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years, and where relevant, within a city-wide perspective and nationally. It later analyses identified themes in greater detail and triangulates information where possible to identify commonalities across all sources of intelligence.

Areas for concern:

- There is limited information from the Friend and Family Test (FFT) surveys
- Complaint numbers are relatively low but themes remain consistent with last year
- Learning is being used for service change and improvement, however this is not consistent
- There has been a reduction in no harm and minimal harm incidents
- A current theme in incidents is the incorrect identification/categorisation of pressure ulcers

Actions:

- Use of FFT will be reviewed
- Process to support patient engagement and experience will be reviewed as part of the development and implementation of an Organisation-wide Engagement strategy, due to be completed in August 19.
- The pressure ulcer categories list has been updated for 2019/20 and is included in all Datix training sessions

RECOMMENDATIONS (including level of assurance: Full, significant, limited, or no assurance)

The Trust Board is recommended to:

- Receive this report
- Note the updated information

1.0 INTRODUCTION

The purpose of this report is to provide the Trust Board with the agreed six monthly and annual update of Patient experience: complaints and incidents within Leeds Community Healthcare NHS Trust (LCH) for the current financial year.

2.0 BACKGROUND

2.1 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.

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

3.0 LCH PATIENT EXPERIENCE

3.1 We currently collate feedback via the Friends and Family test (FFT).; The organisational overall recommendation rates are very positive however the response rate for FFT remains very low. Comments from the FFT responses are collated. Although it is difficult to use this data effectively due to a lack of context to the comments, it is possible to identify some themes. Ongoing development of how we use FFT and other feedback tools will take place over the next 3 months.

3.2 Complaint numbers are relatively low in comparison to other Trusts, and all complaints receive a completed action plan and response. It is possible to identify themes and trends from the complaints that we receive and there are examples of learning to affect service change and improvement. However, this will be developed further over the next 6 months to ensure that this is consistent and is supported by robust processes.

4.0 FRIENDS AND FAMILY TEST (FFT)

4.1 In 2018/19 there have been a total of 16,350 Friends and Family Test responses; this is an increase of 1058 responses on last year (17/18 – total of 15,292 FFT respondents). Details of the response rates, levels of satisfaction and themes by business unit are included in appendix 1. The themes common across all FFT comments were included in the report to Quality Committee.

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5.0 COMPLAINTS AND CONCERNS

5.1 Appendix 2 details the comparison of complaints received this year compared to last year. This year the organisation received 152 complaints of which 72 were upheld and 2 reopened.

5.2 To address the limitation of isolated learning, within complaint action plans “learning from mistakes” posters have been introduced. These provide- an opportunity to display the events, the lessons learned and the changes made within the service to avoid reoccurrence. The poster can then be shared electronically on the Trust wide intranet for all staff to access.

5.3 In addition, the feedback from learning from patient safety, complaints and engagement is shared wider as an agenda item for the bi-monthly Patient Safety, Experience Governance Group (PSEGG) meeting to allow for triangulation of themes and wider discussion. The PSEGG meets with the intention to disseminate learning with representatives from the Business Unit’s, Infection Prevention and Control, Safeguarding and Clinical Governance team.

5.4 The PSEGG host 2 events per year that invites members of staff from across the Trust to attend which focuses on learning.

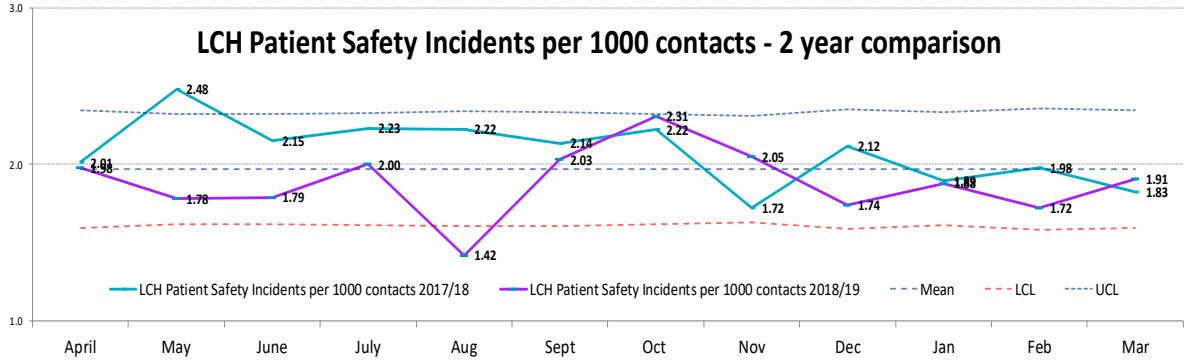
5.5 An aspiration of PSEGG is to introduce an opportunity for members of the public to attend. This concept is being developed as part of the patient engagement and experience strategy.

6.0 PATIENT SAFETY INCIDENTS

6.1 Overview – Comparative Analysis

A total of 6499 incidents were reported by LCH staff onto the Datix system in 2018/19, compared to 6709 in 2017/18 as shown in chart 1 below.

6.2 Chart 1: LCH Patient Safety Incidents over 2 year period



6.3 The number of incidents per 1000 contacts reported each month in 2018/19 has varied more than the previous year but is within normal variance. There was a reduction in incident reports in August 2018 which coincided with fewer patient contacts in that month.

6.4 A review of the services and teams reporting incidents shows that the decrease in reporting for 2018/19 appears to be directly linked to the decommissioning of the South Leeds Independence Centre (SLIC) and Community Inpatient Care Unit (CICU) services in the previous year.

7.0 THEMES IN INCIDENT REPORTING

7.1 A review of the categories of all incidents does not show any large increases of concern in any one area. There has been an increase in the category 'clinical assessments' which covers incidents such as errors with blood tests or other investigations and incorrect identification of pressure ulcers.

There has also been an increase in deaths reported. This is due to a change in reporting requirements rather than an increase in deaths.

A detailed analysis of the categories of patient safety incidents reported by each level of harm is given in appendix 7. When each category is considered in detail, the themes identified for no harm incidents are different to those for minimal moderate and major.

7.2 No harm incidents accounted for approximately 58% of all incidents reported. The top three themes identified as no harm were:

- Medication
- Appointment
- Implementation of care

7.3 Medication incidents (no harm) include missed or out of date medications; transcribing errors and medications not available among others. The medicines management team provides a 6 monthly thematic report to the Quality Committee; this contains a breakdown of all the medication incidents reported and work that is progressing within teams and services to try to reduce incidents.

7.4 Work has been undertaken within services to ensure that staff are following correct referral pathways to specialist services. This includes use of SystmOne reports and tasks to ensure referrals are actioned, a demand and capacity review for specific pathways and additional clinical time to address waiting lists.

7.5 Implementation of care or monitoring**:** contains a mix of clinical incidents that do not fit neatly into any other categories and includes errors with feeds or

syringe drivers; blocked catheters and wounds that did not fit any other criteria.

7.6 The themes from both falls and pressure ulcers show that communication breakdown, either with the patient/carers or within the team were contributing factors to the outcome with documentation and a failure to identify risks also scoring highly for both. Measures to address these recurring themes are a focus of the work plans for the Falls Reduction Steering Group and the Pressure Ulcer Reduction Steering Group.

7.7 The criteria for reportable falls has been updated and circulated to all teams. Safety huddles have increased awareness of reporting requirements and it is expected that incident reporting should increase as a result of this.

7.8 Key actions identified relate to reviewing the documentation used for falls assessments; training on measures and options to address identified risks and frequency of reviews. This work is being led by the Interim Deputy Director of Nursing and feeds into PSEGG.

7.9 The templates and documentation used to investigate patient safety incidents has being reviewed to enable us to better capture and report on themes, trends and learning.

8.0 CONCLUSION

8.1 The common theme emerging from both patient safety and patient experience review is communication. Although individual action plans have been developed following each Incident and complaint investigation similar themes continue to be highlighted. The clinical governance team will be working closely with quality leads to ensure lessons from investigation have been shared and actions are monitored to ensure completion and effective implementation.

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

8.3 Further work is under way to develop specific work relating to patient engagement and experience in response to the work completed by Healthwatch Leeds. The findings from this report will inform the development of an Organisation Engagement Strategy and Business Unit/Service specific operational plans. This will include the development of robust processes and guidance; all developed in partnership with out stakeholders.

9.0 RECOMMENDATIONS

The Trust Board is recommended to:

- Receive this report
- Note the updated information

APPENDICES

Appendix 1

The results continue to demonstrate an overall positive response to the FFT question as shown below:

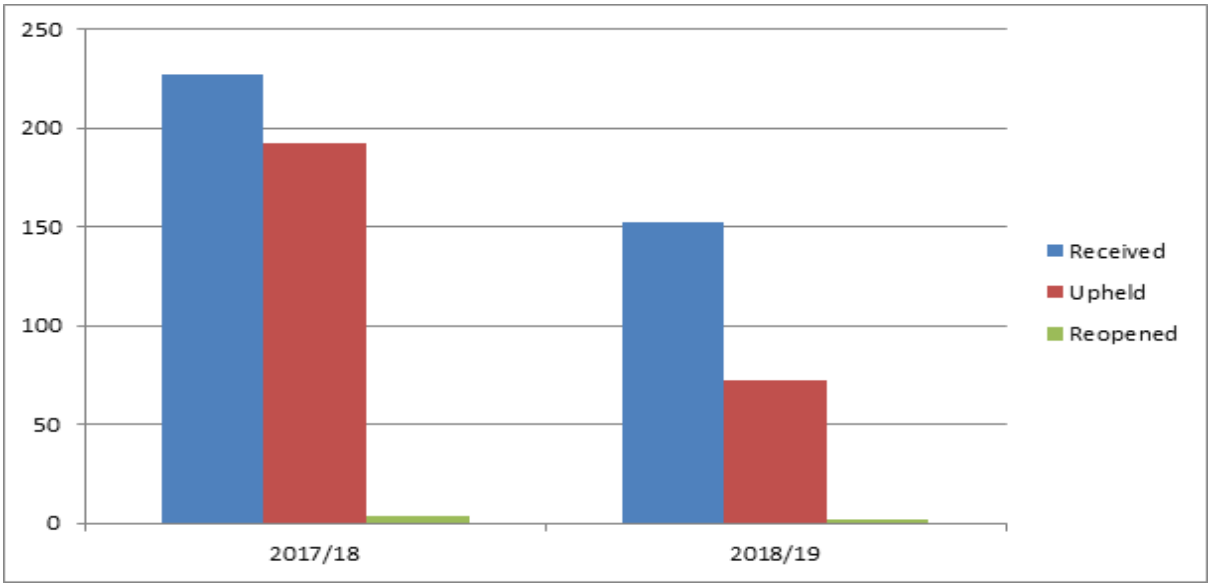
Business Unit	Response Rate %	Recommended Rate %
ABU	3.9%	92.7%
CBU	6.3%	96.5%
SBU	6.5%	96.5%
Trust-wide Community	5.9%	96%
Trust-wide Inpatient	39.4%	94.9%

Summary of number of responses per Business unit and common themes

	FFT Compliments	FFT Complaints/Concerns	Themes
ABU	1,996 92.7%	51 2.3%	Facilities – relaxed, clean Staff – supportive, friendly Communication – informative clear Long waiting times Lack of communication/no reply Staff attitude – dismissive, unhelpful
CBU	Community – 5,471 (96.5%) In-patient – 22 (91.7%) Total – 5,493	Community – 49 (0.86%) In-patient – 1 (4.17%) Total – 50	Staff - Emotional support, compassionate, friendly, polite, professional, thorough explanations Parking – lack of, distance to appointment centre, Waiting time for referral/appointment
SBU	Community – 8,130 (96.5%) In-patient – 71 (95.9%) Total – 8,201	Community – 129 (1.53%) In-patient – 2 (2.70%) Total – 131	Environment – relaxed and comfortable Staff attitude – helpful, supportive, encouraging, polite Clear, practical advice and information Waiting time in clinic/for referral Parking

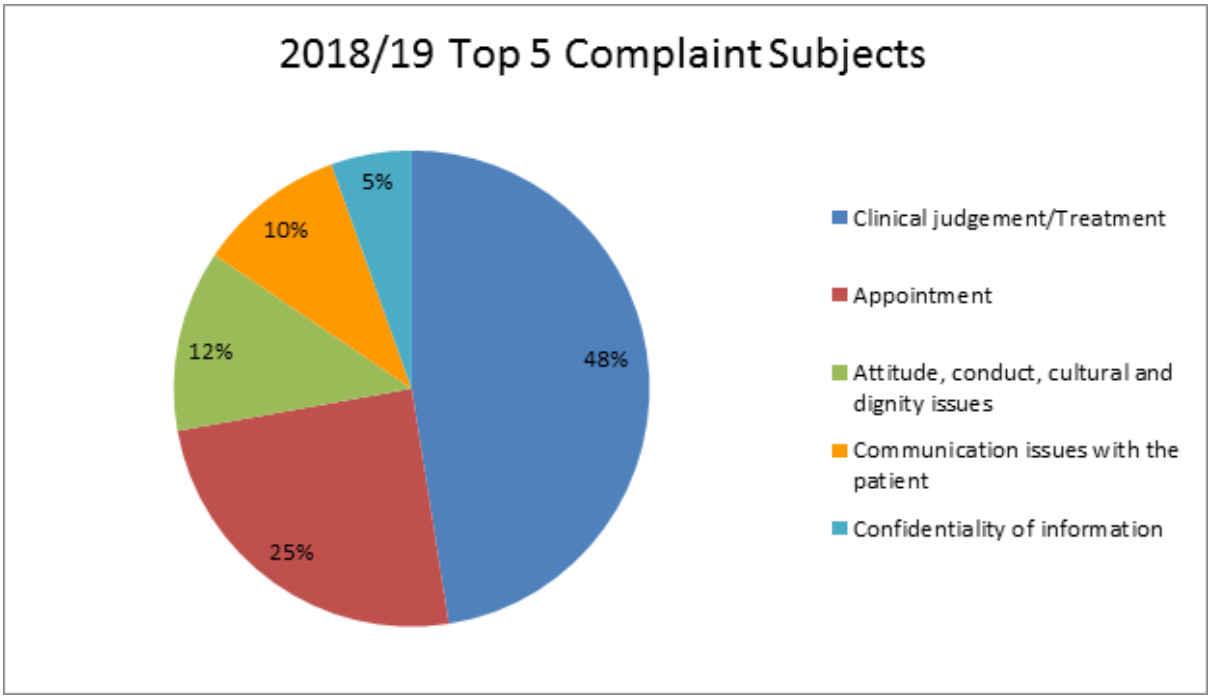
<u>Summary of number of responses per Business unit and common themes</u>
(Green=positive, Red= Negative themes/comments)

Appendix 2



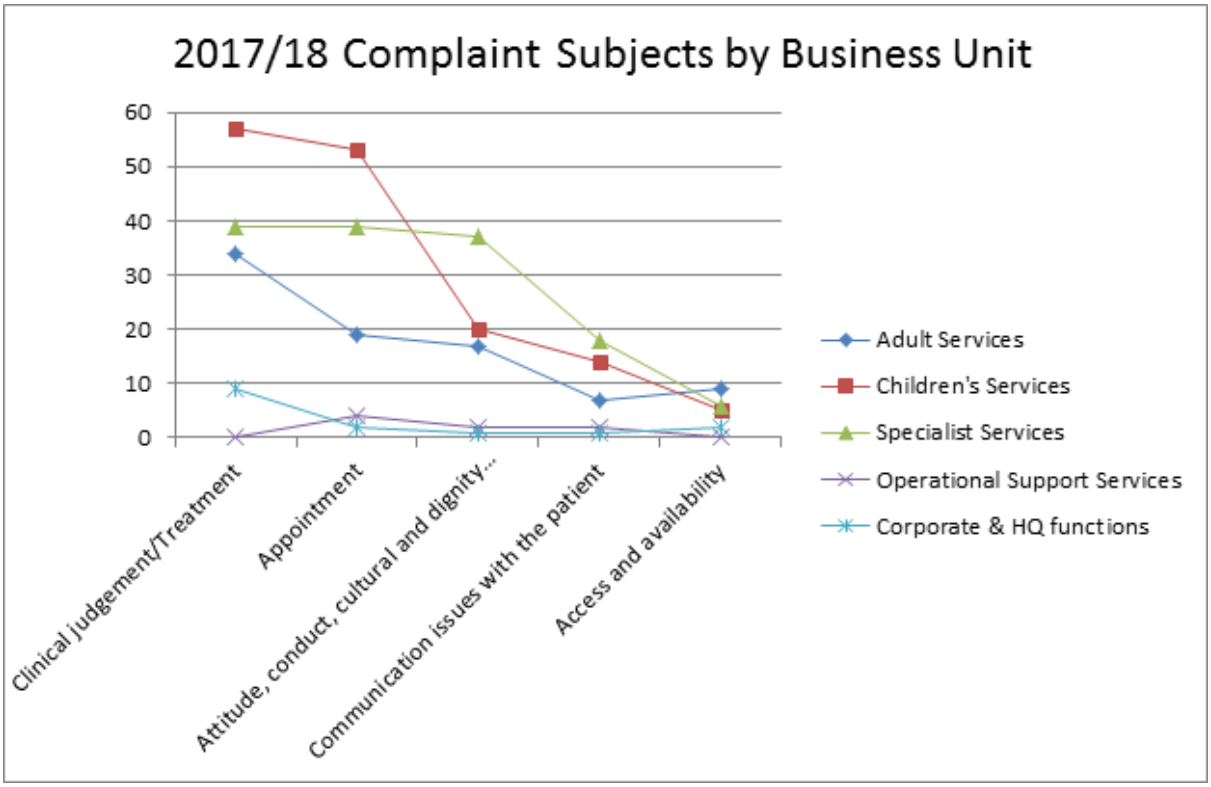
A graph to show a comparison of Complaints received, upheld and re-opened 17/18 and 18

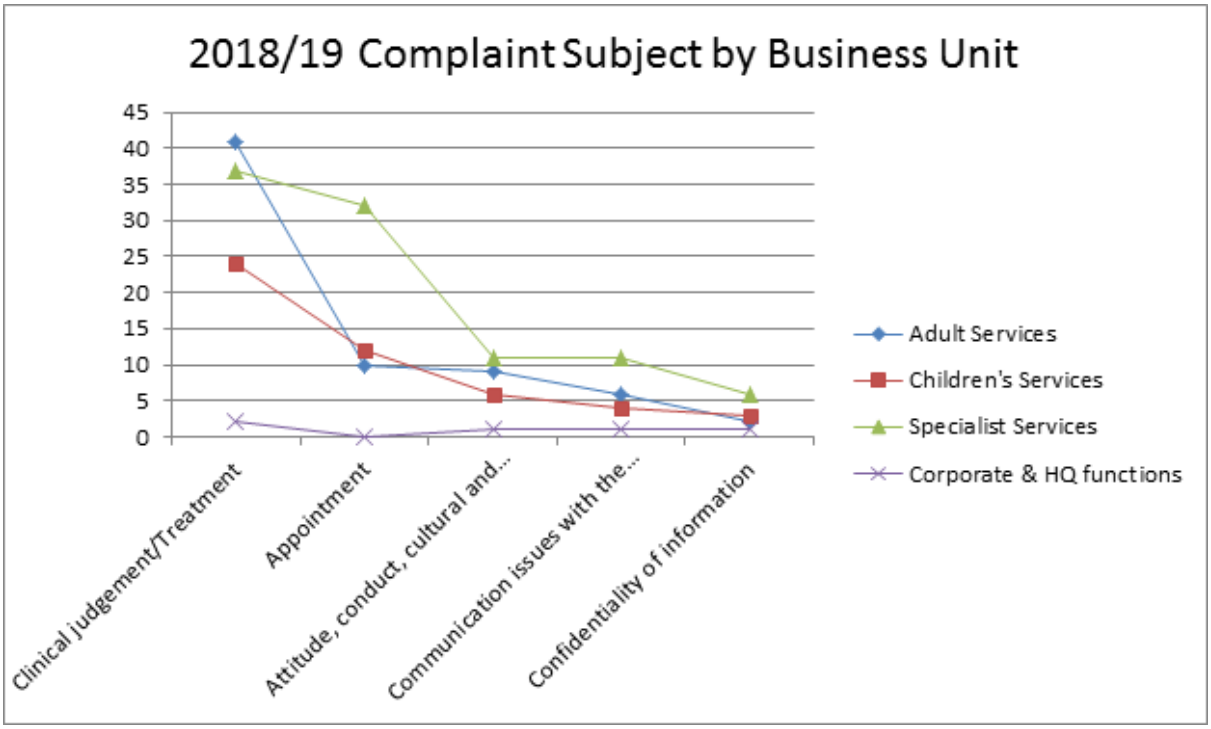
Appendix 3



A visual representation of the top 5 complaints subjects across the Organisation

Appendix 4


2017/18 Complaint Subjects by Business Unit
60
50
40
30
20
10
0
Clinical judgement/Treatment
Appointment
Attitude, conduct, cultural and dignity...
Communication issues with the patient
Access and availability
Adult Services
Children's Services
Specialist Services
Operational Support Services
Corporate & HQ functions


2018/19 Complaint Subject by Business Unit
45
40
35
30
25
20
15
10
5
0
Clinical judgement/Treatment
Appointment
Attitude, conduct, cultural and...
Communication issues with the...
Confidentiality of information
Adult Services
Children's Services
Specialist Services
Corporate & HQ functions

Appendix 5 Numbers of complaints for each top 5 subject area, broken down into Business units.

