Leeds Community Healthcare NHS Trust
Board Meeting (held in public)
Friday 2 August 2019, 9.00am – 12.10pm
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 (27)	Welcome, introductions and apologies: *Professor Ian Lewis and Laura Smith*	Neil Franklin	N
9.05	2019-20 (28)	Declarations of interest	Neil Franklin	N
9.10	2019-20 (29)	Questions from members of the public	Neil Franklin	N
9.15	2019-20 (30)	Minutes of previous meeting and matters arising: a. Minutes of the meetings held on 24 May 2019 b. Actions' log	Neil Franklin	 Y Y
9.30	2019-20 (31)	Patient's story: Infection control - e-coli	Steph Lawrence	N
		Quality and delivery		
9.45	2019-20 (32)	Chief Executive's report	Thea Stein	Y
9.55	2019-20 (33)	Committees' assurance reports: i. Charitable Funds Committee: 21 June 2019 ii. Nominations and Remuneration Committee: 21 June 2019 iii. Quality Committee: 24 June 2019 and 22 July 2019 iv. Business Committee: 26 June 2019 and 24 July 2019 (verbal) v. Audit Committee: 1 August 2019 (Verbal)	 Brodie Clark Neil Franklin Ian Lewis Brodie Clark Jane Madeley	 Y Y Y Y Y
10.05	2019-20 (34)	Performance brief and domain reports: June 2019	Bryan Machin	Y
10.20	2019-20 (35)	Significant Risks and Board Assurance Framework (BAF) Summary Report	Thea Stein	Y
10.30	2019-20 (36)	Working with primary care networks	Jenny Allen/Laura Smith	Y
10.40	2019-20 (37)	Safe staffing report	Steph Lawrence	Y
10.45	2019-20 (38)	Serious incidents report	Steph Lawrence	Y
10.50	2019-20 (39)	Freedom to Speak Up Guardian annual report	Thea Stein	Y
11.00	2019-20 (40)	Guardian for Safe Working Hours – update report	Turlough Mills	Y
		Strategy and planning		
11.10	2019-20 (41)	Workforce i. Workforce strategy: Resourcing ii. Interim NHS People Plan: implications for LCH	Laura Smith/Jenny Allen	 Y Y
11.15	2019-20 (42)	Research and development strategy: update	Ruth Burnett	N
11.20	2019-20 (43)	Quality improvement strategy	Sam Prince	Y
11.25	2019-20 (44)	Workplace Disability Equality Standard: action plan	Laura Smith/Jenny Allen	Y
		Governance		
11.35	2019-20 (45)	Medical Director's annual report on doctors' revalidation	Ruth Burnett	Y
11.40	2019-20 (46)	Nurse and Allied Health Professionals revalidation	Steph Lawrence	Y
11.45	2019-20 (47)	Health and safety policy – ratification	Bryan Machin	Y
11.50	2019-20 (48)	Procedure for emergency powers and urgent decisions	Diane Allison	Y
11.55	2019-20 (49)	Urgent decisions taken: • Mobile phone contract: new arrangements • CAMHS Tier 4 development stage 3 contract procurement	Bryan Machin	N
12.00	2019-20 (50)	Board workplan	Thea Stein	Y
		Minutes		
12.05	2019-20 (51)	Approved minutes for noting: a. Quality Committee: 20 May 2019 and 24 June 2019 b. Business Committee: 22 May 2019 and 26 June 2019 c. West Yorkshire Mental Health Services Collaborative Committees in Common -Chair's report 28 June 2019	Neil Franklin Brodie Clark	 Y Y Y
12.10	2019-20 (52)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 4 October 2019 9.00am -12noon

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

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

Friday 24 May 2019, 9.00am – 12.00noon

AGENDA ITEM 2019-20 (30a)

Present:	Neil Franklin	Trust Chair,
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Sam Prince	Executive Director of Operations
In attendance:	Diane Allison	Company Secretary
	Megan Rowlands	General Manager Adult Services
	Chris Lake	Involvement Lead, Children's Business Unit (for item 10)
	Dr Turlough Mills	Guardian for Safe Working Hours (for item 20)
Minutes:	Liz Thornton	Board Administrator
Observers:	Penny McSorley	Deputy Director of Nursing, NHS Leeds Clinical Commissioning Group
Members of the public:	One member of the public was in attendance.	

Item	Discussion points	Action
2019-20 (6)	**Welcome and introductions** The Trust Chair welcomed Board members, a member of the public, members of staff from the Trust and one observer attending the meeting. He particularly welcomed Helen Thomson to the Board following her appointment as a Non-Executive Director and Richard Gladman following his re-instatement as Non-Executive Director on the Board by NHS Improvement. **Apologies** Apologies were noted from the Executive Director of Operations.	

2019-20 (7)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2019-20 (8)	**Questions from members of the public** There were no questions from the member of public in attendance.	
2019-20 (9ai)	**Minutes of the previous meeting held on 29 March 2019 and matters arising** **Minutes of the previous meeting held on 29 March 2019** The minutes were reviewed for accuracy and agreed to be a correct record subject to the addition of some text to Item 121: Gender pay gap report, to be agreed following the meeting. **Action:** The Director of Workforce, Organisational Development and System Development (JA) and the Company Secretary to agree additional text for inclusion under Item 121: Gender pay gap report, of the minutes of 29 March 2019. **Items from the actions' log** The Trust Chair asked for a verbal update on two completed (blue) actions: *2018-19 (71): Committees' assurance reports: HR representation at the Quality Committee* – the Chief Executive advised that a representative of the Workforce Directorate would attend the Quality Committee when specific workforce issues were on the agenda. *2018-19 (95): Future reporting of avoidable and unavoidable serious incidents* **–** the Executive Director of Nursing and Allied Health Professionals advised that report formats had been amended to capture the recording of such incidents in future particularly where the Trust was not in the control of the factors surrounding the incident. The Trust Chair asked for the response to completed action: *2018-19 (93): clarification of the requirement In NICE guidance 11 for CAMHS staff* – to be circulated by e-mail following the meeting. The other completed actions from previous meetings were noted. All other actions were on track for completion by the due deadline or were to be discussed as part of the meeting's agenda.	**Director of Workforce, OD and System Development (JA) and the Company Secretary** **Executive Medical Director**
2019-20 (9aii)	**Minutes if the extraordinary meeting held on 22 May 2019** The minutes were reviewed for accuracy and agreed to be a correct record.	
2019-20 (10)	**A patient's story** The Executive Director of Nursing introduced the patient's story item and welcomed the family which included a mother and two children, one of whom had a genetic disorder and complex specialist needs, to share their story about their experience of the Integrated services for Children with Additional Needs (ICAN) service provided by the Trust. Also in attendance at the Board to support the family was Chris Lake, Involvement Lead for the Children's Business Unit. The mother described the 'forward thinking' team who were involved with her child's care and she spoke of the important role of the clinical psychologist who provided support for parents. Whilst recognising that the NHS had its challenge, she made some suggestions for how the service could be improved in ways that would not require a lot of resource, including clinicians having access to books about clinical information on the rare genetic disorders for the children in their care, and for eye-gaze equipment to assist children with complex needs to communicate. The Board reflected on how to improve the decision making processes for purchasing such resources. A Non-Executive Director (JM) asked what other support was available to the family	

	in addition to the support received from the Trust. The Chief Executive said that there were various charities in the area who provided support to families who had a member with a serious physical or mental health illness. She agreed to ensure that the family were made aware of any further support they could access. The Trust Chair thanked the family for attending and praised the mother for being such a fantastic advocate for her child and for the way she was coping with the challenges the family faced.	
2019-20 (11)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • CQC Well-led inspection visit due in June 2019 • Chief Nurse's visit to the Trust in April 2019 • Award winning Thank You awards • Participation in the ICS Financial Framework • NHS Improvement Transition Collaborative The Board was particularly pleased to see that the new Chief Nursing Officer, Ruth May had visited the Trust. She had spent time in two of the Trust's clinical services including the Elland Road Police Custody Suite. The General Manager for Adult Services provided a verbal update on the Newton Europe audit work undertaken in 2018 to support health and social care economies in improving flow; in particular she spoke about the repeat audits which had taken place on 10 and 13 May 2019 to highlight the impact of the actions taken. She reported that the re-audits had evidenced improvements in processes, increased capacity and the establishment of an environment where patients were discharged to the right place every time. The Board noted the further work that Newton Europe had been commissioned to undertake over the summer which would include a repeat of the cultural survey and looked forward to receiving further reports during the year. In response to a question from a Non-Executive Director (RG), the Chief Executive reported that an analysis of the study report would be made available to the Board in due course. No further questions were raised on any other items in the Chief Executive's report. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2019-20 (12)	**Assurance reports from sub-committees** **Item 12(i) – Business Committee** The reports were presented by the Committee Chair and Non-Executive Director (BC) who highlighted the key issues discussed, namely: **24 April 2019** • **EPR project update** – the committee had received a presentation and supporting documentation on the benefits realisation of the EPR project. The Committee recognised that the evaluation was ongoing and was keen that patients' views were taken into consideration and evidenced in the next report to the Committee. • **Business Development Strategy Update** – the Committee received a progress report on the Business Development Strategy for 2017-20. The Committee was advised that 2018/19 had been a successful year for the	

Trust, with £13.55 million of existing income protected and retained, and nearly £5 million of additional income generated through bids and business cases.

- **Workforce quarterly report including WRES action plan** – the Committee received assurance that diversity and inclusion was moving forward at a good pace and noted the successful Race for Equality Event held in March 2019, the development of a reverse mentoring scheme and the appointment of a disability project officer.

22 May 2019

- **Digital strategy update –** the Committee received an update on progress of implementation of the Trust's digital strategy. The report covered areas of progress on the existing strategy and also identified those which were either completed or had moved to business as usual. Where work was delayed or off track, reasons were identified and actions taken to bring the activity back in line with the plan. The update also outlined the proposed approach for developing the replacement digital strategy along with potential timescales.
- **Neighbourhood teams Key Performance Indicators report** – the Committee received a dashboard report which provided a detailed analysis of the position within the adult business unit for the quarter four period. The Committee received reasonable assurance that evidence was emerging to show that some of the workforce gaps were closing and reducing the requirement to use agency staff over time.
- **Performance brief -** overall performance remained good in April 2019. Under the Well-led domain the Committee noted that well led measures were positive in a number of areas, whilst appraisals remained an area requiring ongoing focus and support.

Item 12(ii) – Audit Committee

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

26 April 2019

- ***Internal audit* –** The 2018-19 internal audit programme was almost complete, one final audit was in draft, awaiting manager's comments. The Committee reviewed the two completed audits along with the recommendations. These audits had been shared with the relevant committees. The annual audit plan for 2019-20 was approved; all audits had been aligned with the board assurance framework and risk register and assigned to an executive lead and a committee.
- **Board sub-committees' annual reports 2018-19 –** the Committee's annual report and terms of reference were reviewed. 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 reports were recommended for submission to the Trust Board for approval.
- **Partnership Governance standards –** following a recommendation from Internal Audit the Committee had asked the Company Secretary and the Executive Director of Finance and Resources to draft a set of governance standards for partnership working. The Committee had reviewed and commented on an initial draft of the standards and suggested a number of refinements.

22 May 2019

- **Annual update from Chief Executive**
  The Chief Executive had presented an overview of the Trust's four strategic goals and reflected on the challenges and successes of achieving these throughout the past year.
- **Internal audit**
  The 2018/19 audit programme had been concluded and the Committee reviewed the final completed audit on the self-assessment and evidence

based processes that supported the Trust's Well-led framework. This audit received reasonable assurance, with one important recommendation, which was to ensure that there was a continuous review process for the framework.

- **Annual report**
  The Committee reviewed the annual report and recommended it to the Trust Board for adoption.
- **External audit of annual report and accounts**
  KPMG are providing an unqualified opinion on the financial statement and use of resources (VFM). The significant risks highlighted in the audit plan had been reviewed and the auditors were satisfied there were no issues arising. There were no audit differences reported and the auditors made no recommendations in respect of management action. The external auditors and the Committee had thanked the Trust's finance team for their hard work and support to deliver the end of year accounts. The Committee recommended that the annual accounts for adoption by the Board.

Item 12(iii) – Quality Committee
The reports were provided by the Committee Chair and Non-Executive Director (IL) who highlighted the key issues discussed, namely:
29 April 2019 (workshop)

- **Focussed workshop session covering two areas –** patient and family engagement in the Children's Business Unit and the work of the Clinical Education Team.
- **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 Leeds and York Partnership Foundation Trust. 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, aligned with the directives given by the coroner and would be presented at the July 2019 Committee meeting for assurance.
- **2019/20 KPI's approved –** the Committee had reviewed and approved the proposed key performance indicators for the Safe, Caring and Effective domains of the 2019/20 Performance Brief.

20 May 2019

- **Committee effectiveness review -** the Committee reviewed its current format and considered the structure and effectiveness of the business and workshop meetings, including the Committee's work plan and agenda. It also reviewed the function and presentation of the 'Service Spotlights' which featured in the 6 business meetings.
- **Freedom to Speak up Guardian Report and Peer Review–** the Committee had received a 6-monthly overview of the Guardian's activities, the nature of the issues raised by staff and themes emerging from this work. The Freedom to Speak up Guardian had confirmed that he felt well supported by the Board, and his work was recognised and appreciated by the Trust.
- **Complaints review -** the Committee had reviewed the findings of the review into complaint responses undertaken by Healthwatch and of the quarterly review meeting held between the Executive Director of Nursing and Allied Health Professionals and the Trust Chair. The Healthwatch report would be reviewed under item 18 on the agenda for this meeting.
- **Performance brief -** the Committee reviewed the end of year performance report for 2018/19 and the April 2019 performance brief. The Committee noted that two category 4 pressure ulcers had been reported in 2018/19, which were avoidable to the Trust, and in April 2019 there had been an increase in category 3 pressure ulcers. The Committee was advised that the Patient Safety and Experience Group (a sub-group of the Quality Committee)

	was examining learning from pressure ulcer incidents in greater detail. **Outcome:** The Board noted the update reports from the committee chairs and the matters highlighted.	
2019-20 (13a)	**Performance brief and domain reports April 2019** The Executive Director of Finance and Resources presented the report, which provided a high level performance summary within the Trust during April 2019. The Executive Director of Finance and Resources said that the report highlighted any current concerns relating to contracts held by the Trust, a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. The information within the performance brief was limited as it was month one of 2019-20. He highlighted the following: ***Safe*** The Board noted that two category 4 pressure ulcers had been reported in 2018/19, which were avoidable to LCH, and in April 2019/20 there had been an increase in category 3 pressure ulcers. A Non-Executive Director (IL), in his capacity as Chair of the Quality Committee reported that the Committee had received an update on the actions following investigation into the Category 4 pressure ulcer incidents and received assurance that clear care plans were now in place and further incidences were not anticipated. Clinical Leads were revisiting training and pressure ulcer review panels were taking place out in the community. **Effective domain** It was noted that the measures in this domain were reported quarterly so would first appear in the Performance Brief for June 2019. ***Responsive*** The Trust had performed well in respect of its indicators relating to waiting lists and all were rated green for April 2019. The Board discussed the data relating to CAMHS next steps waits and noted that an improvement plan relating to Children's waiting lists was being developed. ***Well-led*** The Board noted that the well led measures were positive in a number of areas, but appraisals remained an area requiring ongoing focus and support. The Director of Workforce (LS) said that she remained confident that appraisals were happening but the problem related to services not having confidence in the electronic staff record (ESR) system. The Executive Director of Finance & Resources said that it was important to note that work was on going to target the most underperforming areas with support from the workforce directorate. He said that those low performing areas were reported to the operational performance panel meetings where the general managers were accountable and were asked about processes in their local areas and their action plans. The Board heard that the Statutory and Mandatory Training Compliance Project was focussing on improving the configuration and structure of ESR to make its information more reliable and the training matrix was being redesigned to provide better information for staff about the specific training required by different roles within the Trust.	

	In summary the Trust Chair said that there were some satisfactory outcomes in the well-led domains in terms of a number of issues particularly the position of sickness absence, retention and statutory and mandatory training but concerns remained in recruitment and appraisal rates. The Committee noted that actions to remedy this were underway to get those targets on track. ***Financial position*** The Executive Director of Finance & Resources said that the headline for this month was that the Trust was slightly overspending. The Trust would need to take action to reduce spending by £2m to meet the control total by the end of the financial year. The Trust's cash position remained positive. The Executive Director of Finance & Resources advised that very careful monitoring of the budget performance would be required with options being developed to reduce spending levels if necessary. He added that any over spending above current forecasts in the business units was also discussed at the operations performance panel meetings resulting in actions being taken to bring budgets back into balance. **Outcome:** The Board noted the Trust's performance for April 2019.	
2019-20 (13b)	**Performance brief and domain annual report 2018-19** The Executive Director of Finance and Resources introduced the report which provided a high level summary of performance within the Trust during the financial year 2018/19. **Outcome:** The Board noted the year-end performance brief.	
2019-20 (14)	**Significant risk and risk assurance report** The Company Secretary presented the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures and the board assurance framework (BAF) summary which gave an indication of the current assurance level for each strategic risk. *Summary of risks scoring 12 (high)* The Board noted there were no risks with a current score of 15 (extreme). There were four high risks scoring 12 relating to: • Prevalence of staff sickness • New CAMHS Tier4 building • High turnover of staff in Neighbourhood Teams • Increasing numbers of referrals for complex communication assessments in the ICAN service The Board discussed the current risk scores and targets for each of the four high risks including the importance of setting realistic targets particularly in relation to staff sickness. The General Manager for Adult Services referred to the risk related to turnover in the Neighbourhood Teams, which she reminded the Board was a long standing risk on the register. She reported on the work underway to develop and expand the role of nurses in the Neighbourhood Teams and the availability of funding to support new initiatives identified by individual teams. In response to a question from a Non-Executive Director (JM), the Executive Director of Finance and Resources said that he had nothing further to report in relation to the risk associated with the new CAMHS Tier 4 building but he believed that the current risk score was correct. He added that the Business Committee would be monitoring developments and receive an update report at each meeting	

	and further update reports would be made available to the Board in due course. The Board noted and discussed the risk themes. A Non-Executive Director (JM) requested that a report on the three emerging themes should be provided for the next Board meeting. **Action:** A report on the three emerging themes to be provided for the next Board meeting. *BAF risk score movement* The Company Secretary advised the Board that there were two positive assurance moves which meant that the committees had received assurance that things were improving. These were patient and public engagement and retaining and winning viable business. She also advised the Board that the BAF was going through an initial review process. Individual directors, Business, Quality and Audit Committee would review the outcome from the review in July 2019. The Board were asked to review the risk scores for BAF risks 4.1 and 4.2 and consider whether they should be lowered. Following discussion it was agreed that: Risk 4.1: the scoring of this risk should be considered collectively by representatives from the Quality, Business and Audit Committees. **Action:** The scoring of risk 4.1 to be discussed by representatives from the Business, Quality and Audit committees. Risk 4.2: as the Trust had built strong relationships with stakeholders and the likelihood of the Trust not being involved in new business opportunities had reduced the risk score should be reduced from 12 (high) to 8 (high). **Outcome:** The Board noted: • the contents of the risk register • noted the themes identified in the report • agreed the revised BAF risk score for risk 4.2 • agreed that consideration of the BAF risk score for risk 4.1 should be remitted for discussion collectively by representatives from the Business, Quality and Audit committees.	**Company Secretary** **Company Secretary**
2019-20 (15) **(15a)**	**Annual report and accounts 2018-19** The matters under agenda item 15 were re-ordered and dealt with as set out in the minute below ***Annual report*** The Executive Director of Finance and Resources introduced this item and began by referring to the Audit Committee meeting on Wednesday 22 May 2019 at which the Chief Executive had spoken about the achievements and challenges in 2018-19. A Non-Executive Director (JM), in her capacity as Chair of the Audit Committee, said that the Committee had welcomed the Chief Executive's attendance at the meeting and the opportunity to comment and contribute to the draft annual report. She added that the Trust's external auditors had confirmed that the annual report's content was in line with the requirements stipulated by the Department of Health.	

	The Audit Committee had recommended the draft annual report for adoption by the Board.	
(15b,c &d)	***Annual accounts, letter of representation and external auditors' opinion*** The Executive Director of Finance and Resources stated that the Audit Committee had given full and proper scrutiny to the Trust's accounts for 2018-19. At the Audit Committee meeting on Wednesday 22 May 2019, the Committee had also reviewed the letter of representation and the audit memorandum on the Trust's financial statements issued by the external auditors, KPMG. The Executive Director of Finance and Resources confirmed that, as noted in the letter of representation, directors had provided confirmation that, to the best of their knowledge, all information relevant to the financial statements had been disclosed. The external auditors had confirmed their confidence that this had been the case. Referring to the external auditors' opinion on the accounts, the Executive Director of Finance and Resources said he could report that the auditors would issue an unqualified opinion on the Trust's accounts. A Non-Executive Director (JM), as Chair of the Audit Committee, reported that she was very satisfied with the opportunity the Committee had had to review the accounts and she extended her thanks to the finance team for their efforts in maintaining a robust process both throughout the year and for the year end processes. This conclusion had been supported by the external auditors' opinion on the accuracy of the financial statements. **Outcome:** The Board accepted the recommendations of the Audit Committee and: • adopted the draft annual report, including the annual governance statement • adopted the annual accounts, having noted the external auditors' opinion • approved the letter of representation.	
2019-20 (16)	**Operational plan 2018-19:end of year report** The Executive Director of Finance and Resources presented the report which provided an overview of delivery at the year-end of the Trust's 14 priorities for 2018-19. The Business Committee would be monitoring progress against the plan on a quarterly basis in 2019-20. This would allow more flexibility to review and amend targets in-year to reflect exceptional circumstances. **Outcome:** The Board received and noted the year-end progress report in delivering the 2018-19 priorities and success measures.	
2019-20 (17)	**Quality Account 2018-19** The Executive Director of Nursing and Allied Health Professionals introduced the Trust's Quality Account for 2018-19. She advised the Board that the account, in its draft format, had been scrutinised in detail by the Quality Committee. The Trust Chair stated that he felt that the document was comprehensive and struck the correct balance between realistic expectations and aspirations. He noted his thanks to the team responsible for the compilation of the document. **Outcome:** The Board : • received the report • approved the final version of the quality account for 2018-19.	