Clinical judgement/ poor treatment
Clinical Judgement/Treatment remains the subject with the highest number of complaints for all business units:

Children's Business Unit: There has been a significant decrease of more than 50% in the number of complaints in this area for the Children's Business Unit; reducing from 57 related complaints in 17/18 to 24 in 18/19.

Adult Business Unit: There has been an increase in complaints in this area for the ABU; however, this is a rise of only 7 on the previous year; with 34 related complaints in 17/18 rising to 41 in 18/19.

Specialist Business Unit: Figures for the SBU remains relatively consistent in this complaint area; with 39 related complaints in 17/18 reducing slightly to 37 in 18/19.

Appointment issues
Appointment issues remain the subject area with the second highest number of complaints for all business units:

Children's Business Unit: There has been a significant decrease in the number of complaints in this area for the Children's Business Unit; reducing from 53 related complaints in 17/18 to 12 in 18/19.

Adult Business Unit: There has been a reduction of almost half for the ABU in related complaints; with19 related complaints in 17/18 reducing to 10 complaints related to appointment issues in 18/19.

Specialist Business Unit: Figures for the SBU remain relatively consistent in this complaint area; with 39 related complaints in 17/18 reducing slightly to 32 in 18/19.

Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)
There has been an overall reduction in the number of complaints related to Attitude, conduct, cultural and dignity issues.

Children's Business Unit: There has been a reduction from 20 complaints in 17/18 in this area for the Children's Business Unit to 6 in 18/19.

Adult Business Unit: There has been a reduction from 17 related complaints in 17/18 to 9 in 18/19.

Specialist Business Unit: There has been a significant reduction for the SBU in the number of complaints received in this subject area; reducing from 37 in 17/18 to 11 in 18/19.

Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)
There has been an overall reduction in the number of complaints related to Attitude, conduct, cultural and dignity issues.

Children's Business Unit: There has been a reduction from 20 complaints in 17/18 in this area for the Children's Business Unit to 6 in 18/19.

Adult Business Unit: There has been a reduction from 17 related complaints in 17/18 to 9 in 18/19.

Specialist Business Unit: There has been a significant reduction for the SBU in the number of complaints received in this subject area; reducing from 37 in 17/18 to 11 in 18/19.

Communication issues with the patient
Communication issues with the patient remains the 4 most frequently received complaint subject, this is consistent with 17/18 reporting.

Children's Business Unit: There has been a reduction from 14 complaints in 17/18 in this area for the Children's Business Unit to 4 in 18/19.

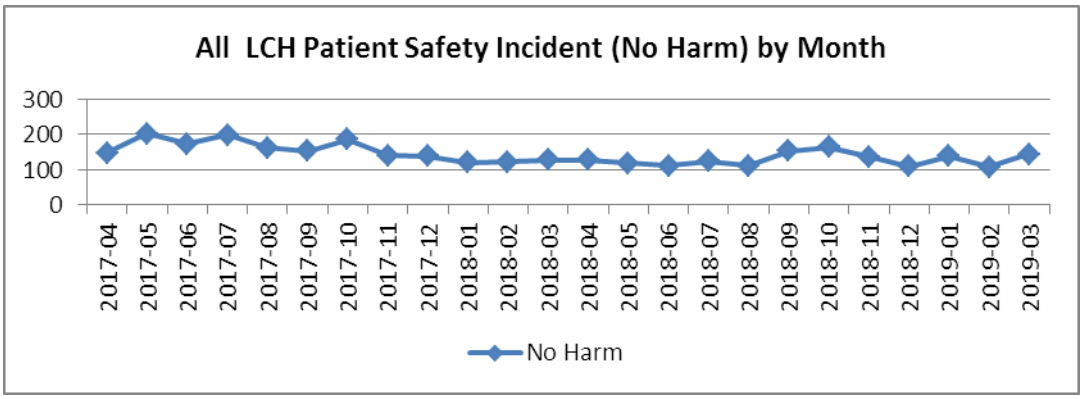
Adult Business Unit: There has been a slight reduction from 7 related complaints in 17/18 to 6 in 18/19.

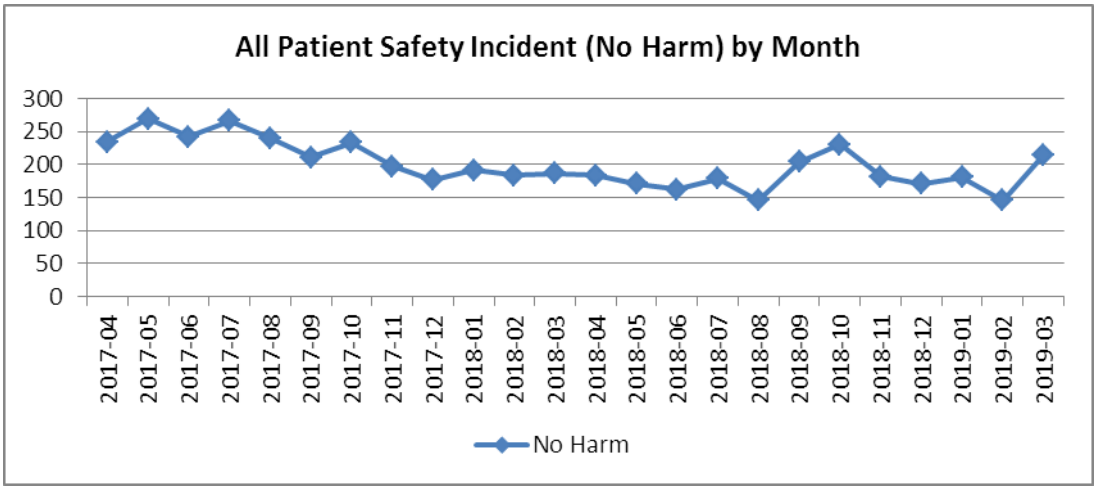
Specialist Business Unit: There has been a reduction for the SBU in the number of complaints received in this subject area; reducing from 18 in 17/18 to 11 in 18/19.

Appendix 6

Incidents Focus

3809 (58.6%) of all incidents reported in 2018/19 were no harm or near miss incidents, compared to 4802 in 2017/18 as shown in the line graph below.





1973 (51.8%) of these affected patients receiving care from LCH services in 2018/19

	No harm	Percentage
LCH Patient Incident	1973	51.8%
Other NHS Patient Incident	804	21.1%
Incidents affecting the staff	558	14.6%
Incidents affecting students or visitors	40	1.1%
Incidents affecting the Trust	434	11.4%
Total	3809	

The top three LCH patient incidents that were identified as no harm are as follows

	No harm
Medication (all)	544
Appointment	261
Implementation of care or monitoring - other	179

Appendix 7

Incidents Focus

3809 (58.6%) of all incidents reported in 2018/19 were no harm or near miss incidents. 1973 (51.8%) of these affected patients receiving care from LCH services.

	No harm	Percentage
LCH Patient Incident	1973	51.8%
Other NHS Patient Incident	804	21.1%
Incidents affecting the staff	558	14.6%
Incidents affecting students or visitors	40	1.1%
Incidents affecting the Trust	434	11.4%
Total	3809	

The top three LCH patient incidents that were identified as no harm are as follows

	No harm
Medication (all)	544
Appointment	261
Implementation of care or monitoring - other	179

Medication incidents (no harm) include missed or out of date medications; transcribing errors and medications not available among others. The medicines management team provides a 6 monthly thematic report to the Quality Committee; this contains a breakdown of all the medication incidents reported and work that is progressing within teams and services to try to reduce incidents

Appointment incidents, when broken down to service level do not show any particular team or service spikes. The largest reporters are split between the Specialist BU services of Podiatry/MSK and reception teams (figures are higher here as they are citywide services) – where the errors often occur, in 2018-2019 the podiatry service were the highest reporter of incidents relating to appointment

Reducing the incidents of appointments - Summary 2018/19

Following the ‘letter’ project a system has been put in place to ensure that admin services send out appointment letters and not the HCP.

Service Caseload holders continue to work with the admin teams to ensure patients are appropriately recorded as arrived on SystmOne and that for patients who arrive late the admin teams will have a discussion with the HCP on appropriate action to take.

Work has been undertaken within services to ensure that staff are following the correct referral pathways to specialist services including use of SystmOne reports and tasks to ensure referrals are actioned.

Services have undertaken a demand and capacity review for specific pathways and have identified additional clinical time to address waiting times.

Implementation of care or monitoring – contains a mix of clinical incidents and includes incidents such as errors with feeds or syringe drivers; blocked catheters and wounds.

The clinical governance team is reviewing how their current resource can be used for the timely data validation of all incidents

The categories list has been updated for 2019/20 and is included in all Datix training sessions, has been sent to and distributed via the Quality Leads, Community Talk and is available to download on Elsie.

Review of 'incident categorisation' has identified gaps in data validation of all incidents which includes correct categorisation of PSI, level of ham and post investigation avoidability.

Minimal Harm Incidents

1504 (23.1%) of all incidents reported in 2018/19 were of minimal harm. *"Any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons".*

	Minimal Harm	Percentage
LCH Patient Incident	948	63.0%
Other NHS Patient Incident	413	27.5%
Incidents affecting the staff	127	8.4%
Incidents affecting students or visitors	15	1.0%
Incidents affecting the Trust	1	0.1%
Total	1504	

The top 3 categories for incidents affecting LCH patients were:

Minimal Harm	
Slips, trips, falls and collisions	342
Pressure sore / decubitus ulcer	248
Incorrect identification of pressure ulcer (MASD)	73

The criteria for reportable falls has been updated and circulated to all teams. Safety huddles have increased awareness of reporting requirements and it is expected that incident reporting should increase as a result of this.

Minimum harm pressure ulcers are reported under category 2 ulcers only, however over the year this has also included tissue injuries, moisture and skin tears. The new

category set up in datix of Skin Damage will help to better group these incidents in future.

During 17/18 financial year, a review took place of the investigation process of Serious Incidents and PUs, this work included the introduction of 72 hr review for all category 2 PU's. As a result all Cat 2 incidents recorded on datix have been closed; these were all subject to a 72 hour review process, which found 247(94.6%) were deemed to be unavoidable to LCH. The 13 (5.4%) records that were marked as avoidable all have action plans linked to their record on Datix.

The themes from the 13 incidents shows missing information as the most common and was linked to 9 incidents. The text of the investigations regularly stated that the investigator thought that assessments, information & advice would have been done/given but this was not documented.

70% of the themes were linked to documentation or assessments which has remained a recurring theme.

The Wounds Prevention and Management Service (WPaMS), has completed an audit of the 13 neighbourhood teams in Jan/Feb 2019, the audit found that some assessments templates were missing or needed updating. The team is currently the process of interpreting the findings with the clinical effectiveness team.

Each service will compile an individual improvement plan based on the results of the audit.

The audit results and improvement plan is owed by the service but the clinical audit team monitors these each quarter.

Moderate Harm Incidents

794 (12.2%) of the incidents reported this year were identified as moderate harm. "*Any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons*".

Moderate Harm	Moderate Harm	Percentage
LCH Patient Incident	450	56.7%
Other NHS Patient Incident	311	39.2%
Incidents affecting the staff	27	3.4%
Incidents affecting students or visitors	6	0.8%
Total	794	794

The top categories for moderate harm incidents, with over 86% being linked to either pressure ulcers (category 3 or unstageable) or falls. Both of these areas are reported quarterly in more depth.

Sub-Category	Moderate Harm	Percentage
Pressure sore / decubitus ulcer	286	63.7%
Slips, trips, falls and collisions	102	22.7%
Implementation of care or ongoing monitoring - other	16	3.6%

Of the 286 moderate harm pressure ulcer incidents, 25 (9.1%) are still in the investigation process. Of the 261 (90.9%) closed records 247 (94.6%) were unavoidable, (not attributable to care provided by LCH staff). 14 (5.4%) incidents were avoidable. (6 category 3 and 8 unstageable ulcers). All avoidable ulcers have been recorded with StEIS, have action plans and themes have been recorded.

Of the 102 falls, 95 (93.1%) were unavoidable. Of the 7 (6.9%) that were found to be avoidable, 2 were recorded with StEIS.

The themes from both falls and pressure ulcers show that communication breakdown, either with the patient/carers or within the team were contributing factors to the outcome with documentation and a failure to identify risks also scoring highly for both.

Feedback and action plans from panels are taken back to teams and managed locally**.**

Major Harm Incidents

95 (1.5%) incidents were reported as major harm. "*Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons".*

	Major Harm	Total
LCH Patient Incident	78	82.1%
Other NHS Patient Incident	16	16.8%
Incidents affecting the staff	1	1.1%
Total	95	95

The top categories are Falls and pressure ulcers, in depth information is available for these incidents in both the quarterly, pressure ulcer and Serious Incident reports.

91% of those closed were found to be unavoidable with the remaining 6 being avoidable. These have been submitted to StEIS and consisted of two category 4 pressure ulcer and 5 falls. Themes and actions are generated for all of the above which are found to be avoidable (11 remain under investigation).

Themes appear to be similar to both moderate and minimal harm themes.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (20)

Meeting: Trust Board 24 May 2019	**Category of paper** *(please tick)*	
Report title Annual Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director Executive Medical Director **Report author** Guardian of Safe Working Hours	**For assurance**	✓
Previously considered by Quality Committee 20 May 2019	**For information**	

Purpose of the report

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

Main issues for consideration

- This report covers the period from May 2018 to May 2019.
- There has been one exception report in this time, submitted by a CAMHS trainee. Actions to resolve issues raised are detailed in this report.

Recommendations

Trust Board is recommended to:

- Note the Guardian for Safe Working Hours Report

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

1. Executive summary

This report covers the period from May 2018 to May 2019.

There has been one exception reports in this time, submitted by a CAMHS trainee. Actions to resolve issues raised are detailed in this report.

There are longstanding gaps on the CAMHS specialty trainee rota from April 2018. The Trust has been successful in filling these rota gaps with internal and external bank locums.

2. Introduction

This report, as required by the Junior Doctor's contract, is intended to provide the Board with an evidenced based report on the working hours and practices of Junior Doctors within the Trust, confirming safe working practices and will illustrate areas for concern. This report is written with the information available relating to data to date in the period covered.

Purpose: to report on issues affecting trainee doctors and dentists such as working hours and the accessibility of training which forms part of the rotational training programme.

3. High level data

Number of doctors / dentists in training (total): 19
Number of doctors / dentists in training employed by LCH 4

4. Annual data summary

Trainees within the Trust (May 2019)

Department	No.	Grade	Status
Adults	0		Employed
CAMHS	3	STs	Employed
	5	CT	Honorary (1 maternity leave)
Community Paediatrics	5	STs	Honorary
Sexual Health	1	ST	Employed
Dental Services	5		Honorary

5. Exception Reporting

One report raised.

5.1 Working Hours

No exception reports raised relating to working hours in this period.

5.2 Educational Opportunities

One exception report raised by a CAMHS trainee: in relation to increased service provision linked to CAMHS outreach consultant's paternity leave.

Action points:

- The trainee's timetable was reviewed and revised to their satisfaction in a meeting with their clinical supervisor and medical lead.

6. Rota Gaps

6.1 Out of Hours on call rota gaps in CAMHS

From April 2018, there are regular rota gaps in the CAMHS 2nd on call rota.

The trust has been successful in covering these gaps as locum shifts, using both existing and external workforce. Since the last GfSWH report, the Trust has developed a "bank" of suitable doctors, safeguarding against future rota gaps.

7. Guardian for Safe Working Hours

7.1 Dr Turlough Mills was appointed in October 2017.

7.2 The Junior Doctor's Forum (JDF) was held in November 2018 and in March 2019. There were no trainees in attendance at the March JDF. Both the GSWH and the LNC plan to target paediatric trainees in an attempt to boost membership.

7.3 GSWH Data Report

No fines have been levied by the Guardian of Safe Working Hours.

8. Recommendation:

Trust Board is recommended to:

- Note the Guardian for Safe Working Hours Report

Dr Turlough Mills
Guardian of Safe Working Hours
May 2019

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (21)

Meeting Trust Board – 24 May 2019	**Category of paper** *(please tick)*	
Report title Workforce Strategy 2019-2021: Progress & Delivery - Leadership & Skills	**For approval**	
Responsible director: Director of Workforce, OD & System Development **Report author :** Head of OD & Improvement	**For assurance**	√
Previously considered by Business Committee – 22 May 2019	**For information**	√

Purpose of the report

To provide Business Committee with an update on progress and delivery on the Leadership & Skills Development workstream within the Workforce Strategy.

Main issues for consideration

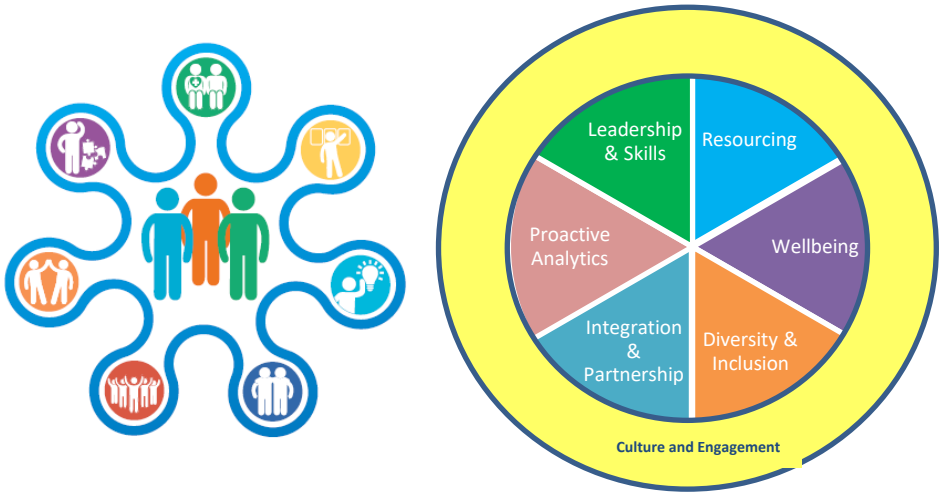
Significant progress has been achieved during the last 6 months:

- The new Leadership offer Leading By Example is operational with excellent take-up
- A Shadow Board development programme has been commissioned for launch in Autumn 2019
- A Trust Board Development programme has been designed for 2019/20
- A Talent Management Approach has been agreed by SMT
- The Statutory& Mandatory Training Compliance project has been established and is making good progress, with demonstrable impact
- The Trust's Learning & Development offer has been scoped and priority work areas for 2019/20 identified

Recommendations

The Board is recommended to:

- Note the progress made on Leadership & Skills development in the last six months
- Endorse the approach identified for this workstream during 2019/20



Workforce Strategy 2019-21: Progress and Delivery

Ensuring LCH's workforce is able to deliver the best possible care in all our communities

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

1. Introduction

The LCH Workforce Strategy 2019-21 was approved by the LCH Board on 1 February 2019. It was agreed that the Board would receive an update on one of the Strategy's 6 priorities at each of 2019/20's Public Board meetings.