2019-20 (18)	**Healthwatch review of patient engagement activity** The Executive Director of Nursing and Allied Health Professionals introduced the paper which highlighted the work undertaken by Healthwatch Leeds for the Trust to scope the current approach to patient engagement and experience and make recommendations for the future. Referring to the findings in the report the Executive Director of Nursing and Allied Health Professionals said that they clearly set out what was working well within the Trust, highlighted some excellent work related to patient engagement and made some recommendations about how this could be embedded across the Trust. **Outcome:** The Board: • acknowledged the work undertaken by Healthwatch Leeds and the subsequent report • agreed the suggested timeline for development of the patient engagement/experience strategy.	
2019-20 (19)	**Serious incidents report and patient experience and complaints annual report** The Executive Director of Nursing and Allied Health Professionals introduced the report which provided an annual update of patient experience and the management of patient safety incidents within the Trust. The report incorporated the statutory information required for the annual complaints report and a summary of the outcomes, themes, actions and learning from serious incident investigations closed during the period 1 April 2018 to 31 March 2019. The Executive Director of Nursing and Allied Health Professionals reported that limited information had been available from the Friend and Family Test surveys. She said that complaint numbers were relatively low; a total of 152 had been received during 2018/19 of which 72 were upheld and themes remained consistent with 2019/20. There had been a reduction in no harm and minimal harm incidents but a current theme in incidents was the incorrect identification and categorisation of pressure ulcers. In response to a question from the Chair, the Executive Director of Nursing and Allied Health Professionals said that key actions for the forthcoming year would be to review the use of the Friend and Family Test, the development and implementation of an Organisation-wide Engagement strategy and an updating of the pressure ulcer categories list which would be included in all Datix training sessions during 2019/20. **Outcome:** The Board received the report and noted the updated information.	
2019-20 (20)	**Annual report of the Guardian for Safe Working Hours** The Guardian introduced his annual report for 2018-19. He explained that the report covered issues affecting trainee doctors and dentists working in the Trust including morale, training and working hours. The Board noted the one exception report raised by a CAMHS trainee which had been resolved to their satisfaction following a meeting with their clinical supervisor and medical lead. The Trust Chair, on behalf of the Board, expressed support for this work across the Trust and thanked the Guardian for attending to present the report. **Outcome:** The report and activity to date was noted.	

2019-20 (21)	**Workforce strategy 2019-2021:progress and delivery – leadership and skills** The Director of Workforce, Organisational Development and System Development (JA) introduced the report which provided an update on progress and delivery on the leadership and skills development workstream within the Workforce Strategy and set out a continuing work programme for 2019/20. The report highlighted the significant progress achieved during the last six months including: • the new Leadership offer Leading By Example now operational with excellent take-up • a Shadow Board development programme had 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 the Senior Management Team • 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 In response to a question from Non-Executive Director (BC), the Director of Workforce, Organisational Development and System Development (JA) said that when the Leading by Example strand was more established in the Trust the plan was to fully evaluate its impact to ensure that the programme captured all managers and aspiring managers across the Trust and individual needs were identified during appraisal processes. The Trust Chair commended the work which had been done in this area and observed that during his visits to services there was clear evidence that leadership across the Trust was improving and there was a strong feeling that staff felt they were working in an inclusive and empowering environment. **Outcome:** The Board: • noted the progress made on Leadership and Skills Development in the last six months • endorsed the approach identified in the workstream during 2019/20.	
2019-20 (22)	**Well-Led Framework: self-assessment update** The Chief Executive introduced the report which provided the Board with an update on the Well-Led Framework self- assessment, progress on addressing key areas for development and the focus for development going forward. The Chief Executive reported that the SMT had reviewed and updated the Well-Led Framework action plan in April 2019. She said that overall the self-assessment rating remained good and all 8 KloEs were rated as good. The Trust Chair observed that further assurance had been received from a recent internal audit of the Trust's Well- led framework approach and processes which concluded a reasonable assurance opinion. **Outcome:** The Board: • agreed the revised RAG rating for the individual KloEs and overall RAG rating: Good • noted progress and the focus for further development.	
2019-20 (23)	**Corporate governance report** The Company Secretary presented the report which covered a number of corporate	

	governance reports for consideration: • ***Annual review of Board and committees' effectiveness –*** The report provided information gathered from a Board and committees' effectiveness review. • ***Audit Committee and committees' annual reports 2018-19 –*** the terms of reference for the Trust's Audit Committee required that the committee had oversight of Board sub-committees. The report demonstrated that the Audit Committee had operated in line with its terms of reference and had undertaken a review of its effectiveness and received annual reports from the Board sub-committees. The Trust's external auditors (KPMG) had confirmed the Trust's annual report contains all the relevant information. • ***Committees' terms of reference –*** in March and April 2019, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness. The Board noted that no changes had been made to amend and update their content. • ***Compliance with the NHS provider licence:*** **self certification –** the Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence. Revised directions from the Secretary of State (effective from 2016-17) required NHS Improvement to ensure that NHS trusts comply with licence conditions as appropriate. The report provided an assessment of the Trust's compliance with the provider licence. • ***Changes to the standing orders, standing financial instructions and scheme of reservation and delegation powers*** – in 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 changes and amendments were agreed by the Committee. • ***Details of the use of the Trust's corporate seal*** – In line with the Trust's standing orders, the Chief Executive is required to maintain a register recording the use of the Trust's corporate seal during 2018/19. The report contained a copy of the register of sealings. **Outcome:** The Board: • noted the outcome of the annual review of Board and committees' effectiveness. • received the Audit Committee's annual report for 2018-19. • noted that no amendments had been made to the terms of reference of Board sub-committees. • received and agreed the self-certification against required NHS provider licence conditions. • approved the revisions to the standing orders and standing financial instructions. • noted the use of the corporate seal and noted the content of the sealings register.	
2019-20 (24)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information. She said that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. The Company Secretary advised the Board that currently there was no provision within the work plan for the Board to directly receive reports on health and safety, and specifically no reports concerning detailed analysis of staff incidents. Currently the Health and Safety Group provided meeting minutes and escalated issues to the Business Committee, and the Performance Brief provided the Board and Business Committee with some brief information about staff incidents. The Board agreed that	

	a six-monthly report should be added to the work plan commencing October 2019 and the requirement conveyed to the Operations Support Manager and Health and Safety Adviser by the Executive Director of Finance and Resources. **Action:** 6-monthly report on health and safety, including detailed analysis of staff incidents and resultant actions, to be included in the Board meeting work plan. **Action:** The Executive Director of Finance and Resources to convey the requirement for a health and safety report to the Operations Support Manager and Health and Safety Adviser. **Outcome**: The Board noted the work plan and supported the addition of a 6-monthly health and safety report.	**Company Secretary** **Executive Director of Finance and Resources**
2018-19 (25)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Quality Committee: 18 March 2019 b. Audit Committee: 22 March 2019 c. Business Committee: 25 March 2019	
2019-20 (26)	**Close of the public section of the Board** The Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 2 August 2019, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair:
Date: 2 August 2019

V2 12 06 2019

AGENDA ITEM 2018-19 (30b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 2 August 2019

Agenda Number	Action Agreed	Lead	Timescale	Status
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 – written report to be provided post 24 May 2019 – **completed 5 June 2019**
Meeting 24 May 2019				
2019-20 (14)	**Significant risk and risk assurance report:** A report on the three emerging themes to be provided for the next Board meeting.	Company Secretary	Trust Board 2 August 2019	Agenda
2019-20 (14)	**Significant risk and risk assurance report – BAF risk score movement:** the scoring of risk 4.1 to be discussed by representatives from the Business, Quality and Audit committees.	Company Secretary	Post meeting	Meeting fixed for 8 July 2019
2019-20 (24)	**Board work-plan Health and Safety Action:** 6-monthly report on health and safety, including detailed analysis of staff incidents and resultant actions, to be included in the Board meeting work plan. **Action:** The Executive Director of Finance and Resources to convey the requirement for a health and safety report to the Operations Support Manager and Health and Safety Adviser.	Company Secretary Executive Director of Finance and Resources	Post meeting Post meeting	

Actions on log completed since last Board meeting	
Actions not due for completion before 2 August 2019; progressing to timescale	
Actions not due for completion before 2 August 2019; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 2 August 2019; not having met agreed timescales and/or requirements	

V1 07 06 2019

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (32)

Meeting: Trust Board 2 August 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:

- Leeds Mental Wellbeing Service ('IAPT' contract)
- Chronic Pain Management (Spinefit+) service tender awarded
- Long Term Plan (LTP) implementation framework
- Sir David Behan visit
- Mental Health Support Teams in Trailblazer sites
- Media report for June (appendix one)

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 how we are ensuring we are working with key stakeholders both locally and nationally

Chief Executive's report

1. New contracts awarded

Leeds Mental Wellbeing Partnership has been awarded the contract to provide primary care liaison, improving access to psychological therapies (IAPT) and perinatal mental health. The contract is for five years from 1 November 2019 with an opportunity for it to be extended for a further two years. There are eleven partners in the partnership and they include LCH, Leeds and York Partnership Foundation Trust, Leeds GP Confederation, Northpoint, Community Links, Touchstone, Women's Counselling Therapy Service and Homestart Leeds, IESO, Silvercloud and Sign Health. The service will be clinically led by Leeds GP Confederation and Leeds Community Healthcare will be the lead contract holder.

The Chronic Pain Management (Spinefit+) service tender has now been awarded and the Trust has been successful in retaining this service. This is a growth for the organisation as it includes the service currently delivered by In-Health. We scored 95% in our bid. Mobilisation began on 22.07.2019 and includes a TUPE transfer from In-Health.

Well done and thank you to everyone involved in these two successful contract tenders.

2. Recovery Hub CQC rating

We are very pleased that the Recovery Hub @South has just been rated Good overall and Outstanding for Well led by the CQC. The centre operated by Leeds City Council provides recovery and rehabilitation services - the Trust is the lead contractor and provides nursing and therapy input.

Well done to Sarah Crabtree, Clinical Quality Lead, and all our staff at the Recovery Hub @South.

3. Final inspection report on the joint inspection of HM YOI Wetherby and Keppel published

We have received the final CQC Health & Justice inspection report on the joint inspection of HM YOI Wetherby and Keppel which took place during the week commencing 11 March 2019. We are working through the recommendations but, as reported previously to Board this is a good report and is a testament to the hard work and dedication of our staff there. The report is publically available and can be viewed via the following link:
https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmyoi-wetherby-and-keppel-3/

4. Long Term Plan (LTP) implementation framework

NHS England and NHS Improvement (NHSE&I) have published an implementation framework, setting out further detail on how the Long Term Plan will be delivered. This Framework is intended to guide the creation of five-year strategic plans by Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). These local-level plans should be completed by November 2019, covering the period 2019/20 to 2023/24, to be incorporated into a national implementation plan. The national bodies will use the system plans to inform a national implementation plan to be published by the end of the calendar year.

The implementation framework makes it clear that each system plan will be unique as systems will have substantial freedoms to respond to local need and prioritise the pace of delivery for the majority of commitments However it also states that some commitments are 'critical foundations' for service transformation and system development and that systems will need to demonstrate plans for organisational financial recovery.

The four strategic priorities for community services within the plan are:

1. Delivering improved responsiveness of crisis response within two hours and reablement care within two days;
2. Providing 'anticipatory care' jointly with primary care (a joint enterprise with GP practices as part of PCN delivery);
3. Supporting primary care to developed enhanced health in care homes (a joint enterprise with GP practices as part of PCN delivery);
4. Building capacity and workforce to do these three things, including by implementing the Carter report and using digital innovation.

We are working on understanding the timing and implications of these priorities with the CCG and GP Confederation. There are also priorities in the areas of all long term conditions such as stroke, key developments in children's mental health and IAPT, all of which impact on LCH.

5. Sir David Behan visit

Sir David Behan Chair of Health Education England visited the Trust on 4th July 2019. This was a good opportunity to demonstrate all the great work the trust is doing with community and primary care integration, whilst raising awareness of how complex community care can be. Sir David spoke with a range of staff including clinical staff and support staff discussing opportunities within the NHS and he visited the Wound Care Clinic at Rutland Lodge, accompanied a therapist on a home visit to a patient and met the outreach nurse for the Gypsy/ Traveller community.

6. CQC visit update

The CQC conducted a well led inspection visit on 3-5 June 2019. This included discussions with all Board members and senior leaders within the organisation. In addition to this there were a number of unplanned service visits during May 2019. The CQC have now advised that they will be contacting the Trust on 26 July 2019 to

discuss the timescale for the Trust receiving and reviewing the draft report for factual accuracy. An update will be provided at the Board meeting.

7. Mental Health Support Teams in Trailblazer sites

We are pleased that, within the West Yorkshire and Harrogate Health and Care Partnership, Leeds, Bradford and North Kirklees are three of 48 new 'Trailblazer' areas identified by the NHS, to provide support to young people with mild to moderate mental health needs through a total of six mental health support teams.

Mental Health Support Teams (MHSTs) will be introduced across these West Yorkshire trailblazer sites over the next few months as part of a national programme jointly delivered with the Department of Education. Each team will support several schools and colleges, covering a population of around 8,000 children and young people. Their new workforce of Education Mental Health Practitioners will work with education settings to provide early intervention on mental health issues and provide help to staff in schools and colleges.

Learning from these pilots will provide an opportunity to share good practice across West Yorkshire and Harrogate so that more young people will get fast and appropriate support for emerging mental health problems, and that all children will receive the highest quality pastoral care through their adolescence. We will be recruiting to this service as part of our CAMHS service and are setting up the recruitment process currently.

8. CAMHS Tier 4 building project

The CAMHS Tier 4 building project was now at the planning permission stage of the development. A public information drop-in event was held on 16 July 2019 at Holly House, on the St Mary's Hospital site where the public could see and ask questions about the finalised plans submitted to Leeds City Council for the new mental health in-patient unit for young people in West Yorkshire. It was a positive meeting with good engagement with councillors, members of the public and young people.

9. Newton Europe

Last year NHS Improvement commissioned Newton Europe to support the Leeds system in identifying potential improvements to patient flow. The main finding was that 56% of patients were discharged from hospital on a less than ideal pathway. This generally meant that patients were routed to a more dependent discharge destination than they required. Another finding directly affecting LCH demonstrated that patients stay in hospital after stroke was significantly higher than the national average.
The project helped the system identify key areas of improvement work and a year on Newton Europe was invited back to Leeds to repeat the work. This year they found:

- 45% of patients were discharged on a less than ideal pathway – the 11% improvement suggests that processes have improved but there is still work to do on promoting a “Home First” culture
- Significant progress had been made on the stroke length of stay. At the time of their visit last year, length of stay was 34 days. It is now 18.5 days compared to the national average of 21 days. This is due to excellent work from LCH and LTHT clinicians and extra funding from the CCG
- No-one waited in hospital for mental health bed funding
- Access to social work was streamlined and waiting times had significantly reduced

In addition Newton Europe coordinated a deep dive into the opportunity for admission avoidance following attendance at A&E. The data suggested that at least 28% of admissions could have been avoided. The main areas to focus on were identified as:

- Improving decision making in A&E by ensuring consultants understand the range of community options available
- Improving discharge home in the twilight period through a take home, make safe service
- Improving access to the Community Intravenous Administration Service

The system is now working on the findings with a view to developing an improvement plan. This will include investment in CIVAS / shift of resources, development of a twilight ‘take home’ service with neighbourhood teams and further education for A&E staff.

10. Talent Pool

A talent pool is being developed, which is part of the LCH’s talent management strategy and offers exciting opportunities for staff who are keen to take on a ‘stretch’ role in project management. The Trust often has time-limited projects that need management and support, the pool will allow managers to get the right people in place quickly and staff will be able to take advantage of training and development opportunities.

11. Board to Board

Board to Board met on 11 July 2019 and considered a series of update on winter, Newton Europe audits (see earlier in the agenda), Primary Care Networks and Local Care Partnerships. The second part of the meeting was a workshop facilitated by Professor Paul Stanton looking at deprivation in Leeds, our work collectively on Left shift and the urgency of continuing to focus on this agenda to ensure we make a difference to the health of the poorest the fastest – in line with the Health and Wellbeing Board strategic direction.

12. National Award for Infant Mental Health

The Infant Mental Health Service has had its 'Babies, Brains and Bonding' training recognised nationally by winning the very first Association for Child and Adolescent Mental Health (ACAMH) 'David Cottrell Education of CAMH Professionals Award'.

The team are passionate about developing a shared understanding with practitioners from a diverse range of professional backgrounds about the importance of early relationships and having this recognition from ACAMH will support the infant mental health agenda, the need to support parents in caring for their infants and in influencing consideration of the earliest relational experiences of children, young people and adults.

13. Giving Voice Choir celebrates 5 years

The Giving Voice choir, run by Speech and Language Therapist Wendy Neill, has just celebrated its fifth birthday. The choir is an inclusive choir for adults with neurological conditions and their carers. Wendy Neill, Speech and Language Therapist, was awarded an extra special 'Thanks a Bunch' for five successful years of running the Giving Voice Choir.

Wendy was presented with a certificate and flowers by Brodie Clark, Deputy Chair at the beginning of the five year celebratory concert.

14. Queen's Nurse

The Trust has a new Queen's Nurse, Fiona Louth, who works in the children's business unit. 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.

15. Recommendation

The Board is recommended to:

- Note the contents of this report and the work undertaken to drive forward our strategic goals and particularly how we are ensuring we are working with key stakeholders both locally and nationally

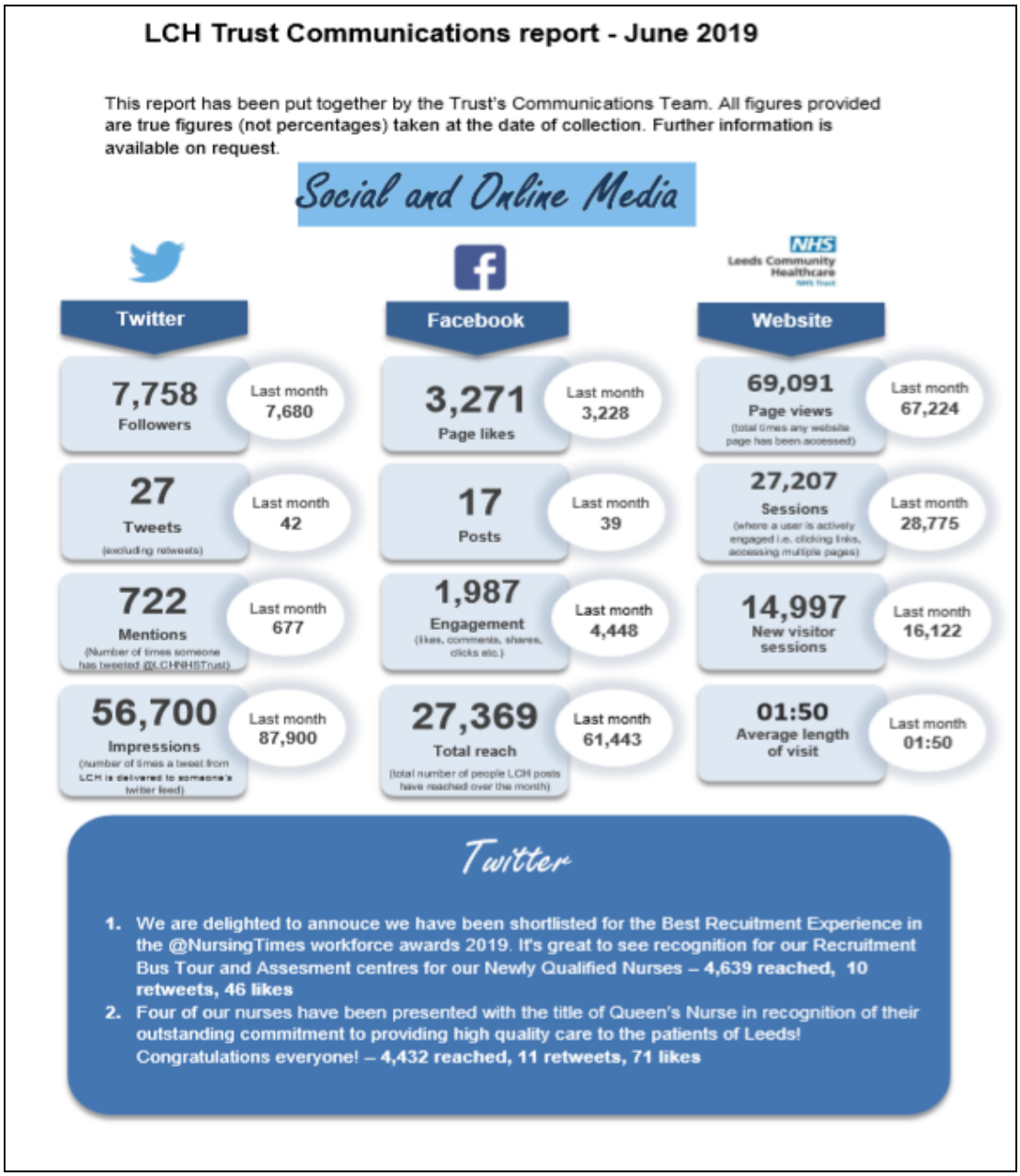
Appendix one

Trust's media report for June

In June the Trust's media presence was extremely high due to a number of successful press releases including:

- Article in The Guardian on the director job share
- Queen's Nurses Awards
- CAMHS planning application

The Trust's new external facing website was launched towards the end of June and this will be monitored closely over the coming months. The new site has stronger analytics software than the previous site, which will allows monitoring of page views, searches and downloads in detail.



Facebook

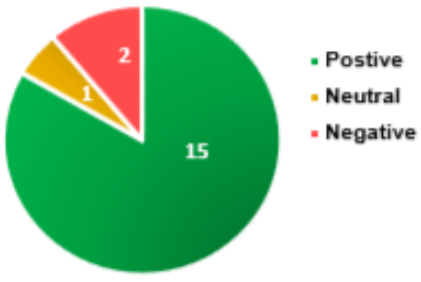
1. It's a common misconception that you can't go into community nursing directly after qualifying. In fact, the community is a great place to start your career! We are in the incredibly privileged position of caring for people in their own homes – which is generally the place people prefer to receive care….4,588 reach, 253 reactions, 91 likes, 10 comments, 36 shares
2. Four Leeds Community Healthcare nurses have been presented with the title of Queen's Nurse in recognition of their outstanding commitment to providing high quality care to the patients of Leeds! Congratulations everyone! – 2,971 reach , 177 reactions, 129 likes, 20 comments, 6 shares
3. Exciting news! We've submitted a planning application for a new mental health in-patient unit for young people in West Yorkshire with Leeds and York Partnership Foundation Trust. It will provide 22 inpatient beds and deliver much needed improvements and facilities. The finalised plans will be on display in the Classroom at Holly House on the St Mary's Hospital site, Green Hill Road, LS12 3QE from 4pm-7pm on Tuesday 16 July.– 1,871 reach, 116 reactions, 95 likes, 5 comments, 12 shares

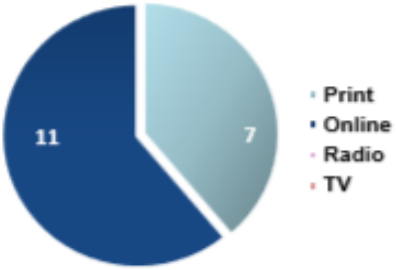
Website

1. IAPT Home – 7,861 page views
2. Homepage – 6,786 page views
3. Our services A – Z – 4,083 page views
4. Neighbourhood Teams – 1,545 page views
5. IAPT Contact – 1,463

Print and Broadcast Media

Coverage by tone and type (total year from 1 April 2019)





Reach:

12 local media hits
6 national media hits

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (33i)

Report to: Trust Board: 2 August 2019
Report title: Charitable Funds Committee 21 June 2018: Committee's Chair assurance report
Responsible director: Chair of Charitable Funds Committee **Report author: Interim** Executive Director of Nursing and Allied Health professionals
Previously considered by: Not applicable

Purpose of the report

This paper identifies the key issues for the Board from the Charitable Funds Committee held on 20 June 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Charitable development updates

The Committee Chair and the Executive Director of Nursing and AHPs gave an overview of their meeting with the Chief Executive of Leeds Cares on 18 June 2019.