This report provides the Trust Board with an update on the progress made on the delivery of the **Leadership & Skills** priority during the period October 2018 – April 2019.

Details of the other 5 priorities and the associated schedule of dates for their updates to be presented at Board are at ***Appendix 1***.

2. Leadership & Skills

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

The Leadership & Skills priority is on target at present. Over the past 6 months, significant progress has taken place in both **Leadership Development** and **Skills Development**. This is described in more detail in sections 3 and 4, below.

Progress has been primarily delivered by the dedicated Organisational Development & Improvement (OD&I) team, with support from other areas of the Workforce Directorate and excellent engagement from across the organisation.

A full summary of the 2019-21 objectives associated with the Leadership & Skills priority is at ***Appendix 2***.

3. Progress: Leadership Development

There has been significant progress on leadership development over the last six months:

LCH's redesigned Leadership & Management offer, **Leading by Example,** was launched in January 2019. Module dates for the calendar year 2019 are now almost full for each component of the programme, which aims to deliver training to 180 managers and aspiring managers before the end of 2019/20.

Take up has been encouraging, with only 13 places remaining in 2019/20 across the 3 modules of the programme and external interest from the GP Confederation and Primary Care Networks. Options for increasing the programme's capacity in-year are being scoped.

- **Leading LCH** commenced in January 2019 and two cohorts (27 leaders) have completed the programme. A further 14 attended the launch in April for the next cohort in May.
- **Management Essentials** went live in February 2019; 2 courses have been delivered (24 participants)
- **Manager as Coach** has delivered three cohorts since January 2019. This continues to be an important and very popular component of our overall programme; all places for 2019/20 have now been taken.

Feedback from participants on the new Leading LCH programme is included below:

"I would like to thank you both again for developing this programme, it held great value and opportunities to reflect and focus on my specific development needs which has been crucial. The conversations in the room, learning from colleagues not only inspired me but comforted and supported me knowing I am not alone with my weaknesses/limitations and the long journey ahead for leadership development.
The content of the three days was better than I anticipated, the underpinning research was helpful and talent management was insightful.
Thank you again"
Sam Austin
Palliative Care Clinical Lead (Palliative Care Service)

"The peer support group we set up including Ikenna, Julia, Sam and myself met last Wednesday and had a really positive couple of hours together. It was a great start, we set some clear terms of reference for the group as advised in the workbook and have scheduled recurring get togethers every 6 weeks. I think we all felt they will be really helpful moving forward.
Thanks for your support, we'll keep you updated on how it progresses."
Sam Coupland
Change and Development Lead – Adult Business Unit

The Systems Leadership component of Leading LCH is being adopted as a city-wide module by our partner organisations; and a cohort of GP Confederation colleagues will complete the overall Leading LCH programme during 2019/20. Feedback on this component of the programme has also been very positive:

- *"Thinking in a systems way for the first time – I have never thought of my system before"*
- *"Feel enlightened about Leeds and its direction feel excited at the potential progress for the population and what we can achieve by working together"*
- *"I was struck by the data of the poor health of communities"*
- *"Understanding the wider picture as health leaders – very powerful!"*
- *"The importance of understanding different perspectives"*
- *"The sessions being so interactive – lots of great thought provoking discussion"*

A **Leadership Competency Framework (LCF)**, which is rooted in the LCH 7 Behaviours, has been developed and tested with the early cohorts of participants on Leading LCH. Feedback from this, and the preceding engagement period, has been very positive. Further publicity and positioning of the LCF is scheduled through the summer of 2019.

A **Shadow Board** development programme has been commissioned and will be launched during 2019/20 which targets below Board level senior managers. Invitations for participation have gone out in May 2019, and the programme goes live in September 2019.

A **Board Leadership** programme has been developed and discussed with SMT for implementation during 2019/20.

All of the leadership development activity over recent months is beginning to demonstrate an impact. Staff survey results for 18/19 indicate an increase of 6% regarding satisfaction with support from line managers from the previous year. This is reinforced in the Q4 Friends 7 Family Test data which shows a 4% increase in satisfaction with support received from line managers.

4. Progress: Skills Development

The **Statutory & Mandatory Training Compliance Project** targeted at the six statutory and seven priority training competencies for the Trust launched in January 2019. Its focus is on consolidating the training matrix, and improving the configuration and structure of ESR. The benefits of this project are twofold:

- greater clarity for staff and managers about the specific training required by different roles within the organisation
- increased accuracy and reliability of compliance recording and monitoring via ESR

The project is also ensuring alignment of LCH training with the Core Skills Training Framework to ensure that staff within Leeds who move between organisations, can retain their compliance.

The project is demonstrating impact; compliance for Statutory and Mandatory Training has improved, currently standing at **93.5%**

A **Talent Management** approach has been developed and approved by SMT. The priority areas of focus are organisational succession planning for critical roles and the promotion of a development culture, using appraisals as the vehicle for high quality career development discussions. Work is now underway with Business Units and Corporate colleagues to implement the approach, with an early focus on the role of and support for appraisals.

The current **Learning & Development offer** for the organisation has been mapped in conjunction with colleagues leading Clinical Education. This is informing key areas of focus for 2019/20 including the completion of an organisational Training Needs Analysis, improved communication and coordination of the Learning & Development offer to staff, capacity for student and learner support, the role of apprenticeships and support staff training opportunities. This work programme will be defined by June 2019, and the governance arrangements for monitoring implementation and progress will be agreed.

5. Risks to Delivery:

Identified risks to the Leadership and Skills Development workstream are set out below, together with mitigating actions

Risk	Likelihood (RAG)	Severity (RAG)	Mitigation
Capacity to deliver: The significant work agenda associated with this workstream is dependent upon a small number of people, including one role which is funded non-recurrently.			• Recruitment is underway to secure established posts within the ODI team. • Options for increasing capacity are being explored, around leadership development delivery and Statutory & Mandatory compliance project. • Resourcing conversations also underway with QPD colleagues around shared capacity for the Learning & Development agenda
Impact of leadership development interventions is not manifested in practice: Leadership and management culture and capability across the organisation does not reflect LCH vision, values and behaviours, despite extensive leadership development opportunities			• Robust evaluation framework for leadership development programmes • Regular monitoring of outcome indicators: staff views via FFT & Staff Survey, Business Unit performance, organisational reputation • Ongoing communication with organisational leaders to ensure appropriate targeting of leadership development opportunities for individuals

6. Recommendations

The Board is recommended to note the significant progress which has been made in the area of **Leadership & Skills Development**, and endorse the continuing work programme as set out for 2019/20.

Appendix 1: LCH Workforce Strategy Priorities & Board dates

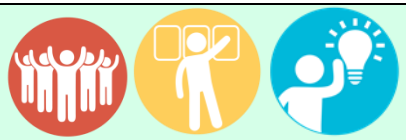
Priority	Priority's Aim	RAG status	Planned update to LCH Board
Leadership & Skills	We support the development of our leaders to ensure that every individual at LCH experiences good or excellent leadership and has access to appropriate training and development, regardless of where in the organisation they work.		**May 2019**
Resourcing	We recruit the right people with the right skills and deploy them to deliver the best possible care in all of our communities for now and for the future.		**August 2019**
Health & Wellbeing	Our staff at LCH are more likely to be well and at work as well as more engaged with work irrespective of service or geographical location than in 2016-18.		**October 2019**
Diversity & Inclusion	Each member of the workforce is treated as an individual, with particular regard to advancing equality for those with a protected characteristic.		**December 2019**
Integration & Partnership	We work effectively as a system partner in the development and implementation of workforce and HR strategies, systems and plans across primary care, the city of Leeds and the West Yorkshire & Harrogate Integrated Care System (ICS)		**February 2020**
Proactive Analytics	Workforce systems including the Electronic Staff Record are improved by a newly-created Systems & Intelligence function, delivering sophisticated workforce data and analytics that drive impactful business decisions.		**March 2020**

Appendix 2: Leadership & Skills Objectives (from the LCH Workforce Strategy 2019-21)

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

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

This priority aligns with the following organisational behaviours:



Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (22)

Meeting Board 24 May 2019	**Category of paper** *(please tick)*	
Report title Well Led Framework Self-Assessment Update	**For approval**	✓
Responsible director Chief Executive **Report author** Business Planning Manager	**For assurance**	
Previously considered by	**For information**	

Purpose of the report

The purpose of this report is to provide an update to Board on our Well-Led Framework self-assessment, progress addressing key areas for development and the focus for development going forward.

Main issues for consideration

Self-assessment rating

The report to Board in February 2019 set out SMT's assessment of the Well-Led Framework which was informed by a review of other Trusts' CQC reports, extensive engagement with managers, staff and Staff side and the Well Led peer review by Cambridgeshire Community Services NHS Trust as well as key internal documents such as the BAF and the Trust risk register.

Board agreed:

- ✓ **self-assessment overall rating: GOOD**.
- ✓ **rating of KLOEs 1-6: GOOD**
  - 1: Leadership capacity and capability
  - 2: Clear vision and credible strategy to deliver high quality sustainable care and robust plans to deliver
  - 3: Culture of high quality sustainable care
  - 4: Clear responsibilities, roles and systems of accountability to support good governance and management
  - 5: Clear and effective processes for managing risks, issues and performance
  - 6: Robust and appropriate information being effectively processed and challenged
- ➢ **rating KLoEs 7 and 8: REQUIRES IMPROVEMENT**:
  - 7: service user, public, staff and external partner engagement. The rating reflected the lack of an overall organisational strategy for engagement although

these existed at unit or service level and the need to consider whether there was enough staff resource focussed on to support effective service user engagement across all services Iit was recognised that there is outstanding practice across several services.

8: Systems and processes for learning, continuous improvement and innovation. The rating reflected the requirement to continue to develop and embed our quality improvement approach building on good progress in 17/18 and start of 18/19

SMT reviewed the updated Well-Led Framework action plan 24 April and the KLoE ratings.

- ✓ **SMT's self-assessment overall rating remains: GOOD**

- ✓ **SMT now rates all 8 KLoEs: GOOD**

KLoE 7: service user, public, staff and external partner engagement: is now rated 'good' reflecting:

- ✓ resource to provide strategic leadership and support to services is now well established in post and having good impact across services: Band 7 Lead and Band 5 Officer
- ✓ SMT have considered the report that we commissioned from Healthwatch's which baselines patient involvement and engagement, across the Trust highlights good and outstanding practice across all 3 Business Units, and recommends areas for development
- ✓ Engagement with commissioning and provider partners across the city to explore potential for joined up / common approaches

✓ Overall strategy development is underway

✓ KLoE 8: systems and processes for learning, continuous improvement and innovation: is now rated 'good' reflecting:

- ✓ All 3 BUs continuing to focus on improving staff's ability to contribute to improvements as 1 of their obsessions for 2019/20.
- ✓ Good progress aligning Quality Improvement (QI) with other quality and cultural development initiatives e.g. clinical audit, Research, quality challenge CEG, PSEG and through the QI Steering Group
- ✓ Further development of skills and expertise: in 2018/19 76 additional staff participated in internal and external QI training. QI training is now included in the Management Essentials training which is well attended
- ✓ Multiple QI projects underway at business unit and system level including a very successful Diabetes Integrated Pathway rapid improvement event and 4 'learning' projects, supported by the QI Team and Improvement Academy, which we are using to test the QI methodology and provide learning about our QI approach
- ✓ Resources and information developed and available via Elsie QI Hub page

Progress in Other Key Areas for Further Development

Our People

- ✓ Staff engagement and morale: the 2017 and 2018 national staff survey results provide significant encouragement that the sustained focus on engagement and creating a supportive, inclusive, open culture is driving improved staff morale and satisfaction.
- ✓ We are particularly proud of our work to support race equality, people with

disability and / or mental health issues. This includes the Race for Equality event, our Reverse Mentoring scheme, and work to raise awareness about and create an open and supportive environment for staff with mental health issues including training 16 Mental Health First Aiders. Staff continue to join the BME network and come forward to get involved in 50 Voices, become disability champions and talk about mental health

- ✓ Leadership and management development: excellent progress in refreshing our leadership and management offer for junior and middle managers. The key focus going forward will be developing our approach to talent management and succession planning.Courses are increasingly oversubscribed and high level of positive feedback. 73% of all staff said they had good support from their immediate manager (staff survey survey)

Quality

- ✓ LCH and the CCG have invested in additional resource for 2019/20 to enable the work to develop reporting on outcomes to progress at a faster pace
- ✓ Ensuring effective oversight by SMT in relation to response time for complaints and incidence of restraint through regular reporting

Governance and strategy

- ✓ Board visibility: Board members are out and about but this was not widely understood except by visited services or through Thea's blog. This is being successfully addressed through the introduction of 'Postcards from LCH' on Elsie
- ✓ Developing understanding about LCH strategy: Chief Exec vlogs introduced May '19 focussing initially on our strategic objectives and priorities for 19/20. Business Unit 19/20 plans on a page will be cascaded within Business Units. February 2019 Board received a paper outlining our strategy.
- ✓ Ensuring discussions and decision-making at SMT and Board workshop sessions are fully minuted.
- ✓ Continued work to ensure that information is triangulated at business unit, senior ops, SMT and committees and boards so we are always looking for patterns and trends
- ✓ Current limitations of ESR is now reflected on the risk register. Phased programme of work to address this continues to be progressed as a priority to ensure successful implementation of E-rostering

Key Areas For Further Development

Our people:

- ✓ Talent management and succession - this work is underway but not fully developed
- ✓ Implementation and further development of our health and well-being offer
- ✓ Implementation and continuing to develop our work on WRES and disability action plans
- ✓ Reviewing training and development to ensure alignment to organisational objectives
- ✓ Progressing work to establish senior oversight of service specific statutory and mandatory training

Quality improvement:

- ✓ Continuing to consolidate and embed our Quality Improvement approach across all areas of the Trust and grow the great work already underway

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 the new strategy and continues to develop to all areas are outstanding
- ✓ Continuing to develop our approach for reducing unwarranted variation, including making effective use of benchmarking data
- ✓ Continuing to develop our work on outcomes across all service areas

Governance and strategy

- ✓ Completing the excellent work already undertaken to clarify and ensure effective, robust partnership governance as increasingly complex partnerships develop
- ✓ Maintaining focus on developing further staffs understanding of our strategic direction and demonstrating link to overall strategy
- ✓ Ensuring further focus on triangulation of data to understand services better and drive improvement
- ✓ Completing the work to ensure ESR is accurate, reliable and timely and meets staff and managers needs
- ✓ Embedding mechanisms to share learning routinely across Business Units

Finance

- ✓ Developing new processes for CIP/ waste reduction with our staff.
- ✓ Ensuring finance and QIA continue to work closely together in understanding our money and its impact on quality and outcomes.

Audit report

Since the report to February Board, the Internal Audit of the Trust's Well Led Framework approach and processes has been completed. The audit concluded:

The self-assessment and evidence based processes that support the Trust's Well-Led framework are robust. The introduction of continuous review of the framework will serve to further strengthen processes. Overall assurance assessment: reasonable assurance

The recommendation for continuous review of the framework was accepted and is consistent with the approach previously agreed with SMT and this indeed provides the first review and update to Board.

Recommendations

The Board is recommended to:

- Agree the revised RAG ratings for the individual KLoEs and overall RAG rating: Good
- note progress and the focus for further development

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (22)

Meeting Board 24 May 2019	**Category of paper** *(please tick)*	
Report title Well Led Framework Self-Assessment Update	**For approval**	✓
Responsible director Chief Executive **Report author** Business Planning Manager	**For assurance**	
Previously considered by SMT 24 April 2019	**For information**	

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- ✓ Engagement with commissioning and provider partners across the city to explore potential for joined up / common approaches
- ✓ Patient Engagement Champion network re-established and the Patient Engagement Champion role is being formalised, supporting effective leadership for patient engagement in every service
- ✓ Overall strategy development is underway

KLoE 8: systems and processes for learning, continuous improvement and innovation: is now rated 'good' reflecting:

- ✓ All 3 BUs continuing to focus on improving staff's ability to contribute to improvements as 1 of their obsessions for 2019/20.
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The recommendation for continuous review of the framework was accepted and is consistent with the approach previously agreed with SMT and this indeed provides the first review and update to Board.

Recommendations

The Board is recommended to:

- Agree the revised RAG ratings for the individual KLoEs and overall RAG rating: Good
- note progress and the focus for further development

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (23)

Meeting: Trust Board 24 May 2019	**Category of paper**	
Report title: Corporate Governance Report	**For approval**	√
Responsible director: Chief Executive **Report author:** Company Secretary	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This paper covers a number of corporate governance requirements for consideration.

Main issues for consideration

The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust. In the main, these are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

Adherence to this governance framework enables the organisation to demonstrate it is well governed and meets the requirements of corporate governance codes.

In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met.

This paper covers a number of annual requirements, including:

- Board and Committees' effectiveness review (section 3)
- Audit Committee annual report 2018-19 (section 4)
- Committees' terms of reference review (section 5)
- Statement of NHS provider licence compliance (section 6)
- Amendments to standing orders and standing financial instructions (section 7)
- Details of use of the Trust's corporate seal (section 8)

Recommendations

The Board is recommended to:

- Note the outcome of the annual review of Board and Committees' effectiveness
- Receive the Audit Committee's annual report 2018/19
- Note there are no changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions
- **Approve** the revisions to the standing orders/standing financial instructions
- Note use of the corporate seal within the register of sealings

Corporate Governance Report

1 Purpose of the report

1.1 The purpose of the report is to provide a number of requirements for consideration on an annual or infrequent basis in relation to the effective corporate governance of the Trust.

2 Background

2.1 The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust.

2.2 In the main, these statutes, regulations and guidance are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

2.3 Adherence to this governance framework enables the organisation to demonstrate that it is well governed and meets the requirements of corporate governance codes.

2.4 In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met. This paper deals with a range of related assurances.

3 Annual review of Board and Committees' effectiveness

3.1 At all levels in the NHS, boards are encouraged to periodically review their own performance in order to build on strengths and to identify areas where there is room for further development in order to draw out the full benefits of the NHS unitary Board model.

3.2 The report at **Appendix A** provides a summary of the outcomes from an exercise to review the effectiveness of the non-executive and executive contribution to the Board, Board sub-committees and the wider Trust.

4 Committees' annual reports 2018/19

4.1 The terms of reference of the Trust's Audit Committee require that the committee has oversight of Board sub-committees annual effectiveness process and reviews the adequacy of the governance of the sub-committees. This assurance is given through the provision of an annual report from Board sub-committees to the Audit Committee.

4.2 In turn, the terms of reference for each committee require that the committee's chair submits an annual report to the Audit Committee which demonstrates how the committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and committee's work plan. The reports provide an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference.