The Committee Chair stated that the conversation had gone well and each party had felt open about the arrangements, benefits and obligations.

The Committee Chair highlighted the main points from the discussion as per the minutes of the meeting. It was felt it had been a useful discussion but some areas of note and further work is required as below:

- It had reflected a fundamentally different approach to the 'charity' agenda.
- The Committee Chair stated that it would not remove obligations or work from the Trust; rather it would require a very different mind-set with a high-level partnership commitment from LCH.
- The Committee Chair felt that there was value in progressing towards the partnership with Leeds Cares subject to three pieces of work:
    1) An informal 'assurance' conversation with LTHT on their experience with Leeds Cares is needed and both Executive Director members of the committee agreed to pursue this.
    2) A more considered examination of Leeds Cares accounts to provide a satisfactory level of assurance is required and the Executive Director of Finance and Resources agreed to do this.
    3) A piece of work to explore and define the Trusts necessary contribution to successfully make the partnership work. The Executive Director of Nursing and AHP's agreed to do this.

In response to a query from the Executive Director of Finance and Resources around protecting donations made to particular teams within the Trust. The Committee Chair said that an explanation could be given to the donor to clarify that the money donated would sit in a restricted LCH 'pot' in Leeds Cares.

The Committee agreed to the potential of this collaboration, however there were a number of areas that required further investigation, including the resourcing of the agreement.

Finance Report

This was accepted by the committee with two queries that the Executive Director of Finance and Resources agreed to follow up.

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

Draft Annual Report and Accounts 2018/19

This was accepted by the committee with one amendment which is the Committee agreed that reference should be made to the Trustees consideration of entering into a partnership with Leeds Cares

.

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

More than a welcome - health centre waiting areas improvement plan

The Executive Director of Finance and Resources shared the results of the public questionnaire responses. The Committee agreed the improvements suggested should be progressed. It was agreed that there would be a progress update at the next meeting.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (33ii)

Report to:
Trust Board - 2 August 2019

Report title:
Nominations and Remuneration Committee - Committee Chair's Assurance Report
21 June 2019

Responsible director:
Chair of Nominations and Remuneration Committee

Report author:
Director of Workforce

Previously considered by: Not applicable

Purpose of the report

This paper outlines the key issues for the Board arising from the Nominations and Remuneration Committee held on 21 June 2019.

CEO and Director Appraisals and Pay:

The Committee noted that in line with national guidance all Directors as well as the CEO had been appraised in terms of performance during the 18/19 financial year with the appropriate information returned to NHS Improvement.

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

CEA Awards Process 18/19:

The Committee noted changes to the national CEA Awards process guidance for the 18/19 financial year and approved the introduction of these national changes to the LCH local guidance. It was also noted that the CEA Awards panel for the 18/19 round will meet on 27 August 2019.

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

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (33iii)

Report to: Trust Board (circulated by email)
Report title: Quality Committee (workshop) 24 June 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 24 June 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 June 2019 Quality Committee meeting was a focussed workshop with subjects on Population Health Management (ABU) and on Patient Engagement.

Workshop session one: Population Health Management
The Committee invited representatives from ABU to provide details of Leeds' participation in a national 20 week Population Health Management (PHM) Programme that ran from January to May 2019. The programme progresses a PHM approach to improve outcomes for people living with frailty. PHM is a data driven approach which focuses resources on preventative and proactive care. It provides collective understanding, across organisations, of the needs and behaviours of the defined population they are responsible for and uses data to understand where the greatest opportunities to improve health outcomes, value and patient experience can be made. These are used within available resources to plan, design and deliver care solutions to achieve better outcomes for the defined population. The Committee was advised that four Neighbourhood Teams Leads, Community Geriatricians and Community Matrons were part of the programme supported by Clinical Leads and Business Development Lead.

The Committee workshop involved round table conversations in four groups looking at some of the detail of the work and the impact in each of the LCP areas. The Committee learned that the objectives which were common to all four pilot areas were to have professionals working well together across the system around the needs of people for better coordination of care and improved information sharing in order to reduce duplication. This would reduce disruption to people's lives as a result of avoidable harm and numerous contacts with hospital services. The Committee was advised that quality indicators e.g. patient experience could show an immediate improvement; however improved outcomes such as a reduction in avoidable harm and reduced hospital admissions could be evidenced in the longer term.

Workshop session two: Patient Engagement Strategy
The Patient Experience and Engagement Lead provided the Committee with an update on progress with developing a trust-wide Patient Engagement Strategy. The Committee was advised that following an external review of Patient Experience and Engagement by Healthwatch Leeds, a number of key recommendations were made. The Committee was invited to contribute to the Patient Engagement Strategy development by undertaking a SWOT analysis to understand strengths, weaknesses, opportunities and threats (SWOT) to patient engagement. The analysis from the workshop will feed into the ongoing strategy development. The draft Patient Engagement Strategy will be presented to the Trust Board in August 2019.

Performance brief and domain reports

The Committee reviewed the Performance Brief and noted that there was a fourth category 3 pressure ulcer under investigation and the target for the year was to have no more than 7. The Committee asked for more information about the investigation findings to be included in the July Clinical Leads' report.

The Committee discussed the increased number of incidents being reported; the most noticeable increase was of incidents that were categorised as near miss or no harm. This is seen as a positive sign of a strong reporting culture whereby incidents are recognised and managed before serious harm occurs.

NHS
Leeds Community Healthcare
NHS Trust

Agenda item 2019-20 (33iii)

Report to: Trust Board 2 August 2019
Report title: Quality Committee 22 July 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 22 July 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 July 2019 Quality Committee meeting was a business meeting. As the Committee Chair, Ian Lewis was on leave, the meeting was chaired by the Trust Chair, Neil Franklin.

Serious Incident update report (patient AY)
The Committee received an update on the action plan which had been developed following the investigation into the suicide of a patient who had previously accessed the CAMHS service. 14 recommendations had been made, with involvement from family members of the deceased. The Committee was advised that 12 actions had been completed so far. The final two actions were due to be completed by 31 July 2019. The serious incident investigation process has also initiated further quality improvement around transition from child to adult mental health services. The Committee will receive a further update on progress with the action plan in September 2019.

The Committee reviewed and recommended that the Board approves the following documents:

- Draft Quality Improvement Strategy
- Medical Director's report (revalidation) statement of compliance

The Committee can provide the Board with the following assurance:

1. Pressure ulcers investigation update - Limited assurance

The Committee was presented with the findings of a review into the category 3 pressure ulcers reported in quarter one of 2019/20. The Trust's tolerance for the year is to have no more than seven, and there is a risk that this will not be achieved. The Committee discussed the factors identified as having contributed to the development of pressure ulcers. It was recognised that it was not due to staffs' lack of knowledge about the prevention of pressure ulcers, and more about how the knowledge was being applied – there was a lack of risk assessments and care planning, as well as not using EPR appropriately and some poor communication. An overarching issue was a lack of capacity within neighbourhood teams and it was recognised that teams needed to work differently. The Committee heard that lots of learning had taken place and that the Trust was in a better position, in terms of numbers of 'avoidable' pressure ulcers, than in some previous years. There was however a concern that, given the quarter one data, the situation may have begun to deteriorate. The Committee agreed that scrutiny of pressure ulcers should be delegated to one group (PSEGG) within the organisation, as currently monitoring was taking place in three separate groups. An action plan for the reduction in pressure ulcers is to be presented at the September 2019 Committee meeting.

2. Performance Brief and Domain Reports & Clinical Governance Report – Reasonable assurance

The Committee noted the percentage of positive Friends and Family Test responses (caring domain) and an update was provided on clinical outcome measures (Effective domain), both of which provided the Committee with reasonable assurance. The Committee queried the number of overdue incidents and was advised that these were mainly Adult Business Unit incidents and that the Quality Lead for ABU had a firm grip on this, therefor there was confidence that this situation would improve.

The Clinical Lead reports for each business unit were restructured to be in line with the CQC well-led framework key line of enquiry. The Committee was provided with a review of each business unit under the headings: Leadership, Vision and Strategy, Culture, Governance, Risks and Performance, Information Processes, Stakeholder Engagement, Learning and Improvement. The ABU highlighted the increased challenge for their leadership team to maintain business as usual whilst enabling the developing volume of work streams relating to integration. SBU and CBU both raised concerns about the reliability of workforce information (ESR).

3. Organisational and Quality Account priority report quarter 1 position – Reasonable assurance

The Committee was advised that good progress is being made with the Organisational and Quality Account Priorities. One priority was not forecasting being on track to be completed by year-end; this was Priority 12, concerning the development of an innovative and viable model for the new CAMHS Tier 4 Service within the previously agreed time-frame as it was not anticipated that NHSE/I would be in a position to approve the full business case by the end of quarter three.

4. Quality challenge 2018/19 report – Reasonable assurance

The Committee received an end of year report on the Quality Challenge+ programme 2018/19. A number of planned visits had been cancelled during the year. Some of these had been successfully rearranged. The Quality Challenge+ programme had been reviewed and the learning utilised to ensure that improvements were made to the programme for 2019/20. The Committee was advised that there was now more staff signed up to conduct the quality walks than in the previous year, and that a reasonable number of walks had taken place in quarter one 2019/20. The Committee was also advised that feedback from staff was that, despite initial anxieties about the programme, generally, staff found it a helpful process which enabled them to improve and it was becoming less onerous as the pro-forma had been revised and simplified.

5. Guardian for safe working hours – Reasonable assurance

The Guardian for Safe Working Hours provided a quarter one update. The Committee learned that work had been conducted since the last report to ensure an accurate database was held centrally of doctors and dentists on training placements within the Trust. No issues had been identified in the last quarter via exception reporting or the junior doctors' forum and work was continuing to facilitate improved engagement with trainees across all specialties. The Committee was assured that trainee doctors and dentists were working safely and in a manner compliant with the 2016 Junior Doctors' contract.

6. Clinical audit (retrospective review of 2018/19 programme)

The Committee received a progress report on the (rolling) Clinical Audit Programme 2018/19. The report provided details of clinical audits undertaken and reasons for any audits that were cancelled. The report provided thematic information about learning and improvements made. Examples of this were improved working methods, tighter control of documentation, and increased training. The Committee was keen for clinical audit to follow the established Quality Improvement methodology and was advised the Clinical Effectiveness Group (CEG) was to examine the learning from clinical audit and to incorporate Quality Improvement.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (33iv)

Report to: Trust Board 2 August 2019 (circulated previously by email)
Report title: Business Committee 26 June 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 26 June 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Patient Administration Project
The Committee was provided with an update on this project, including key milestones achieved since the last update: the overarching workforce principles had been agreed, and a single professional structure with three leadership roles had been approved by SMT.

Initial conversations regarding business support (corporate & local requirements) were taking place and staff engagement was going well. Issues currently being experienced included differences of opinion on some aspects of the admin model e.g. clarifying where the appointments function should sit, pay grade inconsistencies, and differentiating between business support functions and patient admin roles. The main challenge was to achieve a balance between quality, staff morale and financial savings. The Committee heard that staff were beginning to recognise what the project was aiming to achieve – an exciting career path, where staff feel valued and their tasks were varied. The Committee was advised that a case for change paper was due to be received by SMT in August 2019. The Committee recognised that this project was now at a critical stage and wanted to be kept close to developments as they shaped up. The next steps would not be easy, organisationally or culturally.

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

Performance Brief
The Committee reviewed the May 2019 performance data. It noted that sickness absence levels were within tolerance levels. The Committee was advised that management of long term absence was currently being concentrated on. Retention figures remained good, compared with the national picture, however it was agreed that the Trust should maintain its focus on this.

Overall, the well-led section of the Performance Brief provided the Committee with reasonable assurance.

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

The Committee was advised that although there was more risk involved in meeting the financial control total this year and that anticipated additional income would not mitigate this entirely, the Director of Finance and Resources remained confident that the control total would be achieved.

Workforce presentation – Learning and Development
The Head of Organisational Development & Improvement provided the Committee with an update on the delivery of the Leadership and Learning Development offer. This included the 'Leading by Example' programme, the leadership competency framework, the Shadow Board development programme and a Board leadership programme. The Committee was advised that the development programme should

move the Trust into being the organisation that it strives to be. The Committee agreed that this programme was progressing at a remarkable pace. The Committee asked about the potential for marketing the programme externally and was advised that the GP Confederation had taken up this opportunity. The Committee discussed how to quantify the impact the programme was having on staff and what the indicators would be. The presentation provided the Committee with reasonable assurance.

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

NHS
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AGENDA ITEM 2019-20 (34i)

Meeting: Trust Board, 2 August 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, 19 June 2019 Quality Committee, 22nd July 2019 Business Committee, 24th July 2019	**For information**	

Purpose of the report

This report seeks to provide assurance to the Board on quality, performance, compliance and financial matters. It highlights any current concerns relating to contracts that the Trust holds with its commissioners. 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 month's Performance Brief contains the most up to date information available June 2019.

Overall performance remained good in June. A summary of the Performance Brief is included at the front of the document. The relevant domains were considered in detail at the Quality and Business Committees. Additionally, this month the Business Committee considered the finance report in greater depth; and plans to do so on a quarterly basis.

The Committee Chairs will report on the Committee's deliberations elsewhere on the agenda.

As part of its consideration of Trust finances the Business Committee received and agreed two proposals from the Executive Director of Finance and Resources. Board agreement is also sought:

1. Board members will recall from the financial plan for 2019/20 that there were two outstanding financial issues for which an in year solution was assumed; the £500k balance of the 'roadmap' issue and a £300k corporate CIP. It is proposed to apply the "public health" pay award funding of circa £700k and IAPT contract contribution of circa £400k to offset the total £800k issue. In year the balance will mitigate net overspending in other budgets; utilisation recurrently being subject to next year's financial planning process. Board approval of this allocation of additional funding is sought.
2. In response to a 20% national shortage of capital funding the West Yorkshire and Harrogate ICS was asked to deliver a formula based 21% reduction in its capital plans. All Trusts, working together have agreed a set of individual organisational reductions that deliver that target. Given the short timescale the Executive Director of Finance and the Chief Executive agreed that LCH could defer £302k of our 2019/20 capital plan. Retrospective Board approval to the revised capital plan is sought.
3.

Recommendations

The Board is asked to note the contents of the Performance Brief and agree the two financial proposals above.

Performance Brief – June 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 – 19th July 2019
Quality Committee – 22nd July 2019
Business Committee – 24th July 2019
Trust Board – 2nd August 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 June 2019.

Overall performance remained good in June.

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

In the **Safe and Caring** domain, the method of identifying and reporting avoidable pressure ulcers has changed. This will allow for more timely StEIS reporting of pressures ulcers and falls when avoidability is determined. Five of the avoidable pressure ulcers which have been signed off and reported within the previous monthly performance briefs of 19/20 reporting period have been moved to the 18/19 reporting period due to incident date and identified avoidability. This is to ensure accurate data is reported within the appropriate timeframe. The Adult Business Units have completed a deeper review of pressure ulcers to identify themes with a robust action plan agreed to support improvements across the neighbourhood teams.

We continue to trial complaint resolution meeting guidance from NHS England with another meeting booked for July.

Overall, 97.37% of Community patients would recommend the service to family and friends. Of inpatients, 100% would recommend.

Changes to the FFT will be formally announced in September 19

Performance in the **Responsive** domain remains good with the majority of targets being met. Scrutiny of waiting times has identified downward trajectories within the overall good performance and areas of concern are being addressed

The IAPT targets remain challenging. The Trust (with its partners) has been awarded the new contract to provide Mental Wellbeing Services from 1 November 2019. The new contract will provide a more comprehensive service and will address the current waiting list challenges. In the meantime the service continues to work with commissioners on a waiting list initiative.

Well Led: This month, turnover remains low, standing at 13.1%, supporting a high stability index of 87.6%. Both are better than target.

Sickness absence remains below target and well within tolerance.

Appraisal compliance rates have improved again this month, currently standing at 84.6%. A particularly big improvement has been seen in the Corporate Directorates in the past month, increasing their compliance from 82.8% to 88.9%.

Statutory & mandatory training rates have dropped slightly, with the organisational compliance rate standing at 93.8% from last month's 94.4%.

In the **Finance** domain, at the end of Quarter 1 the Trust's surplus is in line with plan. The year to date position is £57k underspent compared to budget overall; Pay costs are £52k overspent non-pay is £60k over. The main change in the pay is as a result of the additional funding for the First Contact

Practitioners which has been agreed in June and is therefore no longer a risk for the service. The Children's Business Unit has a small overspend overall at the end of Quarter 1; this is as a result of pay costs.

The Corporate directorate is overspent at the end of June by £150k; this is as a result of historic CIPs £0.8m plus a further £0.2m of un-identified CIPs from the 2019/20 planning process. The financial plan requires underspending across the Trust to deliver these savings and these are not being achieved in May.

Overall reserves are over committed by £0.1m for the year at this early stage. This is being offset by anticipated additional income and contribution to fixed costs.

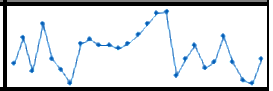
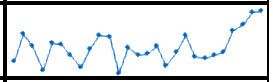
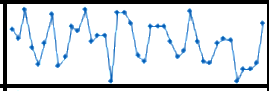
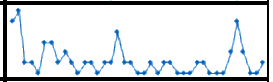
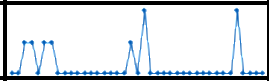
In year CIP delivery continues to be less than planned this month due to the £0.2m un-identified CIP for 2019/20. The Trust's better payment practice code delivery has returned to above target this month. Capital expenditure is more than planned at the end of June however this is a timing issue in respect of estates work and will return to planned levels as the year progresses. All other financial targets are on plan for the end of the first quarter.
The forecast outturn is an over spend of £1.7m; of this £1.1m is within the corporate directorate in respect of the historic CIPs and £0.4m is for the Children's BU £0.4m as a result of pay costs for interim medical staff. This will be mitigated by additional income and cost savings so as to deliver the agreed control total by the end of March.

The forecast outturn requires £1.7m of savings based on current expenditure levels. Of this £0.4m is within the Children's BU and £0.1m in the Specialist BU. The most material area to address is the general savings requirements within the Corporate Directorate where the current forecast is £1.1m overspend. With the additional income anticipated, the "corporate" position will return to balance leaving the Children's and Specialist Business Units to need to recover the current forecast underspend for the Trust to achieve the control total.

Safe – June 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%	94.2%	97.6%	-	●	
	2018/19		-	99.7%	101.0%	102.4%	101.0%		
Patient Safety Incidents Reported in Month Reported as Harmful	2019/20	0.56 to 1.12	1.23	1.10	1.21	1.23	1.23	●	
	2018/19		0.90	0.91	0.83	0.85	0.86		
Serious Incident Rate	2019/20	0 to 0.1	0.07	0.02	0.02	0.07	0.07	●	
	2018/19		0.05	0.05	0.03	0.04	0.04		
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	2019/20	1	1	0	0	1	1	●	
	2018/19		12	1	0	0	1		
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	2019/20	0	0	0	0	0	0	●	
	2018/19		2	0	0	0	0		

Areas noted as a result of this report are as follows

- Continued Increase in overall incident reporting
- Continued rising trend of the SPC chart
- Number of overdue incidents increase

Follow-up from May Report – Avoidable Pressure Ulcer

There has been one category 3 pressure ulcers this month recorded on StEIS. There has also been a category 4 unavoidable pressure ulcer reported by the Children's business unit.

Themes remain similar in nature to earlier serious incident findings and are

- Record keeping; Assessments not completed or delayed / Documentation not updated
- Poor care / case management
- Staff skills/knowledge
- Failure to identify risks

The ABU have undertaken a review of pressure ulcer incidents and have developed a bespoke action plan and further lines of enquiry. These will be actioned through the agreed pressure ulcer action plan and any further actions identified at PSEGG.

All Incidents Reported

This month 649 incidents were reported on Datix. This is a small reduction on the peak of last month (663). The reporting of Deep Tissue Injuries and Moisture Lesions is thought to be a contributing factor to this rise along with a continued increase in reports generated from a small number of patients residing in Little Woodhouse Hall.

144 (32%) of all patient safety incidents originated from other providers which is consistent with previous months. A deeper review of how non LCH patient incidents are reported and investigated and possible ways for sharing these incidents will be included in the next PSEGG agenda.

There were 44 staff incidents reported in the month. 82% were reported as no harm. There were 2 moderate harm incidents and no major harms reported. The 2 moderate harm incidents were:

- A staff member had a needle stick injury whilst taking a blood sample within the Sexual Health Service.
- A member of staff was subjected to a physical attack by a patient whilst visiting. Patient threw a pair of scissors caused an open wound to leg.

Patient Safety Incidents (LCH only)

There were a total of 334 LCH PSIs reported in June 2019; this has reduced to a more usual figure this month from an unprecedented high last month.

Across the Children's Business Unit, 52 incidents were reported. 1 moderate and 1 major harm incidents were reported. The major harm was an unavoidable category 4 pressure ulcer reported by Children's Continuing Care. The moderate harm incident was reported by ICAN Administration and is a report of a delay in referral for a child with worsening symptoms. This is undergoing a full serious incident investigation. The highest reporting team was Little Woodhouse Hall with 38 incidents all of no or low harm. All 38 were generated from 4 individual in-patients. Incident categories include Self harm; Discharge (not returning from authorised leave) and medication. The 2 medication incidents were all reported as 'no harm' and were categorised as medication record keeping and a prescribing error.

Across the Adult Business Unit 3 major harm falls (2 already found to be unavoidable, the third still undergoing investigation) and 36 moderate harm LCH PSI's were reported, 19 of these were pressure ulcers. It is noted that both moisture and other skin damage have been categorised as moderate harm in the first instance. These are being investigated and likely to be re-categorised on review. Therefore it is expected that the number of moderate harm incidents will reduce when the report is re-run in July.

The highest reporting teams were Middleton and Chapeltown Neighbourhood Teams with 22 incidents each. The teams generating the fewest LCH patient safety incidents was Wetherby who reported 4 incidents in June

In the Specialist Business Unit, 58 incidents were reported across all teams. Six moderate harm incidents were reported and no major harm incidents.

The highest reporters were the Community Rehab unit with 8 incidents of various categories and Community Neurology with 6 incidents the majority of which were falls.

Incidents causing harm (LCH PSI's only)

The LCH PSI's causing harm per 1000 contacts SPC shows a decrease against contacts in June, this is still outside of the upper control level.

An in-depth review of all LCH patient safety incidents causing harm reported in June shows that a decrease of 11 incident records and a decrease of over 4350 contacts in the month have contributed to the reduction seen in the chart above. The data in the chart for June will be re-run for the July report where any amendment to incorrect Datix records will be reflected.