4.3 At the Audit Committee on 26 April 2019, the annual reports for 2018/19 for the following committees were received:

- Quality Committee
- Business Committee
- Charitable Funds Committee
- Nominations and Remuneration Committee

4.4 Each report had been reviewed by the committee's chair and executive lead and by the relevant committee. The reports provided an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference. Sections within each annual report described:

- Duties of the committee
- Membership and attendance
- Review of committee's activities
- Review of effectiveness
- Areas for future development

4.5 In order to complete this cycle of review, the Audit Committee's annual report for 2018/19 is attached at **Appendix B** for receipt by the Board and demonstrates that the committee has operated in lines with its terms of reference and has undertaken a review of its effectiveness.

5 Committees' terms of reference

5.1 The Trust's Board has appointed five sub-committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically (as recorded in standing orders). In March and April 2019, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

5.2 No changes were made to the five sub-committees terms of reference following the review.

5.3 In order to reflect the best distribution of Board membership across the committees so that they are able to fully discharge their respective responsibilities, committee membership for 2019/20 is shown in the table below.

	Non-executive directors	Executive directors
Audit Committee	Jane Madeley (chair) Richard Gladman Prof Ian Lewis	N/A
Quality Committee	Prof Ian Lewis (chair) Helen Thomson Neil Franklin	Chief Executive Executive Medical Director Executive Director of Nursing and AHP's
Business Committee	Brodie Clark (chair) Helen Thomson Richard Gladman	Chief Executive Executive Director of Finance & Resources Executive Director of Operations
Charitable Funds Committee	Brodie Clark (chair) Neil Franklin	Executive Director of Finance & Resources Executive Director of Nursing and AHP's
Nominations and Remuneration Committee	Neil Franklin (chair) Brodie Clark Jane Madeley	N/A

5.4 In addition, the Quality Committee has a number of sub-groups, one of which, the Mental Health Act Governance Group, is chaired by a non-executive director; this function currently rests with Prof Ian Lewis.

6 Compliance with NHS provider licence: self-certification

6.1 The Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence. Although NHS trusts (which are not NHS foundation trusts) are exempt from holding the NHS provider licence (as required for foundation trusts), NHS Improvement is required to ensure that NHS trusts comply with the licence conditions as it deems appropriate. NHS Improvement's single oversight framework bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including condition G6 and condition FT4) and must self-certify under these licence provisions.

6.2 In particular, providers need to self-certify against the following two conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (condition **G6**) (self-certification required by 31 May 2019)
- The provider has complied with required governance arrangements (condition **FT4**) (self-certification required by 30 June 2019)

6.3 The document attached at **Appendix C** is a tabulation showing an assessment of compliance with the provider licence's conditions; including the two conditions (G6 and FT4) against which the Trust is required to self-certify. It should be noted that a limited number of conditions are not applicable as they apply to foundation trusts only.

6.4 When reviewing the document, the Board will note that the Trust is recording compliance against all applicable conditions.

7 Changes to standing orders, standing financial instructions and scheme of reservation and delegation of powers

7.2 NHS trusts are required to adopt standing orders and standing financial instructions and to establish a schedule of powers reserved to the Board and a scheme of delegation.

7.3 Standing orders and standing financial instructions are essential foundations for the good governance of the Trust and set out:

- Mechanisms for how the Trust Board conducts its business
- Decision making powers delegated from the Board
- Expectations of the Trust as to the conduct of individuals entrusted with public resources
- Principles and procedures that direct financial conduct

7.4 On 22 March 2019, a review of the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers was completed and reported to the Audit Committee. The Audit Committee noted and approved the amendments in line with the summary of changes. The table shown at **Appendix D** summarises the changes to be made in order to amend and update content.

8 Use of the corporate seal

8.1 In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal. During 2018/19 the seal has been used on a small number of occasions. The details are contained within a copy of the register attached as **Appendix E.**

9 Recommendations

9.1 The Board is recommended to:

- Note the outcome of the annual review of Board and committees' effectiveness
- Receive the Audit Committee's annual report 2018/19
- Note there are no changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions
- Approve the revisions to the standing orders/standing financial instructions
- Note use of the corporate seal within the register of sealings

Appendix A

Leeds Community Healthcare NHS Trust
Reviewing Board and Committees' effectiveness

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the comments received from the review, by Board members, of the effectiveness of the Board and the Board's sub-committees.

1.2 The sections below provide anonymised information gathered from a Board effectiveness diagnostic exercise and the conclusions from a Board effectiveness workshop held on 4 January 2019.

2.0 Background

2.1 By way of context, the purpose of NHS Boards is to govern effectively and in doing so to build patient, public and stakeholder confidence that health and health care is in safe hands *(The Healthy NHS Board 2013).* In meeting this purpose the Board has three key roles, to:

- Formulate strategy
- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of controls are robust and reliable
- Shape a strong culture for the Board and the organisation

2.2 The Trust Board reflects on an annual basis how non-executive and executive colleagues can further develop as a team to:

- Ensure strong and effective leadership at Board level and throughout the Board sub-committees
- Develop a culture of full and proper personal accountability
- Maintain a strategic perspective
- Ensure the Trust identifies the necessary operational changes to meet the quality and financial sustainability challenge
- Balance risk and opportunity
- Work in a partnership environment

2.3 Two questionnaires were completed by Board members; one related to Board effectiveness and the second was applicable to committees' effectiveness. The questionnaires comprised 20 statements grouped under the headings of *leadership and accountability* and *strategy development and operational delivery* (Board questionnaire) and *capacity, capability and ways of working* and *conduct of business and effectiveness of decision-making* (committees' questionnaire).

2.4 The questionnaires asked for ratings on a scale of 1 (strongly disagree) to 5 (strongly agree); plus narrative comment on opportunities for change. Responses in the questionnaires remain anonymous and have only been used to distil themes to facilitate discussion.

3.0 Board self-assessment: summary of responses

3.1 The Board scored itself highly on the following areas:

- The Board was assessed as being high quality, with a complimentary mix of members
- The Board was regarded as 'well-led' with strong, visible leadership.
- The Board demonstrate the Trust's values and behaviours in the conduct of its business
- Board members bring expertise, perspective and challenge to strategy development
- Clear and objective decisions are made and there is clear accountability for subsequent action

3.2 The Board viewed the following areas as possible scope for improvement, as although these areas also scored reasonably well, they achieved the lowest scores:

- Quality of information/ reports
- Clearly described vision and strategy, aligned to internal capacity and capability and the wider external environment
- Communication of early warning signs

3.3 The Board workshop event on 4 January 2019 provided an opportunity to review the information in the self-assessments.

3.3.1 The Board reflected on issues with reports and how reports were being improved. The question was how to get the right level of information, triangulated, in order to ask the right questions and to be concerned about the right things. Some reports are not able to help provide assurance via committees to the Board. The Board agreed that services should feel confident to speak up about issues and recognise that the organisation can help. It was agreed that the narrative in some reports had improved. The length of reports remained an issue – they should be succinct, with analysis and recommendations – details could be appended. The Board reflected that it needed to be clearer on what is wanted. The executives needed to 'own' the papers. A report writing course has been commissioned, with staff who write high-level reports being asked to attend.

3.3.2 Early warnings – the senior management team was conscious that it needed to act on early warnings and these could be obtained through softer intelligence, not just through key performance indicators.

3.3.3 Regarding strategy, the Board agreed that the work plan schedule of reports for the Board takes up the majority of time on the agenda and the agenda needed to reflect what SMT was discussing in terms of strategy. Other papers could be briefings that do not necessarily need discussion. A 'star' system could be used for items that are for information, but are individually flagged if a Board member needs to raise a point.

3.3.4 Visibility of the Board was also discussed. It was suggested that when Board members were conducting service visits they should photograph themselves

out and about (CEO has emailed Board members to suggest this already). This information could feature in Community Talk. Another suggestion was a guest blog in Community Talk. To enable improved visibility there needed to be better and more advanced communication of any events that the Board may be able to attend. A Trust diary/ year planner was suggested.

3.4 The agreed next steps were to have a development day for the whole Board; possibly an 'away day' or facilitated event.

4.0 Audit Committee self-assessment: summary of responses

4.1 The Audit Committee scored highly in all areas, it scored particularly well in core purpose, values and behaviours, leadership, encouraging participation and consensus, recording and completing actions, relationship between Committee and Board.

4.2 The Committee members reflected on the self-assessment scores and comments and discussed the ways in which the Audit Committee linked in with other Board Subcommittees and agreed the following improvements:

- The Committee members will spend time at the end of each meeting to review how it has gone
- The Committee will review the information governance material provided to itself and to the Business Committee to ensure that there is no duplication or blurring of responsibilities

5.0 Quality Committee self-assessment: summary of responses

5.1 All members of the Committee were asked to complete a self-assessment questionnaire. A range of statements were scored. The main points raised were as follows:

- The Committee scored itself highly on the following areas: Individual members and attendees values and behaviours, their skills and knowledge, the open and constructive debate, and the Committee's relationship.

- The Committee scored itself lowest in these two areas: Information received, which is improving however limited analysis, repetition and inconsistencies have sometimes hampered discussion. The scale of membership and attendees is very broad and not all attendees are engaged

- Other comments made were: The Committee/Board relationship is strong; however there is some repetition of business. The relationship with subgroups is improving, and identification of key issues in subgroup minutes is helpful. Leadership of the subgroups had improved.

- Whilst the Committee has an existing work plan for 2019/20, the Committee is currently reviewing its format and flow of business. The above information will be used to inform the Committee's revised format and work plan.

6.0 Business Committee self-assessment: summary of responses

6.1 All members of the Committee were asked to complete a self-assessment questionnaire. A range of statements were scored. The Committee followed up this exercise with a discussion and consensus about the responses. The main points raised and discussed were as follows:

- The Committee scored highly in all areas, with the exception of receipt of adequate and appropriate information
- The Committee recognised that whilst information in the form of reports presented to the Committee was improving, there was still further improvement to be made as there was occasionally too much detail and not enough focus. The Committee was advised that report-writing courses are being offered to key staff, with the first course on 19 March 2019
- Creation and use of Business Intelligence information could be improved
- A high level of commitment is demonstrated by all members, with an increasing level of 'off-line' sponsored work being progressed by Committee members
- A more challenging approach and scrutiny of financial information is needed
- More time is required on the agenda to consider cross-cutting topics, for example service development, digital, estates. The Committee was advised that Workforce Information and Business Intelligence were working together to devise a process of triangulation of data
- The relationship between the Committee and its one subgroup, the Health and Safety Group, is relatively new therefore difficult at this stage to evaluate

7.0 Charitable Funds Committee self-assessment: summary of responses

7.1 Members of the Committee have assessed the effective working of the Committee and have also regularly reviewed the Committee's work plan during the course of the year. Some of the main points of consideration are been as follows:

The committee's strengths

- The Committee meets the requirements for effective governance
- Leadership of the Committee is effective and participation is encouraged
- Discussion is uninhibited, clear and open with robust, purposeful and constructive scrutiny and challenge

Some improvements have been identified

- Reports and information is of variable quality and sometimes received at the last minute
- Actions are not always being completed within timescales

- The Committee does not have members with significant experience of fund-raising.
- A Trust Board steer has been requested on the direction of travel of the charity and this is currently being followed up by the Board

8.0 Nominations and Remuneration Committee self-assessment: summary of responses

8.1 The Committee reviewed its effectiveness and agreed:

- It is a well led committee with clarity on aims and requirements.
- Reports provided to the Committee have improved since the permanent appointment of the joint Workforce Directors.
- There is good recording and proper follow up of actions
- The review of effectiveness has not identified any weaknesses that require remedial actions

Audit Committee: Annual Report 2018/19

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the Audit Committee's activities during 2018/19.

1.2 The terms of reference for the Committee require that the Committee's Chair submits an annual report which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2.0 Background: Duties of the Committee

2.1 The Audit Committee is one of five committees established as sub-committees of the Trust's Board and operates under Board approved terms of reference.

2.2 The Committee is well established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the Committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- **Internal audit:** ensuring that there is an effective internal audit function that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud, managing security and shall review the annual plan and outcomes of work.
- **Data security and information governance:** ensuring the Trust has robust information governance processes and that it complies with National Data Security Standards.

- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work.
- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the Board of Directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board.
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation.

2.5 The Information Governance (IG) Group is a subcommittee of the Audit Committee. The Group meets every two months and discharges a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference. The IG Group is responsible for ensuring that the Trust has effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. Approved minutes from the Group are received by the Audit Committee.

3.0 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership, which is as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience and who serves as the chair of the committee
    - Jane Madeley (Chair)
    - Richard Gladman (Deputy Chair)
    - Professor Ian Lewis

3.2 In addition to the membership, the following participants are required to attend meetings:

- Executive Director of Finance and Resources
- Company Secretary
- Internal audit representative
- External audit representative
- Counter fraud specialist

3.3 The Chief Executive attends to discuss the process for assurance that supports the annual governance statement, the annual report and accounts and the draft internal audit plan.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally six times in the last 12 months and has been quorate on all occasions. In addition, there was one informal meeting. A table recording attendance is shown below.

Attendee	20 April	11 May (informal)	23 May	20 July	19 Oct	14 Dec	22 Mar	Total (7)
Jane Madeley	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Richard Gladman	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Ian Lewis	Yes	Yes	No	Yes	Yes	Yes	No	5/7

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting.

4.0 Review of Committee's activities

4.1 The Audit Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasional further items that have arisen as a result of specific issues brought to the Committee's attention from internal or external sources.

4.2 *Governance, risk management and internal control*

4.2.1 The Committee reviewed the annual governance statement for 2018/19 in March 2019 prior to it being submitted for approval by the Board. In considering the statement, the Committee reviews assurances from a range of sources including the Head of Internal Audit opinion which it expects to receive in April 2019. The Committee requested additional information to be added including a section on counter fraud and an expansion of the data security section.

4.2.2 Annual reports have been received from internal audit, counter fraud, security management and Board sub-committees.

4.2.3 The Committee reviewed the process for, and the nature of strategic risks contained within the board assurance framework (BAF) in July and December 2018. The effectiveness of the controls in place was questioned by the Committee particularly where the initial and current scores were rated the same score and a further review of the strategic risks, controls and mitigations was then conducted by the relevant directors.

4.2.4 When the Committee conducted a review of the BAF in July 2018 it recommended that an additional strategic risk should be added concerning the threat of cyber security. The Board agreed and the risk was added and assigned to Audit Committee in order that the Committee can determine assurance levels from the sources of assurance it receives and report these to Trust Board.

4.3 *Internal audit*

4.3.1 The Audit Committee has delegated authority to ensure the Trust has an effective internal audit function. The Internal Auditors provide an essential part of the Trust's system of internal control. The Trust's internal audit service is currently provided by TIAA Ltd.

4.3.2 The Committee reviewed and agreed an annual internal audit plan for 2018/19, which proposed 22 audits. In completing the audit plan, the Committee reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and overseen progress. Topics have included a broad mix of financial, governance, operational and quality topics.

4.3.3 Where deemed appropriate the outcome of internal audits was shared with the relevant Board committee, which provided the opportunity to consider the robustness of actions to address recommendations and the associated timescales.

4.3.4 The Committee closely monitored progress against the internal audit plan in an effort to avoid slippage and over running toward the end of the financial year. The Committee received a progress report against the audit plan in April 2019 and was pleased to note that all but one audit had been completed, with the final audit in draft version. All but one of the internal audits completed have been given a reasonable assurance opinion.

4.3.5 In April 2019, the Head of Internal Audit reported that the draft Head of Internal Audit opinion was that reasonable assurance could be given that there were adequate and effective management and internal control processes to manage the achievement of the Trust's objectives. The conclusion was based on the current findings including those audits recently completed.

4.3.6 In addition to monitoring progress of the audits, the Committee also regularly monitored progress against internal audit management recommendations and associated actions. The Committee requested and received further explanation and background on the priority 1 and 2 recommendations from the audits which have been agreed to be delivered by a certain date but not completed on time. The Committee also reviewed the robustness of the proposed actions and provided feedback.

4.3.7 In March 2019, the Committee reviewed the draft proposed internal audit plan for 2019/20, which was amended and approved in April 2019.

4.4 *Counter fraud and security management*

4.4.1 The Committee received the local counter fraud annual report and the security management annual report in July 2018. The Committee received a mid-year update on progress against the counter fraud plan for 2018/19, which noted local counter fraud activity, and introduced lessons learnt from fraud incidence from elsewhere.

4.5 *External audit*

4.5.1 In July 2018, the External Audit Manager presented KPMG's annual audit letter for 2017/18. It stated that the auditors' had issued an unqualified opinion on the Trust's 2017/18 financial statements and concluded that there were no matters arising from KPMG's 2017/18 audit work.

4.5.2 Regular technical updates have been provided by KPMG to the Committee to highlight those issues that impact on the NHS and to which the Trust should be aware. These include for example, changes made to staff pay awards, review of the fit and proper person test, updates to charges for overseas visitors' regulations, and lessons learnt from contract resolution. The Committee sought assurance that the Trust was aware and was managing such issues.

4.5.3 The ISA 260 external audit opinion was presented in May 2019, detailing the external auditors' work in relation to use of resources and the 2018/19 annual accounts.

4.6 *Financial reporting and annual accounts review*

4.6.1 The Committee (with the Chief Executive in attendance) reviewed the annual report and accounts in detail in May 2018 prior to recommending the annual report and accounts to the Board for approval.

4.6.2 The Committee reviewed the charitable funds annual report and accounts in July 2018 prior to approval by the Charitable Funds Committee.

4.6.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.7 *Standards of business conduct*

4.7.1 The Committee reviewed waivers to tendering procedures, the reference costs process, and the register of gifts and hospitality.

4.8 *Data security and Information Governance*

4.8.1 The Committee pursued evidence of compliance with data security requirements and received regular reports, which provided assurance that risks associated with data security were being adequately managed.

4.8.2 The Committee reviewed the internal audit recommendations for the Trust's cybercrime security incident response management, which was conducted in March 2018. There were seven important recommendations made and the Committee requested a progress report to be provided to the July 2019 Committee meeting, regarding the completion of the associated management actions. The update provided the Committee with assurance that the actions were robust and being progressed to the agreed timescale.

4.8.3 The Head of IG and Data Protection Officer regularly attended the Committee to provide an update on progress against the guidance issued for the General

Data Protection Regulation (GDPR) compliance, which was in force from May 2018.

4.8.4 The Committee monitored progress with the data mapping exercises throughout the organisation. An information asset register was populated from the data mapping exercises.

4.8.5 The Committee monitored information governance/data security training compliance across the Trust and regularly received up to date information on the percentage of staff that had completed training.

4.8.6 The revised IG policy framework, which included the organisation's arrangements and responsibility for complying with GDPR was reviewed by the Committee in March 2019.

4.8.7 An internal audit was undertaken to provide assurance of the Trust's approach and the arrangements that are in place for compliance with GDPR. The audit report provided a reasonable assurance opinion, with recommendations being actively addressed.

4.8.8 Updates in relation to information governance and level of compliance with the Data Security & Protection Toolkit were considered by the Committee in July 2018 and March 2019. The reports described any matters related to non-compliance with the information governance policy. The Trust received a positive audit and submitted confirmation that standards had been met with the 10 Data Standards, via the Data Security & Protection Toolkit by the 31 March 2019.

5.0 Assessment of Committee's effectiveness

5.1 All members of the Committee were invited to complete a self-assessment questionnaire in December 2018, including rating elements of performance. The main points raised were as follows:

5.2 The Committee scored highly in all areas, it scored particularly well in core purpose, values and behaviours, leadership, encouraging participation and consensus, recording and completing actions, relationship between Committee and Board.