294 LCH patient safety incidents were reported (not including deaths) 154 (52%) of these caused harm to patients and 15% were of moderate harm and 2% recorded as major. These figures are not confirmed and the majority are still being investigated and subject to change.

It has already been noted that the number of major harms has reduced to 4 due to incorrect selection of the patient safety question (patient injured themselves in their own home – not a fall) and a downgrade of an incident which was marked as major for a category 3 pressure ulcer.

Moderate & Major Harm Incidents

4 Major harm incidents have been reported in June, this is low but within normal range.

3 were falls; both resulting in neck of femur fractures; two have been found to be unavoidable following 72 hour review, the other is still awaiting a review to be completed. One category 4 pressure ulcer was reported in the children's continuing care service. The outcome of 72 hour review found it to be unavoidable

45 Moderate harm incidents have been reported in June; 26 Skin Damage, broken down to 20 pressure ulcers and 2 moisture (requires de-grading to minimum harm), 4 other skin damage. 6 falls and 6 implementation of care (2 of these were pressure related incidents and require re-categorising. 7 other incidents had the categories of Self harm or treatment/procedure failure and abuse (this also appears to be incorrectly categorised and requires father review.

No Harm incidents

This month no harm incidents was original reported as 140, and accounts for 48% of all LCH patient safety incidents. However this has risen to 186 with extra checks and changes in Datix which have taken place prior to writing this report and will be updated in the next month data.

Overdue Incidents

There are 576 live incidents in Datix as of 10/07/2019 (not including serious incidents), of these 40 have breached the 30 days investigation timescale and 167 have breached the 15 days investigation timescale, this makes a total of 207 (36%) overdue incidents. This is another increase month on month; this could be due to the fact that there have been more incidents reported in the past quarter but a delay in 72 hour reports has also been noted which can be contributing to this.

Duty of Candour

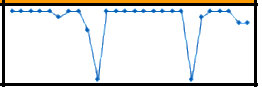
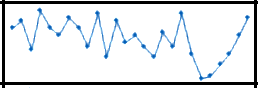
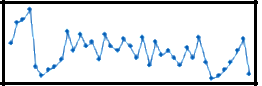
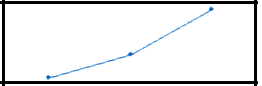
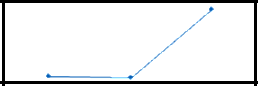
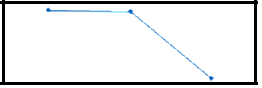
Twelve incidents were identified as avoidable to LCH in June. All of these patients and/or families have been offered an initial apology. Staff have been reminded to also update questions regarding whether the option of receiving further information about the completed investigation and/or a written apology sent as these had not been completed on 4 of the 12 records in Datix.

All incidents were for pressure ulcers, 5 of which were reported by Seacroft NHT and 3 from Woodsley. However it is worth noting that these were records closed in June and had been reported between December 2018 and March 2019

Caring – June 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 Inpatient Care (FFT)	2019/20	>=95%		81.8%	83.3%	100.0%		●	
	2018/19		-	100.0%	100.0%	75.0%	91.7%		
Percentage of Respondents Recommending Community Care (FFT)	2019/20	>=95%		96.9%	95.9%	97.4%		●	
	2018/19		-	95.6%	96.5%	95.5%	95.9%		
Total Number of Formal Complaints Received	2019/20	<175	62	16	21	25		●	
	2018/19		144	14	16	13	43		
Number of Formal Complaints Upheld	2019/20	<175	19	5	8	6			
	2018/19		-	-	-	-	-		
Number of Formal Complaints Responded to within timeframe	2019/20	<175	33	11	8	14			
	2018/19		-	-	-	-	-		
Number of Compliments Received	2019/20	No Target	132	132	128	114			
	2018/19		-	-	-	-	-		

Friends and Family Test (FFT)

There are ongoing updates to the Membership experience system (MES) including new processes and feedback tools such as Heat Maps, feedback posters and service team FFT summaries.

The Health & Homeless Inclusion Team are now completing FFT cards with patients being seen at SJUH and St George's Crypt. This means we are starting to reach parts of the Gypsy/Traveller community and the homeless, with 100% of respondents completing the FFTs so far recommending the service.

MES (membership experience system) training is taking place on 10th July for designated staff (Patient engagement champions); this will allow services to use the system more frequently and utilise the feedback they receive to influence service improvements, change and sharing learning.

Overall, 97.37% of Community patient respondents would recommend the service to family and friends. Of inpatients, 100% of respondents would recommend. There have been no FFT returns for SBU Inpatient services in June.

It has been announced that National changes to the FFT will be formally announced in September 19.

	Number of responses received	% of which recommended	% of which would not recommend	Number of comments received	Overall response rate
ABU Services	200	97%	2%	305	5.66%
CBU Services	304	98.03%	0.99%	416	4.17%
CBU Inpatients	4	100%	0%	6	N/A
SBU Services	683	97.07%	1.76%	846	6.50%
SBU Inpatients	0	0	0%	0	0

There have been a number of FFT responses where patients have reported they would not recommend the service. For the ABU one of the responses is related to treatment and for SBU there are 3 negative comments relating to lack of appointments and waiting times. Across ABU and SBU there are 3 FFT reports that appear to be inconsistent; the forms are completed with the negative tick boxes being ticked but with positive comments.

Complaints, Concerns, PALS and Claims

The table below highlights the number of complaints and concerns that have been received by the PE team in June.

Feedback	May 2019 Received	Notable trends
Complaints	25	Any notable themes from the complaints received have been addressed in the Thematic Patient Experience Report.
Concerns	31	
Clinical Claims	0	
Non-clinical Claims	0	

As prescribed by the NHS Complaints Regulations 2009, it is a statutory requirement that the Trust must acknowledge all received complaints within 3 working days. The regulations also state that all complaints must be responded to, in writing, within 180 working days – unless otherwise agreed with the complainant. We have seen an improvement with the management of complaint responses and are now meeting all our targets. There are no outstanding complaints.

The table below is a review of our response rates for complaint responses for June.

Key Performance Indicators and Developments	Status
Acknowledged within 3 days	100% Compliance
Responded to within 180 days	100% Compliance (closed complaints)
Active PET Caseload	49

The complaints caseload is 49; of which 2 are on hold, 5 reopened and 2 with the PHSO.

Developments to paperwork and process reported in May are ongoing and due to staffing issues the introduction of Audits within the complaints process has been delayed but will be introduced by the end of July 19.

The complaints sub-group meeting (city-wide) is due to meet on 8th August; agenda items include review of equality and diversity monitoring forms across organisations to create some consistency around information gathering.

We continue to trial complaint resolution meeting guidance from NHS England with another meeting booked for July. As an outcome of a complaint resolution meeting held in June it has been identified that improvements can be made in the discharge process following a care home stay; It has been identified that an integral part of the discharge process is to change the GP and pharmacy addresses back to the home address (where these are changed for the period of the care home stay) to allow efficient delivery and collection of prescriptions and treatment. This learning is being shared with the CCG and our Primary care partners.

Effective – June 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.

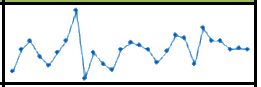
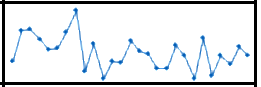
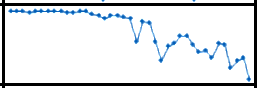
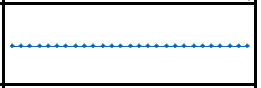
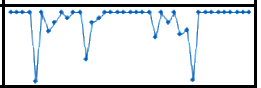
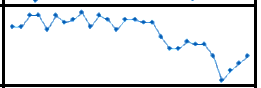
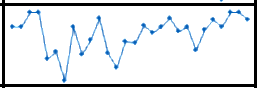
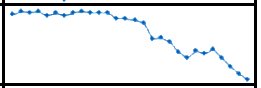
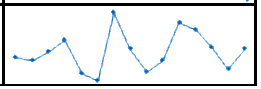
Leeds Community Healthcare NHS Trust

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Financial Year	Target	YTD	April	May	June	Q1	Forecast
Audit: number of mandatory must do (priority 1) and should do (priority 2) audits started *(n = 73)*								
due to start in Q	2019/20	N/A		36			**36**	
started in Q	2019/20	100%		**47.2%**			**47.2%**	
Clinical outcome measures: service self-reporting as achieving *(n = 56)*								
step 2 (outcome measures for service identified)	2019/20	100%		**40.4%**			**40.4%**	
step 3 (outcome measures available in clinical system)	2019/20	75%		**40.4%**			**40.4%**	
Medicines Management: Medicines Control Assurance Check *(n=144)*								
completed at team level within last 24 months	2019/20	100%		**96.5%**			**96.5%**	
meeting all required standards	2019/20	100%		**95.1%**			**95.1%**	
NICE guidance: compliance with guidance published during 2017/18 *(n = 43)*								
full compliance	2019/20	> 90%		**95.2%**			**95.2%**	
action plan in place	2019/20	> 5%		**4.8%**			**4.8%**	
not due yet	2019/20	-		21			21	
Clinical and Corporate Policies *(n = 102)*								
fit for purpose	2019/20	100%		**96.0%**			**96.0%**	
overdue for review	2019/20	< 5%		**4.0%**			**4.0%**	
Quality Challenge+ (QC+) Programme: services *(n = 63)*								
rated as 'good' or 'outstanding' on self assessment	2019/20	> 80%		**79.3%**			**79.3%**	
who have received a QC+ Walk during 2019/20	2019/20	100%		17.2%			17.2%	
who have had a change in rating following QC+ Walk	2019/20	< 10%		10.0%			10.0%	
Research and Development *(n = 720)*								
patients recruited into studies	2019/20	100%		13.6%			13.6%	

Responsive – June 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%		**-4.4%**	**-3.3%**	**-4.1%**	**-3.9%**	●	
	2018/19			**-4.4%**	**-1.7%**	**-3.0%**	**-3.0%**		
Patient Contacts	*2019/20*			124,629	133,198	128,816	386,643	●	
	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%**	**96.4%**	**94.7%**	**94.7%**	●	
	2018/19		-	96.1%	97.2%	97.5%	97.0%		
Number of patients waiting more than 52 Weeks (Consultant-Led)	*2019/20*	0		**0**	**0**	**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%**	**100.0%**	**100.0%**	**100.0%**	●	
	2018/19		-	100.0%	99.1%	100.0%	99.7%		
% Patients waiting under 18 weeks (non reportable)	*2019/20*	>=95%	-	**97.5%**	**97.7%**	**97.9%**	**97.9%**	●	
	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%**	**100.0%**	**99.8%**		●	
	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%**	**57.0%**	**53.4%**		●	
	2018/19		-	92.2%	91.4%	88.9%	98.9%		
IAPT - Percentage of people who complete treatment and recover	*2019/20*	50%	-	**51.1%**	**48.1%**	**51.3%**		●	
	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. June performance was 95.7%. Whilst the Trust comfortably meets the targets performance is on a downward trajectory.

The main area of concern is with the ICAN (integrated services for Children with Additional Needs) bundle of services. Extensive work within the ICAN Transformation Project will deliver a sustainable solution. The first of four three-day workshops was held in early July focusing on referral criteria to the service and how referrals will be effectively triaged to the correct clinician. This will improve the patient experience as they will see the right clinician at their first appointment.