5.3 The Committee members reflected on the self-assessment scores and comments and discussed the ways in which the Audit Committee linked in with other Board Subcommittees and agreed the following improvements:

- The Committee members will spend time at the end of each meeting to review how it has gone
- The Committee will review the information governance material provided to itself and to the Business Committee to ensure that there is no duplication or blurring of responsibilities
- Committee members, may by exception, request the opportunity to review the scope of internal audits to be completed in areas deemed as potentially high risk for the Trust
- The Committee will determine levels of assurance based on evidence received, for the Board Assurance Framework risk (2.6) data security

Leeds Community Healthcare NHS Trust
NHS Provider Licence: compliance assessment

Section 1: general conditions

Condition	**Compliance**
G1: Provision of information *The Licensee shall furnish such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports as NHS Improvement may require.*	**Compliant.** The Trust has systems and processes in place to ensure compliance with all information requests whether routine, regular or ad-hoc in such form as requested and in a timely manner.
G2: Publication of information *The Licensee shall comply with any direction from NHS Improvement to publish information about health care services, in a manner that is accessible to the public.*	**Compliant.** The Trust determines that it is compliant with this condition as a wide variety of routine information published on website and in hard copy documents, including: Board and associated papers; annual reports and information and advice to the public and referrers about services. The Trust is committed to openness and making information available in accessible formats.
G3: Payment of fees to NHS Improvement *The Act gives NHS Improvement the ability to charge fees, the Licensee shall pay all fees to NHS Improvement in each financial year of such an amount as NHS Improvement may determine.*	Not applicable. Fee requirement did not transfer from Monitor to NHS Improvement
G4: Fit and proper persons *The Licensee shall ensure that no person who is unfit may become or continue as a governor (FTs only) or as a director.* *The Licensee shall not appoint as a director any person who is an unfit person.*	**Compliant.** On appointment and annually thereafter, all directors are subject to a fit and proper persons' declaration process. Information is validated externally where possible. All directors complete an annual declaration of interests' statement.
G5: NHS Improvement guidance *The Licensee shall at all times have regard to guidance issued by NHS Improvement.*	**Compliant.** The Trust has full regard to issued guidance. Guidance notified to the Trust is reviewed on receipt by the relevant director and a lead is assigned in accordance with subject matter to enact the guidance as appropriate.

Condition	Compliance
G6: Systems for compliance with licence conditions and related obligations *The Licensee shall take all reasonable precautions against the risk of failure to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution, including: processes and systems to identify risk and guard against occurrence and regular review of the effectiveness of these processes and systems* ***The Licensee must self-certify that:*** *'Following a review, the directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*	**Compliant.** The Trust takes all necessary steps to manage the risk of failure to comply with conditions; there are robust processes are in place to identify and manage risks to compliance. The Trust utilises the Datix® risk management system to create and populate its risk registers. Strategic and operational risks are scrutinised at each meeting of the Trust Board and at Board sub-committees, as well as regular review at executive director and service level. The Audit Committee scrutinises the risk management process and provides assurance to the Trust Board. Risk management training is provided to all staff at induction, and ongoing training and support is provided by a full-time, experienced risk manager. Additional risk management resources are available for staff on the Trust intranet and in the production of a quarterly risk management newsletter. The Trust reviews and revises its board assurance framework annually and mid-year to ensure continued alignment with the operational plan and strategic goals. The board assurance framework includes: identification of strategic risks that would otherwise impede delivery of Trust's objectives, the level of risk in terms of likelihood and consequence, controls to mitigate the risks and the sources of assurance available for committee oversight and assessment. The Trust Board receives board assurance reports at each meeting which provides details of the current assurance level for each strategic risk. The Trust has an up to date risk management policy and procedure which is accessible to all staff via the policy library on the Trust's intranet. The Trust's risk appetite statement is appended to the risk management policy and procedure and describes parameters within which risk is managed. The risk appetite statement is reviewed annually by the executive team.

G7: Registration with the Care Quality Commission *The Licensee shall at all times be registered with the Care Quality Commission.*	**Compliant.** The Trust is registered without conditions. Current rating, published in August 2017, is 'Good'. The Trust has a quality governance approach including quality assessment visits which is fully aligned to the Care Quality Commission's domains.
G8:Patient eligibility and selection criteria *Licence holders are required to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.*	**Compliant.** Service information is published on the Trust's website and in patient information material. Service eligibility and selection information is detailed in service specifications and is available readily to 'Choose and Book' referrers. The Trust investigated the potential for extending service information published on NHS Choices and this is not to be pursued. Published material is comparable to that available from other trusts.
G9: Application of Section 5 (continuity of services) *The condition applies where the Licensee is subject to a contractual obligation to provide a commissioner requested service and relates to maintenance of continuity of services.*	**Compliant.** The Trust is aware of services which the commissioners deem to be commissioner requested services; also known as essential services. The Trust achieves a good level of compliance with commissioned contractual requirements. Contract management arrangements between the Trust and its commissioners provide oversight of service delivery in line with contractual requirements.

Section 2: Pricing

Condition	**Compliance**
P1: Recording of information *The Licensee shall obtain, record and maintain sufficient information about costs of providing services.*	**Compliant.** Finance systems and processes are set up to meet all internal and external reporting requirements. Board approved annual budgets and financial plan in place. Reference costs are reported and examined annually.
P2: Provision of information *The Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require.*	**Compliant.** Trust complies with all requests to supply information as requested. The information collected and recorded in relation to condition P1 is made available as requested.

P3: Assurance report on submissions to NHS Improvement *If required by NHS Improvement, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to the accuracy of costing and pricing.*	**Compliant.** The Trust will fully comply with any such request as and when the requirement arises.
P4: Compliance with national tariff *The Licensee shall only provide health care services for the NHS at prices which comply with, or are determined in accordance with, the national tariff.*	Not applicable. This condition is not generally applicable to community trusts. The Trust only provides one service which is part of the national tariff with which it is fully compliant.
P5: Constructive engagement concerning local tariff modifications *The Act allows for local modifications to prices. The Licensee shall engage constructively with commissioners to reach agreement locally.*	Not applicable. The Trust operates under a block contract. Only one service is subject to national tariff and is supplied at national tariff.

Section 3: Choice and competition

Condition	**Compliance**
C1: The right of patients to make choices *The Licensee shall ensure that at every point where a person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by commissioners, he or she is notified of that choice and told where information can be found.*	**Compliant.** The Trust offers choice where applicable. Choice and 'choose and book' approaches in place in relation to applicable services, namely those described as 18 week reportable services.
C2: Competition oversight *The Licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting completion in the provision of health care.*	**Compliant.** The Trust would pursue service opportunities within statutory and accepted procurement, bidding and contracting practices; this ensures that competition is not prevented, restricted or distorted by the Trust.
Section 4: Integrated care	

Condition	Compliance
IC1: Provision of integrated care *The Licensee shall not do anything that would reasonably be regarded as against the interests of people who use health care services for the purposes of the NHS to be integrated with the provision of such services.*	**Compliant.** The Trust is a significant leader in the development of integrated care approaches as reflected by the role played in the West Yorkshire Health and Care Partnership, Leeds Health and Care Plan, the development of new models of care and initiatives to effect closer integration. Key initiatives, service and pathway developments are captured in the Trust's operational plan 2019/20. Stakeholder engagement underpins the development of integrated approaches.

Section 5: Continuity of services

Condition	Compliance
COS1: Continuing provision of commissioner requested services *The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any commissioner requested service except where permitted to do so in the contract.*	**Compliant.** Contract management arrangements in place between the Trust and its commissioners; any material changes are agreed through contract management board. Trust achieves a good level of compliance with commissioned contractual requirements including those services deemed to be commissioner requested services. Contracts and service specifications are in place and as agreed with commissioners.
COS2: Restriction on the disposal of assets *The Licensee shall establish, maintain and keep up to date, an asset register of assets relevant to commissioner requested services and have due regard to consent before disposal.*	**Compliant.** No issues identified in the disposal of assets related to commissioner requested services without consent of NHS Improvement.
COS3: Standards of corporate governance and financial management *The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:*	**Compliant.** The Trust has robust systems for corporate and financial management including standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2019). Compliance is monitored through Audit Committee, recorded in the annual

(a) suitable for a provider of the commissioner requested service provided by the Licensee, and *(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.*	governance statement and 'going concern statement' and has been subject to external audit.
COS4: Undertaking from the ultimate controller *The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee.*	**Compliant.** This condition requires licensees to put in place a legally enforceable agreement with their 'ultimate controller' to stop ultimate controllers from taking any action that would cause licensees to breach the licence conditions. This condition specifies who is considered to be an ultimate controller.
COS5: Risk pool levy *The Licensee shall pay any sums required to be paid in consequence of any requirement imposed on providers by way of a levy.*	**Compliant.** This licence condition obliges licensees to contribute, if required, towards the funding of the "risk pool" - this is like an insurance mechanism to pay for vital services if a provider fails.
COS6: Co-operation in the event of financial stress *The Licensee shall provide such information as NHS Improvement may direct and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.*	**Compliant.** This licence condition applies when a licensee fails a test of sound finances, and obliges the licensee to cooperate with NHSI in these circumstances.
COS7: Availability of resources *The Licensee shall at all times act in a manner calculated to secure that it has, or has access to the required resources.*	**Compliant.** Evidenced through: annual contract negotiations, approval of operational plan for 2018/19 and associated financial plan and annual budgets, approval of going concern statement and regular monthly monitoring of performance against plan.

Section 6: NHS foundation trust conditions

Condition	**Compliance**
FT1: Information to update the register of NHS foundation trusts *The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:* *(a) the current version of the Licensee's constitution;* *(b) the Licensee's most recently published annual accounts and any report of the auditor on them, and* *(c) the Licensee's most recently published annual report*	Not applicable (Applicable to foundation trusts only.)
FT2: Payment to NHS Improvement in respect of registration and related costs *The Licensee must pay NHS Improvement a fee in respect of NHS Improvement's exercise of its functions.*	Not applicable (Applicable to foundation trusts only.)
FT3: Provision of information to advisory panel *The Licensee shall comply with any request for information or advice made of it.*	Not applicable. (Applicable to foundation trusts only.)

Condition	**Compliance**
FT4: NHS foundation trust governance arrangements 1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health services to the NHS.*	**Compliant.** The Trust develops an annual governance statement which is scrutinised by Board sub-committees prior to Board approval (24 May 2019). The annual governance statement is reviewed by internal and external auditors as part of the process for finalising the Trust's report and accounts. The Trust has satisfactory opinion reports from the Head of Internal Audit (TIAA Limited) and from the Trust's external auditors (KPMG) The Trust operates at all times within a framework of standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2019) and approved policies and procedures.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to	**Compliant.** The Trust's governance arrangements are developed with due regard of all guidance as issued by NHS Improvement from time to time. The

time.	Trust also regularly reflects on guidance information provided by the Good Governance Institute. Governance arrangements are reviewed annually, including a review of the standing orders, reservation and delegation of powers, and standing financial instructions.
3. The Board is satisfied that the Licensee has established and implements: *(a) Effective Board and Committee structures* *(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees* *(c) Clear reporting lines and accountabilities throughout its organisation.*	**Compliant.** The Trust has a fully constituted Board and five sub-committees. The terms of reference for all committees have been reviewed in early 2019; ensuring appropriate membership, lines of accountability and clear areas of delegated responsibility. The Board and committees operate to annual cycles of business. Board and committee effectiveness is reviewed annually (and reported to Audit Committee and the Board). Each committee produces an annual report. There is a robust process for recording assurances provided by committees to the Board against matters contained in the board assurance framework. Details of the Trust's governance arrangements are displayed on the intranet, accessible to all staff. A number of sub-groups have been aligned with an appropriate committee. Each sub-group escalates issues to committees as necessary and provides copies of approved meeting minutes.
4.The Board is satisfied that the Licensee has established and effectively implemented systems and/or processes: *(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively* *(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations* *(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions* *(d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern* *(e) To obtain and disseminate accurate, comprehensive,*	**Compliant.** The Board gains assurance that the Trust operates efficiently, economically and effectively through its standing orders and financial instructions, schemes of reservation, delegation of reporting to Board and its sub committees and the following established organisational processes: The review and approval of The Trust's operational plan 2018/19 involved consideration of key areas of risk in respect of quality of services, financial performance (as recorded in board assurance framework), national and local standards and requirements and delivery of key strategies. Areas of risk have been reported to Board through risk assurance reports and monitoring of delivery of the operational plan; the latter having been considered in detail by the Trust's Quality and Business Committees. Assurances are provided by committees to the Board against matters contained in the board assurance framework. Performance management framework allows the timely monitoring of main

timely and up to date information for Board and Committee decision-making *(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence* *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery* *(h) To ensure compliance with all applicable legal requirements.*	operational, quality, workforce, contractual and financial indicators. Performance reporting is fully aligned to the Care Quality Commission's five domains. Monthly performance data (quality, activity, contractual and financial) is reported to the sub-committees and Board for scrutiny. There are also regular reports on key issues (eg patient safety, clinical effectiveness, patient experience, demand and capacity, recruitment and retention etc). Monthly finance reports track actual performance against plan. The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that the plan is adhered to. An annual 'going concern' review is undertaken by Audit Committee and approved by Board (29 March 2019). Quality priorities are recorded in the Trust's Quality Strategy. Annual Quality priorities are agreed as part of the annual planning process aligned to the operational plan. Actions to enhance quality are contained in improvement plans; performance against which is monitored by Quality Committee and Board. The Trust is registered with the CQC without conditions. The Care Quality Commission inspected the Trust in January 2017 and concluded an overall rating of 'Good'. To ensure compliance with standards set by regulators of health care professionals the Trust has the following arrangements: • On appointment of new staff, status checks are completed with professional bodies. • Periodic checks are made to ensure registrations are renewed appropriately • There is ongoing monitoring of clinical supervision to ensure staff access this. • The Trust has a system of medical revalidation. • Annual appraisals are monitored and cover the professional standards set by the relevant governing body. • The Trust supports continual professional development.

	Monthly performance and finance reports are scrutinised by Business Committee and Trust Board. The Audit Committee provides oversight of systems of internal control including efficacy of financial reporting. The risk appetite statement and board assurance framework were reviewed in 2018. The board assurance framework was updated in 2019 to align with the Trust's operational plan 2019/20. Timely and robust risk reporting processes are in place with scheduled reports to committees and Board. A programme of internal and external audit is in place aligned to strategic risks. An annual business planning cycle produces operational plans aligned with the Trust's key strategies, system plans (West Yorkshire and Harrogate Health and Care Partnership Plan and the Leeds Health and Care Plan) and commissioner plans. Business Committee and Board receive progress reports on delivery of plans. The Trust has policies and procedures in place to ensure it complies with legislation both as an employer and as a provider of NHS services.
5. The Board is satisfied that the systems and/ or processes referred to in paragraph 4 (above) should include but not be restricted to systems and /or processes to ensure: *(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided* *(b) That the Board's planning and decision making processes take timely and appropriate account of care considerations* *(c) The collection of accurate , comprehensive, timely and up to date information on quality of care* *(d) That the Board receives and takes into account accurate , comprehensive, timely and up to date information of the quality of care* *(e) That the Licensee, including its Board, actively engages*	**Compliant.** The Board has strong complementary skill sets amongst non-executive and executive Board members. There is a clear distinction of 'portfolios' whilst remaining fully operational as a unitary board. The 2017 CQC inspection report described the Trust as having 'stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these. Leaders were visible and accessible'. Essential leadership of the quality agenda is provided by medical and nursing directors. Board approved quality strategy sets out strategic action areas enacted through action plans and monitored through quality and safety reports to Quality Committee and Board. Annual Quality priorities are agreed as part of

on quality of care with patient, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources **(f)** *That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate*	the annual planning process. Quality Committee receives a comprehensive monthly Director of Nursing report. Quality account, quality challenge+ and clinical audit programme all require measurement, evaluation and reporting of essential quality data. These are scrutinised by the Quality Committee, which communicates the level of assurance these provide to the Trust Board. Internal audit investigations on data quality have indicated reasonable assurance in all instances. There is an active programme of Board members engagement with patients and staff through visits and leadership initiatives. All Board meetings include a 'patient story', which involves a patient and or a carer attending a Board meeting to provide their account of the quality of care they have experienced. The Trust has multiple means to raise concerns related to quality of care including communicating issues to the patient experience team, stakeholder meetings, staff forums and 'freedom to speak up' activities. The Trust engages with Healthwatch and other key stakeholders in developing and agreeing Quality Priorities and the Quality Account A Quality Impact Assessment process ensures assessment is completed for all service changes that have potential to impact on patient care, including service and pathway improvement, service development and transformation and service offers developed in response to tenders.
6. *The Board is satisfied that there are systems in place to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the NHS provider licence.*	**Compliant.** Trust Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Trust has a fully constituted Board and committees each with full and active membership. Ongoing Board development **i**ncludes workshops, networking events and training opportunities. Full line management structure linked to each executive director's portfolio.

	The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executives are subject to annual appraisals by the Chair, these will inform individual development plans for all Board members. All appointments to senior management positions are subject to rigorous and transparent recruitment processes. All directors must declare that they are 'fit and proper' on an annual basis, and appropriate and proportionate checks are carried out to support the declarations. The Trust develops its leadership capability through its Workforce Strategy which supports the development of staff. Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. Trust Board is fully apprised at each meeting of key quality, workforce and financial indicators. Workforce indicators include compliance with safe staffing ratios, vacancy rates, staff turnover, retention, agency staff deployment, sickness absence, appraisal rates, professional revalidation and training compliance. Business Committee has oversight of workforce issues; extensive consideration of areas of challenge (eg recruitment and retention in clinical services) through a suite of reports including the performance brief and the risk register report, which are received at each meeting. Business Committee communicates the level of assurance these provide directly to the Board.

Leeds Community Healthcare NHS Trust
Summary of changes to standing orders and standing financial instructions

Section	Change
4.8.7 Committees established by the Trust Board	Details of Leeds Primary Healthcare Collaborative Committees in Common added (as described in the Board approved memorandum of understanding and terms of reference).
4.8.8 Committees established by the Trust Board	Details of Leeds Providers Integrated Care Collaborative Committees in Common added (as described in the Board approved memorandum of understanding and terms of reference).

Please note: actual text changes are highlighted in bold in the schedule of changes above.

Leeds Community Healthcare NHS Trust
Register of affixing of corporate seal 2018-19

OCCASION	PARTIES INVOLVED	DOCUMENT APPROVED & SEAL ATTESTED BY	DATE
UPLA: for part of East Leeds Health Centre, 78 Osmondthorpe Lane, Leeds LS9 9EF	Leeds Community Healthcare and Community Health Partnerships Limited	Chief Executive Executive Director of Operations	31.10.18
UPLA: for part of Wetherby Health Centre, Hallfield Lane, Wetherby, Leeds LS22 6JS	Leeds Community Healthcare and Community Health Partnerships Limited	Chief Executive Executive Director of Operations	31.10.18
UPLA: for part of Wortley Beck Health Centre, Ring Road, Leeds LS12 5SG	Leeds Community Healthcare and Community Health Partnerships Limited	Chief Executive Executive Director of Operations	31.10.18
UPLA: for part of Parkside Community Health Centre, 311 Dewsbury Road, Leeds LS11 5LQ	Leeds Community Healthcare and Community Health Partnerships Limited	Chief Executive Executive Director of Operations	31.10.18
UPLA: for part of Woodhouse Health Centre, Cambridge Road, Leeds LS6 2SF	Leeds Community Healthcare and Community Health Partnerships Limited	Chief Executive Executive Director of Operations	31.10.18
Novation contract and parent guarantee for continued use of Allied Healthcare staff in the Trust's night service.	Leeds Community Healthcare and Health Care Resourcing Group Ltd	Chief Executive Executive Director of Operations	13.02.2019
Lease agreement Fourth Floor Stockdale House and counterpart licence for car parking	Leeds Community Healthcare Bonsai Holdings LLP	Executive Director of Operations Executive Medical Director	31.03.2019

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (24)

Trust Board public workplan 2018-19
Version 1:24 April 2019

Topic	Frequency	Lead officer	1 February 2019	1 March 2019 Extraordinary	29 March 2019	24 May 2019	2 August 2019	4 October 2019	6 December 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		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			
Significant risks and risk assurance report	every meeting	CS	X			X	X	X	X
Care Quality Commission inspection reports	as required	EMD							
Quality account	annual	EDN				X			
Mortality report	annual	EMD	X						
Staff survey	annual	DW			X				
Safe staffing report	2 x year	EDN	X				X		
Seasonal resilience	annual	EDO						X CE's report	
Serious incidents report	4 x year	EDN	X			X	X		X
Patient experience: complaints and incidents report	2 x year	EDN				X Annual report			X Six monthly report
Freedom to speak up report	2 x year	CE					X Annual report		X
Guardian for safe working hours report	4 x year	EMD	X			X Annual report	X		X
Strategy and planning									
Operational plan including financial plan	3 x year	EDFR			X 2019-20	x 2018-19 End of year report		X	
Service strategy	as required	EDFR							
Quality strategy	annual	EDN	X						
Workforce Strategy	every meeting from May 2019	DW	X			X Leadership and skills	X Resourcing	X Wellbeing	X Diversity and inclusion
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 Self assess update	X CEs report		X Action plan
Annual report	annual	EDFR				X			
Annual accounts	annual	EDFR				X			
Letter of representation (ISA 260)	annual	EDFR				X			
Audit opinion	annual	EDFR				X			
Audit Committee annual report (part of corporate governance report)	annual	CS				X			
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS				X			
Annual governance statement (part of corporate governance report)	annual	CS				X			
Going concern statement (part of corporate governance report)	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 report)	annual	CS			X				
Corporate governance update	as required	CS			X				
Reports									
Equality and diversity report	annual	DW							X
Safeguarding annual report	annual	EDN						X	
Infection prevention control annual report	annual	EDN						X	
Emergency preparedness annual report	annual	EDO						X	
Additional items									
West Yorkshire Mental Health Services Collaborative	as required	CE							
Leeds Health and Care Academy - Partner Board briefing	as required	CE							
Leeds Providers Integrated Care Collaborative - Committees in Common	as required	CE							
Leeds Community Healthcare/Leeds General Practice Confederation - Committees in Common	as required	CE							
CAMHS Tier 4 - Building	as required	EDFR							
Healthwatch review of patient engagement activity	as required	EDN							
HSCN Migration	as required	EDFR		X					
Proposed new lease for 4th floor Stockdale House	as required				X				
LIFT Under Lease Plus Agreements (ULPAs) from Community Health Partnerships (CHP)	as required	EDFR			X				
West Yorkshire and Harrogate Health and Care Partnership (Formerly STP)	as required	CE							

Key

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

= received
= deferred to another meeting
= not required

Leeds Community Healthcare NHS Trust

PUBLIC MINUTES

Quality Committee
Monday 18 March 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

AGENDA ITEM 2019-20 (25a)

Present	Professor Ian Lewis	Committee Chair
	Dr Tony Dearden	Non-Executive Director
	Neil Franklin	Trust Chair
	Ruth Burnett	Executive Medical Director
	Stephanie Lawrence	Executive Director of Nursing and Allied Health Professionals (AHP)
In Attendance	Sam Prince	Executive Director of Operations
	Carolyn Nelson	Head of Medicines Management
	Diane Allison	Company Secretary
	Caroline McNamara	Clinical Lead for Adult Services
	Helen Rowland	Clinical Lead for Children's Services
	Angela Gregson	Interim Clinical Head of Service for Specialist Services *deputising for Elaine Goodwin*
	Suzanne Slater	Clinical Governance Manager
Item (86)	Melanie Epstein	Medical Lead
	Lisa Baxby	Clinical Service Manager
Item (87c)	Liz Allen	Head of Research and Development
Item (88c)	Graham Hyde	Head of Business Intelligence
Item (88e)	Caroline Schonrock	Business Planning Manager
Observing	Angela Edmonds	Head of Quality and Safety, CCG
	Christine Pearson	Health Visitor
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Thea Stein	Chief Executive
	Elaine Goodwin	Clinical Lead for Specialist Services

Item no	Discussion item	Actions
Welcome and introductions		
2018-19 (85a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed the members. The group introduced themselves. Apologies were received from Thea Stein and Elaine Goodwin. The Committee Chair spoke about the agenda and made the group aware that there would be a tabled paper for item (88c) Schedule of KPIs. He suggested that the paper was reviewed following the meeting and any comments should be sent directly to the Head of Business Intelligence.	
2018-19 (85b)	**Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to	

	ensure there was no known conflict of interest prior to papers being distributed to Committee members. The Committee Chair asked if there were any additional interests. There were no additional declarations of interest received.	
2018-19 (85c)	**Minutes of meeting held on 18 February 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2018-19 (85d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. All actions were tabled on the agenda and it was agreed that they were closed.	
2018-19 (85d) (i)	**Waiting time impact on Adult SLT patients** The Executive Director of Operations gave an update on the waiting time impact on Adult Speech and Language (SLT) patients. It was noted that there had been a system wide review of the service within the Trust and with Leeds Teaching Hospitals Trust (LTHT). The Committee Chair asked about the potential clinical impact for patients who were waiting. The Interim Clinical Head of Service for Specialist Services confirmed that information had been sent out to patients giving them specific advice whilst on the waiting list; however this would only be effective if the patients acted on the advice. The Committee Chair asked how the Trust would know if there was a particular problem. The Interim Clinical Head of Service for Specialist Services also stated that incidents could be tracked via the GP or care home A Non-Executive Director (TD) asked if the Committee could be assured there had been no incidents. It was noted that there had been one incident reported and an investigation was pending. It was agreed that the details of the incident would be included in the Clinical Lead Quality Report for the Specialist Business Unit. **Action:** Reported incident within SLT to be detailed in the Clinical Lead Quality Report for the Specialist Business Unit in April 2019.	Clinical Lead for Specialist Services
Service spotlight		
2018-19 (86)	**Community Paediatrics** The Clinical Lead for Children's Services introduced Melanie Epstein, Medical Lead for Children's Services and Lisa Baxby, Clinical Service Manager. The presentation had been circulated with the papers. The Medical Lead for Children's Services stated that they were relaunching the Integrated Children's Additional Needs (ICAN) programme. The complexity of the services provided was highlighted. It was noted that of the 16.68 whole time equivalents (WTE), not all work in a clinical capacity.	

Challenges

The Medical Lead for Children's Services highlighted the workforce challenges within the national context. The subsequent challenges to the Trust were noted as:

- Workforce – expanding permanent staff and reducing locums – creative and pro-active approach
- Wait times
- Meeting demand – increased need, demand, expectation, complexity of children seen
- Meeting capacity and demand alongside statutory roles, service improvement and leadership development
- Understanding performance data in relation to complexity of roles.

Priorities

The Medical Lead for Children's Services talked about the 2018 priority of engagement, and improving working relationships between managers and paediatricians.

The priorities were noted as:

- Continuing collaborative working between managers and paediatricians at all levels
- Recruitment and retention of permanent paediatric staff
- Improving paediatrician leadership involvement
- Reduction of waiting times and locum costs
- Focus on pathway development
- Support of the EPR transformation programme to enable consistent and co-ordinated patient information and improve performance data.

What is required

- Recognition of achievements
- Understanding of the complex roles
- To feel valued by senior leaders in the Trust
- Patient whilst pathways are worked up and issues with staff are addressed
- Support from corporate services

The Trust Chair referred to the shortage of paediatricians and asked if there was a way for paediatricians to develop more than one portfolio. The Medical Lead for Children's Services explained that some paediatricians are trained in as many services as possible however; the Trust needs to be more robust in ensuring the staff can work across services. It was highlighted that SUDIC requires specialist training.

The Clinical Lead for Childrens' Services stated that the ICAN transformation programme was reviewing the Aetiology service and how to equip paediatricians to be able to work in the service.

A Non-Executive Director (TD) referred to the complexity of the ICAN services and asked how patients/parents navigate these and what is being done to simplify the design. The Clinical Service Manager stated that they are in the preliminary stages of the transformation programme and are hoping to simplify this by considering what a child's perfect journey would look like. The Committee heard that it is currently navigated via a triage service and internal referrals, although the responsibility and coordination is held by one service. The Medical Lead for Children's Services commented that they work with parents to help them to understand the pathway.

	The Executive Director of Operations commented that the solutions to issues are embedded in the transformation programme and this needs to be moved along with more focus and better project management support. The Clinical Lead for Children's Services stated that the leadership team and the business unit are beginning to progress this. The Committee Chair asked about staff feeling valued by senior leaders. The Medical Lead for Children's Services stated that the opportunity to talk to senior managers and/or receive feedback would be welcomed. The Committee Chair asked for thoughts about how closely integrated all children's services should be including primary care. The Medical Lead for Children's Services stated that families should be integrated. It was noted that the services do work more closely with the Leeds Teaching Hospitals Trust (LTHT). Integration is included in the transformation programme. The Clinical Lead for Children's Services stated that there were links with primary care and suggested returning to the Committee at a later date to share the work currently being undertaken. The Committee Chair thanked the Medical Lead for Children's Services and the Clinical Service Manager for their presentation.	
Key issues		
2018-19 (87a)	**Serious incident investigation report** Please refer to the private minutes.	
2018-19 (87b)	**Quality Challenge Plus review** The Executive Director of Nursing and AHP presented the paper which was circulated prior to the meeting and informed the Group that the programme would be reviewed on an annual basis. The main change to note is the intention to have five standards based on each of the CQC domains rather than the ten current standards. The action plan is a live document and teams have been asked to update this on a monthly basis, which will be reported via performance panels. Every service will have a visit in the next 12 months. The Trust Chair asked how individuals would own the performance and outcomes. The Executive Director of Nursing and AHP stated that this would happen over time. There is a question in the document asking if the whole team is involved in the self-assessment, and if not, why not? Ownership when reporting on a monthly basis would mean that the whole team would need to be involved. The Committee Chair queried whether it would be possible to review 56 services in a year. It was noted that this would be monitored; however the onus would be on the Quality Leads in each service to achieve this. It was agreed that administration support was required for the system. The Committee Chair offered to take part in some reviews. **Outcome:** The Committee approved the paper.	

2018-19 (87c)	**Research and Development Strategy update** The Head of Research & Development presented an update of the review of the delivery of the Research and Development strategy 2015-2018 and introduced the key aims and themes within the new Research Strategy for 2019-2023, currently under development, for the Committee to comment on. The Committee was advised that the Research team had undertaken work that addressed the aims of the 2015-2018 however had struggled with the more challenging objectives of the 2015-18 strategy, which were increasing the amount of funding into the organisation, and dissemination of research. The Committee reviewed the draft 2019-23 strategy which addressed the challenging aspects of the previous strategy and proposed aims and objectives to address inherent issues. The Committee explored why Research was not embedded in the Trust, and suggested that LCH should pool resources with similar trusts, and collaborate more with academics. The discussion on the proposals for the new strategy was very positive and supportive but recognised that it might be overambitious. Nevertheless it was recognised that there is an appetite to advance research within the organisation and a proposal emerged that this should be the subject of a Board or Quality Committee workshop in the near future. It was agreed that a further version of the new strategy would be brought back to the Committee. **Action**: Head of Research and Development to present a further version of the new strategy to the Committee in May 2019. **Assurance level:** Reasonable	Head of Research and Development
2018-19 (87d)	**Falls and Pressure Ulcer investigations review** The Executive Director of Nursing and AHP presented the paper and highlighted the review process and actions which offered a more supportive approach. It was intended to roll out the new paperwork from 1 April 2019. The paper was welcomed by the Group and noted that the new approach would be reviewed in the future. The Committee was assured that people are attending the panels. The Committee Chair queried if the bi-annual PSEG learning events were the only mechanism to share learning from the incidents across the organisation. The Executive Director of Nursing and AHP assured the Committee that this was not that case and that there were other mechanisms for sharing in place. The Clinical Lead for Adult Services commented that the learning from incidents templates were helpful.	
2018-19 (87e)	**Quality Improvement update** The Executive Director of Operations updated the Committee on Quality Improvement (QI) reporting arrangements. It was noted that the steering group had met and agreed the terms of reference. There was a query as to how progress could be effectively communicated. It was agreed that the updates should form a regular part of the business unit reports and should also be included as part of the Clinical Effectiveness Group report.	

2018-19 (87f)	**Sub Group items to escalate to Committee** *Clinical Effectiveness Group* • The February deep dive meeting focussed on the engaging front line staff in the draft 2019-2021 research strategy • Significant work is underway to increase the Trust's clinical audit activity and the profile of clinical audit. *Safeguarding Committee* • Implementation of the consent policy • The Trust's target of 95% staff being compliant with Safeguarding Children training by the end of March 2019 had been achieved. • Safeguarding Committee to have an operational focus around incidents and learning in relation to safeguarding issues. *Mortality Surveillance Group* Future reporting will combine Specialist services with Adults. .	
Quality governance and safety		
2018-19 (88a)	**Performance brief and domain reports** The Executive Director of Nursing and AHP provided a summary of the report and apologised that the narrative sections for the Safe and Caring domains were not up to date. It was noted that the report would be updated for the Board meeting in March 2019. *Safe* The Committee noted that there was conflicting information provided about the number of avoidable pressure ulcers. The figures would be confirmed and reported at the Board meeting in March 2019. A Non-Executive Director (TD) asked about VTE assessment reporting and the Executive Director of Nursing and AHP advised the Committee that the percentage of VTE risk assessments completed would not be reported from 1 April 2019 as agreed with the Commissioners, as only 4.5 patients per week required an assessment. *Caring* It was noted that there had been a slight drop in the Friends and Family Test response where people would recommend the services. *Effective* The Trust Chair asked about the percentage of services rated good or outstanding following the Quality Challenge+ peer review Q2 figure. The Executive Director of Nursing and AHP reiterated the capacity issues. It was agreed that future reports would include N/A for this with narrative to explain. *Responsive* Please refer to the private minutes. **Assurance Level**: Limited	
2018-19 (88b)	**Clinical Governance Report** The Committee agreed to focus on the Clinical Lead Quality reports. *Adults Business Unit* The Clinical Lead for Adult Services highlighted the following:	

	• Achievement of the wound care CQUIN • An article by an LCH Occupational Therapist has been published in OT News on the Live Well Leeds approach to proactive personalised care • The Population Healthcare Management (PHM) work stream was proving challenging due to the volume and scale of commitment. *Specialist Business Unit* • The Diabetes Leeds Single Point of Access workshops were hugely successful and commissioners have now appointed a project manager to establish and progress the work streams • The Leeds Stroke Pathway has been shortlisted for a HSJ Value award in the category of Community Services Redesign • A more detailed report on the Virtual Respiratory Ward will be presented in April • CQC inspectors are currently at the YOI. *Children's Business Unit* • 14 health visitors have been recruited to PHINS and the service is over recruiting to manage school nursing capacity • Recruitment continues to be a challenge and work is ongoing to address this • Hannah House: improvement plans are in place following quality visits • Looking at learning from incidents across the business unit • ESR workforce information is not being updated on PIP in line with other quality matters and some inaccuracy of information relating to individual staff members.	
2018-19 (88c)	**Schedule of KPIs** The Head of Business Intelligence tabled a draft proposal of measures for inclusion in the 2019/20 Performance Brief. The Committee was asked to examine the relevance of current and proposed measures and to feedback any comments to the Head of Business Intelligence. Immediate comments from the Committee was that meaningful measures and targets needed to be established and agreement that the Trust should look at measurement for improvement, rather than performance measures. **Action:** Draft KPIs to be circulated to Committee members to provide feedback to the Head of Business Intelligence. **Action:** Schedule of KPIs to be tabled on the Quality Committee agenda in April 2019.	Head of Business Intelligence Company Secretary
2018-19 (88d)	**Quality Account** The Committee was advised of the four Quality Account priorities, which were aligned to the organisation's priorities and that clinical outcomes were included in the operational plan. Quality account priorities: • Patient Engagement and Experience – across LCH • Improvement plan for internal auditing and review of services. • Further development of learning from excellence and incidents • Development of new models of care across health and social care economies within Leeds.	

2018-19 (88e)	**Operational plan** The paper had been circulated prior to the meeting. It was noted that the document was still in a draft version with some details still to be added before the Board meeting in March 2019. The Committee was asked to review the Quality priorities and plans. The Business Planning Manager drew the Committee's attention to the 2019/20 Plan Alignment with the ICS Health and Care Partnership Plan and Leeds Health and Care Plan. The Committee Chair referred to the expected step change in the impact on the Trust of engaging in developing and implementing the Leeds Health and Care Plan 2019/20 and asked if there would be corresponding funding for expansion. The Business Planning Manager explained that there has been a submission for some funding for backfill via IBCF. It was taken out of IBCF as a necessity and is now with Commissioners to confirm how it will be funded. The Committee Chair referred to the three top quality risks and asked if these were on the Board Assurance Framework. It was confirmed that this was the case. The Committee Chair asked where Research would sit in the organisation as it is not included in the report. It was agreed that the Business Planning Manager would look at including this. **Action:** Business Planning Manager to investigate where Research would fit into the operational plan. **Assurance Level:** reasonable.	Business Planning Manager
2018-19 (88f)	**Risk register** The Company Secretary highlighted that there were three new risks added to the register. *Risk 958: Insufficient information provision and communications between LYPFT and Interserve with LCH* The Company Secretary advised that the Business Committee would like Quality Committee members to consider the quality impact of the risk. A Non-Executive Director (TD) expressed concern around the quality impact of not delivering the news CAMHS unit. The Clinical Lead for Children's Services stated that the risk is around the current contract. It was noted that the risk is reducing, but assurance was needed that this was not temporary. It was agreed that the risk to the new build following issues with Interserve would be added to the risk register. The Clinical Lead for Children's Services confirmed that a report had been received from LYPFT detailing repair work to the current CAMHS unit that has been completed and the associated time scales. *Risk 960: Risk of inaccurate reporting of mortality data* The Executive Medical Director explained that the risk was around the ongoing work to improve the accuracy and meaningfulness of the data. It was noted that there was one escalated risk relating to caseload management in children's dietetics: a reduction in the number of experienced clinicians and ongoing workforce instability in the children's dietetic service.	

2018-19 (88g)	**Board members' service visits** The paper was received for information concerning the Trust Chair's visit to the Palliative Care and Night Service.	
Clinical effectiveness		
2018-19 (89a)	**Patient group directions** The Committee was asked to ratify two PGDS: • Administration of Ceftriaxone 1g in Lidocaine 1% • Administration of Bacillus Calmette Guerin (BCG) vaccine It was confirmed that the PGDs had been through the correct processes and were recommended for ratification. **Outcome:** The Committee ratified the two approved PGDs.	
2018-19 (89b)	**Outcome measures update** The Executive Medical Director provided the Committee with an updated position regarding the progress of the LCH Clinical Outcomes Program. The Committee heard that considerable work has taken place between the Clinical Outcomes Project team and the Business Intelligence team to identify the level of support required for the central reporting of clinical outcome measures. The Trust has committed non-recurrent funding for the Project leadership and support model identified over the 2019/20 financial year. It was reported that the CCG have committed to the citywide Business Intelligence (BI) team providing this aspect of the program work required. This would enable LCH, primary care and LTHT to enable the healthcare system in the city to reach a stage where the Trust can report its impact against national clinical outcomes for long term conditions. Work is underway to ascertain whether the citywide BI team can provide the requisite for this program, and if not then the CCG have committed to fund this aspect. A further update will be provided to the Committee in May 2019. **Action:** Executive Medical Director to provide an update on Outcome measures to the Committee in May 2019.	Executive Medical Director
2018-19 (89c)	**Clinical Audit 2019/20 plan** The Executive Director of Nursing and AHP updated the Committee on the Trust's responsibility to ensure that robust systems and processes had been implemented in the development of the Clinical Audit Programme. The Committee Chair commented that clarification was required around the link between the plan and quality improvement. The Executive Director of Nursing and AHP advised the Committee that work was ongoing in regard to this. In response to a query from the Committee Chair, it was noted that although the personal improvement obligation for medical professionals was not explicitly recorded in the plan, it was included in the review of the audit content. **Outcome:** Approved	
2018-19 (89d)	**Internal audit reports: Incident and Serious Incident review** The Company Secretary confirmed that the Incident and Serious Incident review had received a reasonable assurance opinion. It was noted that all	

	the actions have been completed. **Assurance:** Reasonable	
Patient experience		
2018-19 (90)	**Patient experience and engagement: incidents, complaints, concerns and feedback** The Executive Director of Nursing and AHP presented the new style of report with themes from incidents, complaints, concerns, and other feedback as well as a summary of the outcomes, learning and actions from completed investigations. The report gave information about service improvements and actions taken to prevent recurrence. The Committee agreed that the report format had potential, however the information needed to be more succinct in future reports. It was agreed that the report would be reviewed by the Committee prior to presentation to the Board in May 2019. It was agreed that any comments would be sent directly to the Executive Director of Nursing and AHP.	
2018-19 (91)	**Committee's draft annual report 2018/19 and review of terms of reference** The Committee Chair asked the Group to comment on the model of the meetings. It was felt that the model fed correctly in to Board, providing the opportunity for more detailed discussion. There was a discussion about the increase in the amount of papers presented in the formal meetings following the introduction of workshops and how this had impacted on the quality of discussion. It was agreed that this would be reviewed outside of the meeting. **Action:** Committee format to be discussed at the April 2019 agenda setting meeting. The Committee reviewed its existing terms of reference and agreed that no changes were required.	Company Secretary
Committee governance		
2018-19 (92a)	**Clinical Effectiveness Group minutes: 24 January 2019** The minutes were received for information.	
2018-19 (92b)	**Safeguarding Children's and Adults Group minutes: 11 February 2019** The minutes were received for information.	
2018-19 (92c)	**Mortality Surveillance Group minutes: 12 February 2019** The minutes were received for information.	
Quality Committee work plan		
2018-19 (93a)	**Items from work plan not on agenda** • **Patient Safety and Experience Group minutes: January 2019** **Action:** Executive Director of Nursing and AHP to include PSEG minutes from January 2019 in the April Committee papers	Executive Director of Nursing and AHP

2018-19 (93b)	**Work plan** The future structure of the meetings would be discussed at the next agenda setting meeting in April 2019.	
2018-19 (94)	**Matters for the Board and other committees inc. assurance levels** It was agreed that the Committee Chair would provide an update to the Board at the meeting on 29 March 2019.	
2018-19 (95)	**Any other business** There was no further business.	
	Dates and times of future meetings (09:30 – 12:30) 29 April 2019 20 May 2019 24 June 2019 22 July 2019 23 September 2019 21 October 2019 25 November 2019	

Leeds Community Healthcare NHS Trust

Audit Committee

Boardroom, Stockdale House, Headingley Office Park, Victoria Road, Leeds, LS6 1PF
Friday 22 March 2019
8.45am-11.30am

Agenda item 2019-20 (25b)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Associate Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Matthew Moore	External Audit Manager (KPMG)
	Narrissa Leyland	Head of Information Governance and Data Protection Officer (For Items 59a, b and c)
Apologies:	Professor Ian Lewis	Non-Executive Director
	Clare Partridge	External Audit Partner (KPMG)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2018-19 (55)	**Welcome, introductions and preliminary business** The Chair welcomed members and others in attendance.	
2018-19 (55a)	**Apologies** Apologies were received from Non-Executive Director (IL) and Clare Partridge External Audit Partner (KPMG). **Preliminary business** The Committee Chair updated members on a number of matters related to the Trust. <u>Appointments to the Trust Board</u> Two substantive appointments had been made to the Trust Board; Dr Ruth Burnett as Executive Medical Director and Steph Lawrence as Executive Director of Nursing and Allied Health Professionals. <u>Appointment of Chief Clinical Information Officer</u> Dr Rob Arnold had been appointed to this position in the Trust. <u>Care Quality Commission (CQC) –Well Led Inspection</u> A request for preliminary information had been received from the CQC but no date for the inspection had been notified. <u>CAMHS Tier4 and Interserve</u> The Executive Director of Finance and Resources said that the Trust had received a letter of‘re-assurance’ from the Construction Division of Interserve however, the	

	position of the company overall remained unclear. He reminded the Committee that the Trust had not signed a formal contract with Interserve and further discussions would be taking place with Leeds and York Partnership NHS Foundation Trust in due course. The Committee Chair asked whether an alternative provider was being considered. The Executive Director of Finance and Resources advised that the Business Committee would be considering the future of the contract in more detail. **Action:** The Executive Director of Finance and Resources to provide a further update to the Audit Committee meeting on 26 April 2019.	**Executive Director of Finance and Resources**
2018-19 (56b)	**Declarations of interest** Associate Non-Executive Director (RG) declared an interest in Items (59a) and (59b) on the Agenda in relation to his substantive employment at NHS Digital.	
2018-19 (55c)	**Minutes of the previous meeting 14 December 2018** The minutes of the meeting held on 14 December 2018 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the previous meeting held on 14 December 2018.	
2018-19 (55d)	**Matters arising and actions' log** *Item 43d: Data quality assurance* The Internal Audit Manager confirmed that following discussions with the Executive Team three data audits had been included in the 2019/20 audit plan. The Committee Chair asked for the audit of the ESR action plan to be prioritised within the audit plan. **Action:** The audit of the ESR action plan to be a prioritised within the audit plan. *Item 44a: Cyber security – review of proposed renewal date of 31 August 2021 for the update of end user acceptable use policies* The Executive Director of Finance and Resources informed the Committee that the three policies concerned were all due for review in six months and he proposed that the updates be made as part of that review. The Committee felt that the updates should be made before the policies were due for review and asked that this commence immediately. **Action:** Review of the end user acceptable use policies to begin immediately. *Item 45a: External audit annual plan and fees* The Executive Director of Finance and Resources advised that discussions relating to audit fees were ongoing with the External Audit Partner. **Action:** The Executive Director of Finance and Resources to provide a further update to the Committee on 26 April 2019. *Item 44b: ICloud to be disabled from IPADS* The Executive Director of Finance and Resources reminded the Committee that this was on hold due to the unavailability of the MDM solution. He reported that plans including resources to address this would be included in the Trust's 2019/20	**Internal Audit Manager** **Executive Director of Finance and Resources** **Executive Director of Finance and Resources**

	Financial Plan. All other actions had been completed or were covered by the agenda and there were no further matters arising from the minutes.	
2018-19 (56a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report. The Committee received assurance that good progress had been made against the plan in anticipation of the year-end reporting timetable. The Committee was advised that Trust management had supported the process by ensuring that they returned the draft audit reports including their proposed actions promptly. The Internal Audit Manager advised that seven audits had been completed since the Committee's last meeting on 14 December 2018. The Committee discussed the executive summaries and management actions included in the report and noted that six audits indicated a reasonable assurance opinion and one was an advisory opinion on part 1 of the Data Security and Protection Toolkit. These reports were received and considered by the Committee. *Incident and Serious Incident Management* This audit had been determined as reasonable assurance with four important recommendations relating to serious incident investigations, reporting incidents on Datix and distribution of lessons learnt. There was one routine recommendation relating to Serious Incident Lead Investigator training courses. The Committee noted that a number of the recommendations were now due to have been completed and if they had not been they would be reported in the internal audit recommendations update paper; on that basis no substantive questions were raised. *Sickness and Absence* This audit had been determined as reasonable assurance with three important recommendations: management oversight of ESR to record sickness absence, updating the Managing Attendance Policy and Toolkit and establishing a central secure repository for personnel records. The Committee noted that implementation of all the recommendations were progressing to timetable and the Committee had no further questions to raise. *Data Security and Protection Toolkit – Part 1* For Part 1 of this audit there was no overall assessment. The Committee Chair advised that a substantive discussion about the Toolkit would take place under Item (59b) on the agenda. *Change Programme Management* This audit had been determined as reasonable assurance with four important recommendations: the contents of the Programme Management Office page to be reviewed and revised, a review to ensure that the programme is appropriately led, membership of Change Programme Board to be reviewed, management action to be taken in a timely manner to remedy instances where change projects and elements of project assurance were below a reasonable level. The Committee noted that the Change Programme Board reported to the Business Committee and that this audit would be discussed in detail by that Committee in	

	due course. The Committee Chair observed that the audit had raised concerns about the current structures in place and she felt that the organisation's approach to change required more clarity alongside a more effective monitoring process. She asked for a verbal update on the outcome of discussions at the Business Committee to be provided at the next meeting of the Audit Committee on 26 April 2019. **Action:** A verbal update on the Business Committee's consideration of the Change Programme Management audit to made to the Committee on 26 April 2019. *Police Custody Suites* This audit had been determined as reasonable assurance with four important recommendations relating to the review of standard operating procedures, risk assessments of the police custody suites, ensuring that key performance indicator targets were met and the development of a training spreadsheet. The Committee Chair queried the overall assurance assessment as reasonable given the conclusions contained in the four important recommendations. The Internal Audit Manager advised the overall conclusion was deemed as reasonable assurance because there was evidence that many of the concerns raised by the audit were being actively addressed. Referring to recommendation three, a Non-Executive Director (RG) expressed concern that the Police Custody Suite Service Manager felt that due to the limitations of the ESR system a separate system had to be developed to manage and monitor training. The Executive Director of Finance and Resources advised that work was underway to improve the functionality of ESR in this area. *Appraisal Review of Paediatric Neuro Development Service Waiting Lists* This audit had been deemed as reasonable assurance with two important recommendations relating to reporting and controlling waiting lists and the development of a job planning tool and four routine recommendations relating to the functionality of SystemOne, the continued development of the capacity and demand tool and revision of the PND referral form. Referring to recommendation two and five, Associate Non-Executive Director (RG) asked for firm implementation timetables to be agreed for the refinements to the monthly patch report and development of the electronic job planning tool. He also raised concerns about the development of an electronic job planning tool and asked why it was not possible to use the e-rostering system. **Actions:** • The Executive Director of Finance and Resources to work with other members of the Executive Team to agree implementation timetables and monitoring arrangements in relation to refinements to the monthly patch report and development of the electronic job planning tool. • The Executive Director of Finance and Resources to ascertain whether the e-rostering system could be utilised to provide data for the electronic job planning tool.	**Executive Director of Finance and Resources** **Executive Director of Finance and Resources**

	Outcome: The internal audit update report was received and the contents noted.	
2018-19 (56b)	**Internal audit recommendations updates** The Executive Director of Finance and Resources presented the summary report for all internal audit recommendations that had an agreed implementation date by 28 February 2019 and the more detailed report on the overdue recommendations. He noted that there were six recommendations to report that had not been completed by the due date and two proposed as considered complete these were reported in detail with an update from the responsible manager. The Committee discussed the overdue recommendations, the proposal to consider two recommendations complete and the proposed revised deadlines. *Managing wait times –Community CAMHS* The Committee noted that this recommendation was to be considered as closed but asked for ongoing monitoring of waiting times to be undertaken by the Business Committee. *Data quality – opt out letters* The Chair of the Committee asked the Executive Director of Finance and Resources for more clarity on what this action referred to. **Action:** The Executive Director of Finance and Resources to provide more clarity on the context of this action. **Outcome:** The internal audit update report was received and the contents noted.	**Executive Director of Finance and Resources**
2018-19 (56c)	**Head of Internal Audit draft opinion** The Head of Internal Audit introduced the draft year-end report and stated that the draft opinion was that: *"…. a reasonable assurance could be given and that there was a generally sound system of internal control, designed to meet the organisation's objectives and that controls were generally being applied consistently. However, some weaknesses in the design and/or the inconsistent application of controls put the achievement of particular objectives at risk. This conclusion was based on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes and an assessment of the range of individual opinions arising from risk-based audit assignments, contained within the audit risk-based plans that have been reported throughout the year. The assessment had also taken account of the relative materiality of these areas and the management progress in respect of addressing control weaknesses."* **Action:** Final internal audit year-end report to be presented at the next Committee meeting on 26 April 2019. **Outcome:** The Head of Internal Audit draft opinion was noted.	**Head of Internal Audit**
2018-19 (56d)	**Draft internal audit annual plan 2019/20** The draft internal audit annual plan for 2019/20 was presented by the Internal Audit Manager. He advised that during March 2019, meetings had been arranged with all the executive directors to discuss and review the plan and input from the Business and Quality Committees had been received. A final version would be presented for approval at the Audit Committee meeting on 26 April 2019. The Committee reviewed the plan and agreed that:	

	• GUARD Risk Analysis – subsidiaries/joint ventures should be removed • the audit considering the Well-Led framework should reference the CQC inspection • Learning Audit to be moved to the Governance and Risk Management review area • the next audit to review Change Management to be brought forward to 2020/21from 2021/22 • a column referencing the audit work undertaken in 2018/19 to be included **Action:** The Internal Audit Manager to make changes to the draft plan for 2019/20 in response to feedback from the Committee and brought back to the Audit Committee meeting on 26 April 2019 for approval. **Outcome:** The draft internal audit annual plan for 2019/20 was noted.	**Internal Audit Manager**
2018-19 (57a)	**External Audit** **External audit technical update** The External Audit Manager presented the technical update for March 2019. He drew the Committee's attention to the publication of the NHS Audit Committee handbook for 2018 by the HFMA The Deputy Director of Finance and Resources agreed to ensure the Committee had sight of the updated version. **Action:** An updated version of the HFMA NHS Audit Committee handbook for 2018 to be made available to the Committee. **Outcome:** The Committee received and noted the update	**Executive Director of Finance and Resources**
2018-19 (58a) **2018-19 (58b)** **2018-19 (58c)** **2018-19 (58d)**	**Annual report and accounts** **Annual reports and accounts timetable and progress report** The timetable for the production of the Trust's annual report and accounts was received. The Executive Director of Finance and Resources said that all aspects were being completed to timescale. **Outcome:** The detailed annual report and accounts timetable was noted. **Going concern consideration** The Executive Director of Finance and Resources presented the going concern paper for consideration by the Committee. **Outcome:** Based on the paper the Committee recommended to the Board that when approving the annual accounts it does so in agreement that the Trust is a going concern. **Changes to accounting policy** The Executive Director of Finance and Resources presented the report which provided details of recommended changes to the Trust's accounting policies that would be used in preparing the Trust's annual accounts for 2018/19. **Outcome:** The Committee received the report and noted the changes in accounting policies and annual reporting requirements adopted by the Trust, in order to comply with the Department of Health Group Accounting Manual 2018/19. **Revaluation of fixed assets** The Executive Director of Finance and Resources presented the report which set out the consideration undertaken in reaching a recommendation as to whether the Trust should undertake a full revaluation exercise of the Trust's fixed assets at this	

	year-end. The Executive Director of Finance and Resources advised that based on the points set out in the report a revaluation exercise was not deemed necessary at this year-end as there was no reason to expect the carrying values of the fixed assets to be reported in the Statement of Financial Position to be materially different to the market value. **Outcome:** The Committee supported the recommendation not to revalue the fixed assets.	
2018-19 (58e)	**Annual governance statement (draft)** The Interim Company Secretary introduced the draft annual governance statement for 2018/19 which would form part of the annual report and accounts and would be available for external auditors to review as part of the process to finalise the annual accounts. The Committee members reviewed the statement and made a number of observations: *Risk and control framework:* • Risk management procedure - to include a reference to the counter fraud work programme • Data security risk management - to be strengthened and expanded *Committees:* • Audit Committee duties - to include reference to the reports received from the Information Governance Group • Nominations and Remuneration Committee – a review of the terms of reference to ensure that all the business of the Committee is captured in the statement *Incident reporting:* • to include reference to the internal audit conducted during 2018/19 *Review of economy, efficiency and effectiveness and use of resources:* • reference to 2017/18 on page 12 to be changed to 2018/19 *Data accuracy:* • heading to be changed to Data quality • third paragraph – reference to waiting times to be removed *Information governance:* • the Trust's target for compliance with Information governance training at 95% – clarification as to whether this is a national or local target *Appendix 1: changes to the guidance since last year* • Final paragraph – the Executive Director of Finance and Resources advised that currently the Trust's sustainable development management plan did not take account of UK Climate Projections 2018 (UKCP18) and consequently the paragraph would need to be reworded **Action:** Revisions and clarifications to be made to the annual governance statement to reflect the Committee's comments. **Outcome:** The Committee reviewed and commented on the draft annual governance statement 2018/19.	**Company Secretary**
2018-19 (59a)	**Governance** **GDPR update** The Head of Information Governance (IG) and Data Protection Officer attended the meeting to present an update on the progress in terms of the Trust's actions to ensure compliance with GDPR and Data Protection legislation. The Committee noted that the Trust had completed the majority of actions within	

	the GDPR plan to ensure that minimum level of compliance with the GDPR and Data Protection legislation which came into effect on 25 May 2018 was achieved and received assurance of the Trust's commitment to continue maintaining compliance with the new legislation. A post implementation review would be undertaken in September 2019 to assess how GDPR has been embedded into the Trust. The Committee noted that there was a requirement for the Data Protection Officer to be adequately resourced and this had been identified as a risk in terms of the IG Team currently supporting the Trust. The Executive Director of Finance and Resources reported that a proposal for additional resource requirements had been submitted to the Senior Management Team (SMT) for consideration in the business priorities planning for 2019/20. **Outcome:** The Committee received assurance that the Trust's GDPR plans had been implemented and a post implementation review would be undertaken in September 2019.	
2018-19 (59b)	**Data Security and Protection Toolkit Final Assessment** The Head of IG and Data Protection Officer presented the report which asked the Committee to approve the Data Security and Protection Toolkit Final Assessment for publication by the 31 March 2019. The Head of IG and Data Protection Officer confirmed that the majority of actions in the improvement plan had been completed and the Trust was confident that the remaining actions would be addressed before the 31 March 2019. The Committee reviewed the final assessment of the Data Security & Protection Toolkit in detail and noted that although there were some areas where work had not been completed the report provided assurance that the Trust was on track to achieve necessary compliance against the 10 data standards by the 31 March 2019. Internal Audit had also given a 'reasonable assurance' opinion of the evidence base provided. **Outcome:** The Committee received assurance that the Trust was on track to achieve necessary compliance against the 10 data standards and approved publication of a final assessment of standards met on 31 March 2019 without the need for an improvement plan to be approved by NHS Digital.	
2018-19 (59c)	**Information governance policy and framework** The policy was presented for information only. The Committee Chair asked to be informed of any incidents which were reported to the Information Commissioner's Office by e-mail as a matter of routine. The Committee Chair requested that when the policy is reviewed in November 2021 reference be made to the Audit Committee's role in ensuring that the Trust's Information Governance function is effectively resourced and appropriate assurance provided to the Trust Board.	
2018-19 (59d)	**Review of standing orders and standing financial instructions** The Executive Director of Finance and Resources presented the report to the Committee on the work undertaken to update the Trust's standing orders and standing financial instructions. The report summarised a number of amendments and updates.	

	Outcome: The Committee noted and approved the updated standing orders and standing financial instructions in line with the summary of changes.	
2018-19 (60a)	**Financial controls** **Tender and quotations waiver report** The Executive Director of Finance and Resources introduced the report. He advised that the report represented an extract from the 2018/19 register of waivers completed during the financial year. He noted there had been a total of five waivers since the last report to the Committee October 2018. The Committee Chair observed that the notes relating to waiver 18-10 on the report lacked detail and to improve the transparency and assurance contained in future reports more detail should be included. **Action:** The Executive Director of Finance and Resources to review the content and format to ensure more rounded detail is included in future reports. **Outcome:** The Committee received the report and the content was noted.	**Executive Director of Finance and Resources**
2018-19 (60b)	**Losses, compensation and special payments report** The Executive Director of Finance and Resources presented the report which covered any such transactions made between January and February 2019. The Chair of the Committee noted that the total value for the reporting period was £29,047 primarily relating to a small number of the write offs of historic debt and settlements with NHS Resolution. **Outcome:** The losses, claims and special payments report was received and noted by the Committee.	
2018-19 (60c)	**Over and under payments of salary and off payroll payments** The Deputy Director of Finance and Resources presented the report which provided details of under and over payments of salary made in the financial year to the end of February 2019. **Outcome:** The Committee received and noted the report and the current position.	
2018-19 (60d)	**Receivables and Payables** The Executive Director of Finance and Resources presented the report which provided details of aged trade receivables (debtors) and payables (creditors) individually over £5,000 in value as at 28 February 2019, subsequent transactions and actions to clear the balances. Referring to the outstanding debt relating to the St Giles Church of England Academy, the Committee Chair sought assurance that the Trust was no longer providing services to the Academy. **Action:** The Executive Director of Finance and Resources to clarify whether the Trust still provided services to the St Giles Church of England Academy. **Outcome:** The Committee received and noted the report and the current position.	**Executive Director of Finance and Resources**
2018-19 (61)	**Minutes for noting** The minutes of the Information Governance Group on 11 December 2018 were presented.	

	Outcome: The minutes were noted.	
2018-19 (62)	**Audit Committee work plan** The Committee agreed that the requirement for a GDPR update at every meeting should be removed from the workplan and that in future updates be included in the information governance report provided to the Committee twice each year. **Action**: The workplan to be amended to remove the requirement for a GDPR update at every meeting. **Outcome:** The workplan was noted.	**Company Secretary**
2018-19 (63)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to be referred to Board colleagues: • Internal audit • GDPR • Annual governance statement	
2018-19 (64)	**Any other business** There were no matters of any other business raised.	
	Date and time of next meeting Friday 26 April 2019 9.00am- 11.30am, Boardroom, Stockdale House Leeds Community Healthcare LS61PF	

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (25c)

MINUTES

Business Committee Meeting
Meeting Room 1, Stockdale House
Monday 25 March 2019 (9.30am – 12.30pm)

Present:	Brodie Clark (Chair)	Non-Executive Director
	Tony Dearden	Non-Executive Director (TD)
	Richard Gladman	Associate Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Debra Gill	Head of Service, Children and Family Services (for item 82)
	Janet Addison	General Manager; Children and Young People (for item 82)
Observer:	Cara McQuire	Risk Manager
Apologies:	None	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2018/19 **(81)**	The Committee Chair welcomed the Risk Manager to the meeting as an observer. **81(a) - Apologies:** None recorded. **81(b) - Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members. The Committee noted that Associate Non-Executive Director (RG) was an employee of NHS Digital albeit on secondment to another NHS Trust. There were no potential conflicts of interest acknowledged. **81(c) - Minutes of last meeting** The public and private minutes of the meeting dated 20 February 2019 were noted for accuracy and approved by the Committee. **81(d) – Matters arising from the minutes and review of actions** *Item 2018/19(76b) – Risk register* The Executive Director of Finance & Resources said that the issue with Little Woodhouse Hall was the perceived lack of urgency being shown by colleagues at Leeds and York Partnership Foundation NHS Trust (LYPFT) and	

	Interserve as contractors regarding mitigation of ligature risk. He confirmed that he had been advised that the ligature testing work had now been completed, but records did not necessarily confirm that. He would continue to follow up and would confirm when the documentation was satisfactorily concluded. **Action** was deferred to next meeting in April 2019 for a further update. *Item 2018/19(76c) – Internal audit plan* The Associate Non-Executive Director (RG) reported that the discussion at the Audit Committee meeting on 20 March 2019 reflected on the future audit planning; having fewer audits in greater depth for next year. **Action closed.** *Item 2018/19(77) – Business Committee effectiveness annual review* It was agreed to receive a quarterly more in-depth finance report commencing in July 2019 to fit in with the first three months of the finance review. The Committee's work plan was to be updated.	BM DA
2018/19 **(82)**	**Service support session** **0-19 Public health integrated nursing service (PHINS)** **Service Presentation** The Head of Service and the General Manager for children's business unit provided the Committee with an update on progress with the mobilisation plans for the new PHIN service, since the new contract had been awarded in October 2018 by Leeds City Council (LCC) the Public Health Commissioners. The contract brought together the health visiting and school nursing services. The service was commissioned to look after and deliver the healthy child programme covering from pre-birth to 19 years of age, and providing continued care for children with complexities up to the age of 25 years. The Committee viewed a promotional video which described the universal service offer. The new model maximised the public nursing contributions to improve inequalities within the city. The Committee learned that the main challenges were in recruitment and establishing a mobilisation team. The Head of Service said that recruitment at times had been difficult because of the national shortage of school nurses. The financial penalties linked to performance and some external factors, eg. use of children's centres which may affect the financial forecast. The service had specific instructions from Leeds City Council (LCC) that they could not market the new service publically during the pre-election period for local elections. A soft launch for the practitioners was being considered and a hard launch was to be communicated officially in September 2019. The Head of Service said that single point of access (SPA) had been integral to the delivery of the service. A SPA assurance tool was being developed to make sure the key performance indicators (KPIs) closely linked to practitioners. The next steps were to introduce a soft launch and a hard launch and establishing innovations; working eight while eight and engaging teams together and establishing care packages across the 0-19 service. The Committee Chair asked about the extent of engagement with families and was advised that 800 family members had attended focus groups to help shape the new service.	

	The Committee Chair asked about the future direction and the goal of the service. The Head of Service said that there were lots of positives to remarket the school service from April 2019. The service planned to go into schools to promote new business and new process to roll out the comprehensive health assessment tool (CHAT). It was noted that the Trust had close working links since 2011 with other main practitioners and professionals, and with colleagues from LCC as part of the early start integrated working, healthy schools, midwifery and children services and commissioners. The Associate Non-Executive Director (RG) asked about the balance of managing demand within available workforce. The Service Manager assured the Committee that the early assessments suggested that 75% of families came under the universal family package and if an offer of another package of care was required it would be provided in a timely way. The Executive Director of Operations added that a piece of work to look at productivity and staff expectations was undertaken and she was confident that there were no concerns around capacity to meet demand. She said that in the new arrangement, the demand and capacity model demonstrated more one to one interventions, and health visiting was part of re-modelling and identifying any issues for children in key stage one (up to 7 years old). The Committee Chair thanked the representatives from the PHIN service and the efforts and the work of the teams working together and he was pleased to learn about staff engagement and the sense of collaboration across the business, the positive relationship with commissioners, and the ongoing recruitment drive. **Outcome:** The Committee welcomed the long term contract that provided stability for the service and was assured of the progress being made with mobilisation of the new service.	
2018/19 **(83)**	**Business and commercial** **(a) Draft operational and finance plan 2019/20** The Director of Finance and Resources presented the draft operational plan before submission to the Trust Board meeting in March 2019. The intension of the operational plan was to set the plan in the national, regional and West Yorkshire and Harrogate context and Leeds Local Healthcare Plan. The Executive Director of Finance & Resources said that the plan supported Trust strategy, effectively supporting a set of workforce priorities, quality priorities and financial plan for the year. The plan also looked briefly at the 2018/19 priorities before setting out the strategic goals for 2019/20 priorities. The Committee raised a concern that the plan was confusing in that it had too many different dimensions, without clarity of how it will all fit together. The Executive Director of Finance & Resources said that there would be a better flow to the document in the Board version. The Committee discussed and agreed that there should be more emphasis on the plans for estate. The Committee noted there was a greater emphasis on strategic intent and the NHS Long Term Plan clearly supported the direction of travel being pursued. The Committee Chair commented that quality section was worthy of being built into everything and not just a separate subject matter.	

	The Executive Director of Finance & Resources said that another version of this plan was being resubmitted to NHS Improvement (NHSI) before 4 April 2019 as a prescribed document the Trust will work with. He said he would reflect Committee's comments back to the Trust Board meeting in March 2019. The Executive Director of Finance & Resources said that the finance plan supported the operational plan, and in summary described the surplus of £1.7m in the plan and sets out to deliver the control total of £153m. The contract settlement with Clinical Commissioning Group generated £6.3m additional funding of which £4m recurrent was off setting existing costs that included in the new money already committed for next year for significant investment in services. The Executive Director of Finance & Resources referred to the list of approved investments and cost pressures included in the finance plan, agreed by the senior management team (SMT). He said that the national expectation in the tariff for 2019/20 was 1.1%, and after contract negotiation and expenditure proposals the cost improvement programme (CIP) ended up at 1.5% of expenditure or £2.3m plus the brought forward undelivered current CIPs. The Executive Director of Finance & Resources said that the £2.3m CIP was considered to be low or medium risk and the capital plans were consistent with using internal generated funds. The Executive Director of Finance & Resources said that the biggest risk was delivering some of the CIPs brought forward from this year and resulting in low to medium risk to achieve the control total. He said part of the financial gap would be recovered by money flowing through public health services of between £7k and £9k. The Executive Director of Operations explained that the expectation from commissioners is that the additional money through public health is an additional ask and that was how the contract had been written. The Associate Non-Executive Director (RG) said that if there was a reasonable settlement could that be used to improve recruitment. The Executive Director of Finance & Resources said that he would need to clarify that as there was a vacancy factor to be achieved including additional vacancies over and above the vacancy factor and the Trust had to achieve that 5.5% vacancy factor to achieve the control total. Detailed discussions took place on CIPs brought forward from last year. The Executive Director of Finance & Resources said that better efficiency requirements would be considered in the current year plan for 2020/21. The Chief Executive added that for the finance report due in July 2019 against well-led framework financial resources the Trust Board and Business Committee were required to focus on potential CIPs and the processes and would assist the Committee in understanding quality impact assessments and the underlying financial position. The Committee Chair summarised the discussion and said that there were still some incomplete aspects of the plan but felt positive about finances going forward. **Action:** Further information on CIPs to be provided for discussion to July 2019 meeting. **Outcome:**	BM

	The Committee reviewed and provided feedback on the draft operational plan 2019/20 and noted that the control total was achievable. **(b) EU Exit report** (please see private minutes).	
2018/19 **(84)**	**Project management** **(a) Projects reports (Change Board)** The Executive Director of Operations introduced the projects report and said that there were no escalations to report to the Committee. The February 2019 Change Board meeting was held in workshop style to construct a shared benefits plan and the branding of the whole change programme, which was 'flash reports' still in working progress. The Associate Non-Executive Director (RG) noted that the high level plan received at the last Committee meeting, with key milestones had been omitted. He said in terms of information received on the overall plan, it was good to see some of the structures and progress feeding through to give assurance. The Executive Director of Operations agreed to continue to provide flash reports for individual projects. In respond to the Associate Non-Executive Director (RG) asking about branding and scope about Change Board Programme, the Executive Director of Operations said that this was about 'creating the working lives we want' for the whole organisation; making the estates right, right technology supporting people and patients and digital innovation. **Outcome:** The Committee received the report. The high level plan would be included in the next update to provide assurance to the Committee. **(b) E-rostering** The Director of Workforce (LS) introduced the six monthly update on e-rostering system. She said that the project had been in pilot phase implementation of the system to clinical and support service (CLaSS), Armley Neighbourhood team and Police Custody. All three services that had taken part in the pilot had successfully rolled out the e-rostering system and achieved its timescales within the project plan. The Committee was advised that the project would commence implementation phase from April 2019. The project was being well managed and benefits were already identified. Prioritisation of services was still being agreed and neighbourhood teams were being seen as a priority for implementation. Other priority areas were suggested by the Executive Director of Operations. The next stage of the project was to move through to implementation upon improvements associated with the increased size of e-rostering team and to mobilise the project by end of March 2021. The Director of Workforce (LS) said that funding had been secured to ensure ongoing implementation. The Associate Non-Executive Director (RG) asked about the Trust's relationship with Allocate and was advised that the Trust had been supported well and was confident in understanding services of the system. The Director of Workforce (LS) said that staff in Police Custody and Armley Neighbourhood team were strong advocates for the system in terms of lessons learnt. A wider roll-out of the system will be based on a benefits analysis and	

	lessons learnt from the initial pilot. This will enable the project team to create user guides and SOPs for best practice. The Executive Director of Finance & Resources asked about the savings being made in administration time and was advised that information was anecdotal at the moment. **Outcome:** The Committee noted the update and progress made. The current project plan was on track and there were no concerns to raise. **(c) CAMHS Tier 4** (please see private minutes).	
2018/19 **(85)**	**Estates** **(a) Office reorganisation:** **Proposed new lease for 4th floor, Stockdale House** The Executive Director of Finance & Resources presented a proposal to sign a new lease for 4th floor at Stockdale House to provide space for relocation of the Primary Care Confederation, the CAMHS management team from Little Woodhouse Hall and the Safeguarding Team from Armley Moor. He said the lease was strategically important to meet operational needs and provide a base to allow combined headquarter presence on the site. The annual cost of the 4th floor lease was circa £200k with £35k for a one-off cost. The Trust was committed to the rent and service charges up to October 2023. This termination date was coterminous with the other three floors. The Committee reviewed the proposal to enter into a new lease for the 4th floor of Stockdale House. The Committee queried whether new ways of working would be encouraged, and this was confirmed. The Committee explored the rationale for accommodating the proposed teams and was satisfied with the reasons for this; whilst the move was not cost neutral, it was of strategic importance. The Committee Chair asked about the risk of the lease not being renewed after 2023 and was advised this was a risk to the building overall. The Committee Chair asked for clarity on the occupancy figures given in the report, which the Executive Director of Finance & Resources provided. **Outcome:** The Committee was content with the proposal and recommended that the Trust Board approves and signs off the lease for the 4th floor at Stockdale House. **(b) LIFT under lease plus agreements (ULPAs)** The purpose of the paper was to advise the Committee that Community Health Partnerships (CHP) required the Trust to sign the next five ULPAs Agreements, excluding community dental services. This was following the agreement of the first five in October 2018; subject to all the same terms and conditions applied to the first five. The Committee consider the proposal of the LIFT properties lease agreements prior to the Board being asked to approve these. The Committee also considered the overall cost of all five buildings and the minimum of three years charges before which a break in the agreement could be enacted. **Outcome:**	

	The Business Committee agreed to recommend that the Board approve the signing of the ULPAs for the five properties listed in the report.	
2018/19 **(86)**	**Performance management** **86(a) - Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports. He said this was the final version going to the Trust Board including neighbourhood teams update. The Quality Committee reviewed the safe and caring domains at its meeting on 18 March 2019. A Non-Executive Director (TD) said that the Quality Committee discussed the invalidated numbers for pressure ulcers. It had not been determined whether the pressure ulcers were avoidable or unavoidable. *Responsive domain* The Trust continued to perform well against nationally reported waiting lists indicators. *Effective domain* The measures in the effective domain were reported quarterly; there were no new issues to report this month. *Well-led domain* The Committee considered appraisal rates performance and queried whether staff were simply missing their appraisal date by a small margin. The Director of Workforce said there remains an argument that appraisal rates have dipped over the winter months but work had continued in the past few months within her directorate to monitor and hold people to account and making it clear to each of the business units that there was a requirement to increase appraisal rates by end of April 2019 to achieve an improved figure of above 90%. For statutory/mandatory training, the Committee was advised the Trust was an outlier in that it had very high expectations regarding the level of compliance, when compared to other trusts. The Executive Director of Finance & Resources drew Committees attention to the commentary on child and adolescent mental health services (CAMHS). He said the Audit Committee also showed an interest in performance on waiting times in CAMHS and the management of the backlog was discussed. **Finance** The Committee was advised that the Trust continued to be on track to meet the control total. **(b) Performance brief proposed measures 2019/20** (Key Performance Indicators 2019/20) The Committee received a proposal for the measures for inclusion in the 2019/20 performance brief. The report highlighted proposed new measures, measures to be removed and measures to be amended from 2018/19 reporting. The Committee considered the proposed measures and those in development. As these were the first draft of the proposed KPIs for 2019/20, there was an agreement that further work was needed and that approval should be deferred	

	to the extraordinary meeting of the Trust Board following the Board workshop on 3 May 2019. A detailed discussion took place regarding the proposal to remove the Friends and Family Test indicator. A Non-Executives Director (TD) said that concerns were also raised at the Quality Committee about understanding the rationale of removing as the measure for patient experience was important. It was agreed to review the KPIs in an extraordinary meeting of the Board at the May 2019 Board Workshop and submit for approval in June 2019. **Outcome:** The Committee noted the proposed measures but agreed to review outside the meeting before recommending to the Trust Board. **(c) - Operational and non-clinical risks register** The Committee considered changes to non-clinical risks on the risk register as follows: • Two new risks • No risk had an increased score • One risk had a decreased score • One risk had been closed since the previous report. The Company Secretary said that one new risk that the Quality Committee had discussed in depth was relating to risk of inaccurate reporting of mortality data. The deescalated risk related to diabetes service waiting times. There were no extreme risks in total (scoring 15 or more) to report. **Outcome:** The Committee noted the recent revisions made to the risk register. **(d) Internal audit reports:** The reports provided a summary of the outcomes from completed internal audit reports where the reports related directly to the role and functions of the Business Committee. The paper covered completed audits for police custody suites and data security and protection toolkit. Both audits concluded a reasonable assurance opinion. The Executive Director of Finance & Resources said that the Audit Committee took assurance that the Trust was on track to submit a compliance return by 31 March 2019 on the obligations of the new data security and protection toolkit. **Outcome:** The Committee noted the internal audit reviews.	
2018/19 **(87)**	**Annual Reports** **Business Committee draft annual report and review of terms of reference 2018/19** The Company Secretary presented a draft annual report for 2018/19 to provide an overview of the workings of the Committee which demonstrated that the Committee had complied with the respective terms of reference and its activity throughout the year.	

	The Committee's draft annual report was to be submitted to the Audit Committee for approval. One area identified in the Committee's self-assessment was the quality of information provided and the Committee noted that report-writing courses were being offered to key staff, with the first course run on 19 March 2019. The Committee reviewed its terms of reference and agreed that no changes were necessary. **Outcome:** The Committee approved the annual report and its terms of reference prior to submission to the Audit Committee.	
2018/19 **(88)**	**Minutes to note** **Draft health and safety group minutes (19.02.19)** Draft Health and Safety group minutes dated19.02.19 were noted. As the Risk Manager was observing the Committee meeting she was asked to give a further update on the Health and Safety group activities and described the gap analysis being undertaken to ensure the Trust meets health and safety legal requirements.	
2018/19 **(89)**	**Business Committee work plan** **2018/19 Business Committee's work plan** The work plan was reviewed by the Committee members and no changes were requested. Finance quarterly reporting was to be added to the Committee's work plan. The next update was due in July 2019. **Outcome:** The Committee agreed the work plan.	
2018/19 **(90)**	**Matters for the Board and other Committees** • PHIN service mobilisation • Operational plan • EU Exit (private discussion) • E-rostering • CAMHS (private discussion) • Performance brief • Proposed measure for 2019/20	
2018/19 **(91)**	**Any other business** None discussed.	