A separate workstream focusing on the Complex Communication Assessments is also underway. This pathway provides autistic spectrum assessment for children under 5. There are 52 children waiting more than 18 weeks (but each one has an appointment booked). This is mainly due to an increase in demand for these assessments. Commissioners are aware and have provided additional funding for a waiting list initiative to reduce the backlog before the new pathway is put in place

Paediatric Neuro Disability (PND) and Community Paediatric Clinics (CHICs) have a smaller number of breaches. There are 2 breaches in PND, in addition to 12 ASC reviews waiting over 18 weeks. Averages wait times are 14.18 weeks. The ASC referrals are included in wait times; therefore results are skewed by the waiting list initiative. There are currently 5 breaches in Community Paediatric Clinics. All are associated with requests to rebook from parents.

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

Non-consultant-led Referrals

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.

IAPT

There are several national targets applied to the Improving Access to Psychological Therapies (IAPT) service. Access within 6 weeks continues to fall with May performance at 57% (with target 75%). 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 begin treatment within 18 weeks and the service routinely meets this standard.

As expected the IAPT recovery rate has recovered this month rising back above the 50% target.

In order to align to reporting to Scrutiny Board (Adults, Health and Active Lifestyles) the percentage of children and young people with an eating disorder seen within 1 week of an urgent referral has been added to the report this month. We have not received any urgent referrals yet this year. IAPT measures (access, recovery rates of people identifying as BAME and proportion of people aged 65 and over accessing services) will be added to this report in due course to further improve alignment.

CAMHS

In May 2019 the average wait time to Next Steps (previously known as Consultation Clinics) first booked appointment was 9.9 weeks. For patients booked in for a first appointment in June this currently stands at 8.5 weeks.

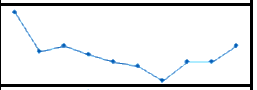
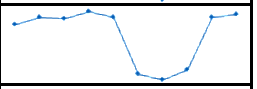
Change in reporting of waiting lists from May related to the CAMHS Neurodevelopment Assessment Pathway Redesign Project. Patients are now held on two lists. The first is the ND Pathway list which is children who have already received a Next Steps Assessment and are waiting for an ND assessment. Waits for the pathway remain high (66% waiting 12+ weeks with average wait time of 45.5 weeks) and continue to be focus of agreed recovery plan with oversight by fortnightly CAMHS waits group. The second list “Neurodevelopmental Assessment waiting list” which is children who have been screened and put directly on to the new pathway for ND assessment is currently in a holding period until July to allow the service to focus on the pathway redesign project. This waiting list is at 199 waiters. 133 of these (67%) are over 12 weeks. All families have been contacted and informed of anticipated longer waiting times while the service undertakes works to introduce a more streamlined assessment pathway.

Well-Led – June 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%	13.2%	13.1%			
	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%	17.2%	20.1%			
	2018/19		-	13.0%	13.0%	13.2%	13.1%		
Executive Team Turnover	2019/20	<=14.5%	-	17.8%	17.7%	29.7%			
	2018/19		-	0.0%	6.7%	0.0%	2.2%		
Stability Index	2019/20	>=85%	-	87.0%	87.7%	87.6%			
	2018/19		-	85.6%	85.2%	85.6%	85.5%		
Short term sickness absence rate (%)	2019/20	<2.2%	-	1.4%	1.7%	1.5%			
	2018/19		-	1.9%	1.6%	2.2%	1.9%		
Long term sickness absence rate (%)	2019/20	<3.6%	-	3.4%	3.5%	3.9%			
	2018/19		-	3.5%	3.5%	3.3%	3.5%		
Total sickness absence rate (Monthly) (%)	2019/20	<5.8%	-	4.8%	5.2%	5.4%			
	2018/19		-	5.4%	5.1%	5.5%	5.3%		
AfC Staff Appraisal Rate (12 Month Rolling - %)	2019/20	>=95%	-	81.1%	83.7%	84.6%			
	2018/19		-	81.9%	80.2%	79.9%	80.7%		
6 universal Statutory and Mandatory training requirements	2019/20	>=95%	-	93.5%	94.4%	93.8%			
	2018/19		-	91.4%	89.9%	89.6%	90.3%		
Medical staff appraisal rate (%)	2019/20	100%	-						
	2018/19		-		100.0%		100.0%		

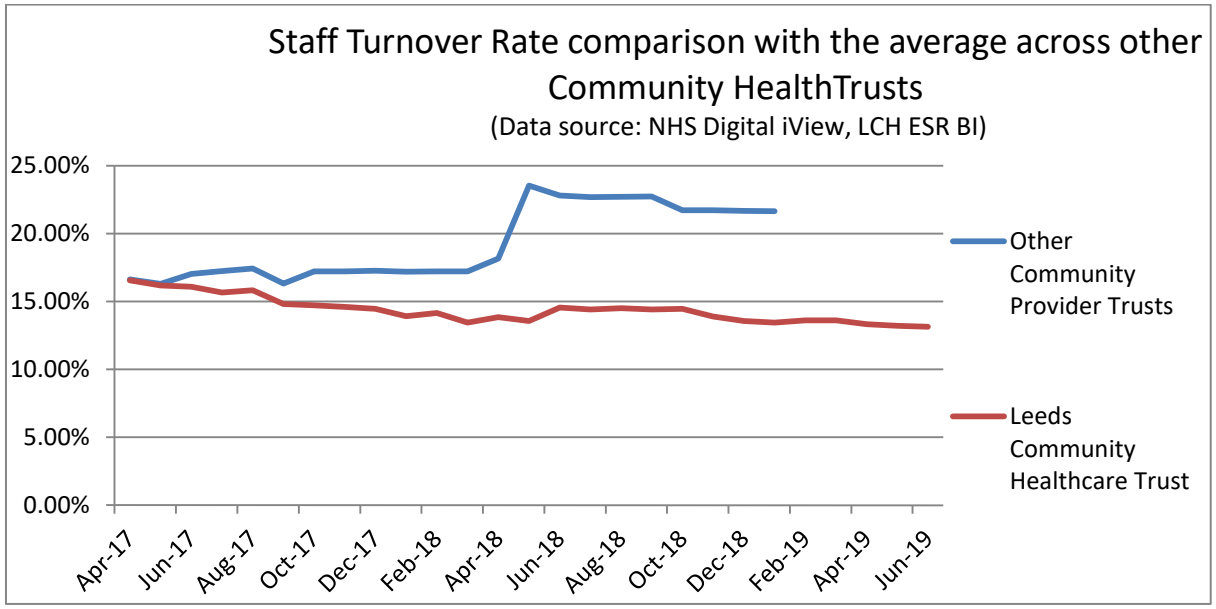
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Financial Year	Target	YTD	April	May	June	Q1	Forecast	2 Yr Monthly Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2019/20	>52.0%	-	71.1%			71.1%	●	
	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%	-	73.3%			73.3%	●	
	2018/19		-	64.0%			64.0%		
Response Rate for Staff FFT	2019/20	>22.0%	-	19.8%			19.8%	●	
	2018/19		-	24.0%			24.0%		
WRES indicator 1 - Percentage of BME staff in the overall workforce	2019/20	No Target	-	9.6%	9.8%	9.8%			
	2018/19		-						
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	2019/20	No Target	-	3.2%	3.2%	3.3%			
	2018/19		-						
Total agency cap	2019/20	£545k	£1,158k	£392k	£306k	£460k	£1,158k	●	
	2018/19		£6,410k	£438k	£417k	£549k	£1,403k		
Percentage Spend on Temporary Staff	2019/20	No Target	6.2%	6.1%	5.1%	7.1%	6.2%	●	
	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 13.1% which is below the 2019/20 outturn target of 14.5%. The stability rate is 87.6% which is above the target of 85%.

Staff leaving within the first 12 months of employment is slightly above the target of 20% at 20.1%. This is the first time in over a year that this threshold has been breached. Further work is being undertaken to understand whether there are any particular trends or particular services or professions contributing disproportionately to this rise: when similar work was carried out recently there were no “hotspots”.

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



Background detail showing reasons for leaving during June 2019 is at Appendix 3.

Health and Wellbeing (HWB)

The overall sickness and absence levels remain within tolerance levels, at 5.4% (1.5% short term and 3.9% long term).

Key pieces of work being led by the HWB Engagement Group include:-

Menopause – promotion/awareness of topic and supporting guidance for Managers and staff

Cancer – handy guides for managers on how to support staff with cancer and/or supporting staff who has a family member with cancer

Time to Change pledge (mental health and wellbeing) – Draft action plan being developed for submission to Time to Change organisation) outlining the organisations commitment to this agenda

Further details on broader HWB work is contained within the Quarterly Workforce Report going to July's Business Committee.

Appraisal Rates

The overall Appraisal Rate has improved this month, currently standing at 84.6%, with improvements reported in all areas with the exception of Specialist Business Unit which has demonstrated a slight decline. Particular improvements are noticed in Corporate Directorate which reports a 6% increase.

AfC Staff Appraisal Rate (12 Month Rolling - %)		Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19
Overall	Imp Traj to 95%	87.5%	88.2%	86.3%	85.4%	84.2%	82.9%	81.1%	83.7%	**84.6%**
Adult Business unit		90.7%	93.3%	90.6%	89.2%	88.2%	86.1%	80.8%	86.0%	**87.7%**
Children's Business Unit		84.3%	82.6%	79.9%	80.4%	79.9%	78.5%	77.9%	80.3%	**80.5%**
Corporate Directorate		85.1%	83.2%	77.9%	85.2%	83.2%	78.3%	79.3%	82.8%	**88.9%**
Operations		90.5%	89.0%	88.9%	88.9%	90.6%	89.2%	86.8%	87.5%	**88.7%**
Specialist Business Unit		86.4%	88.4%	88.5%	85.1%	82.5%	82.5%	83.4%	83.4%	**83.0%**

- An appraisal training package is being delivered as part of Essential Management, as well as pro-active be-spoke support being offered to individual services

Statutory and Mandatory Training

The upward trend for compliance against the universal statutory and mandatory training requirements has stabilised this month, currently standing at 93.8%. All Business Units and Corporate teams have experienced a marginal drop in compliance this month.

The Statutory/mandatory Compliance Project has enabled considerable 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 of the situation.

	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	June-19
Overall	**Imp Traj to 95%**	90.3%	90.0%	90.6%	92.7%	93.5%	92.5%	93.5%	94.4%	93.8%
Adult Business unit		90.6%	89.8%	91.0%	92.7%	92.6%	91.6%	92.7%	93.8%	93.5%
Children's Business Unit		91.5%	90.6%	91.3%	92.6%	94.2%	92.7%	93.5%	94.5%	94.00%
Corporate Directorate		94.1%	92.8%	92.2%	94.8%	95.4%	94.2%	95.3%	96.0%	95.0%
Operations		83.7%	87.5%	88.4%	92.4%	93.7%	92.8%	94.2%	94.9%	93.0%
Specialist Business Unit		90.6%	90.6%	90.0%	93.0%	94.0%	93.7%	93.9%	94.2%	93.7%

Friends and Family Test (FFT)

The overall number of questionnaires completed went down again this quarter to 581 – equating to a response rate of only around 20%, which remains 'qualitative' in nature.

The strongest performing statement was, 'Immediate Manager values my work'; weakest performing was, 'Often think about leaving the organisation'. Work continues with Business Units to improve the associated work with Staff FFT to support greater levels of engagement of staff in the Staff FFT, which acts as a 'pulse' to the National Staff Survey data.

Finance – June 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*	£0.0m	**£0.4m**	**£0.5m**	**- £0.1m**	**£0.0m**	**£0.0m**	●
	2018/19		£4.0m	£0.2m	£0.3m	£0.3m	£0.3m	
Capital expenditure in comparison to plan (£k) - YTD	*2019/20*	£90k	**£223k**	**£0k**	**£147k**	**£76k**	**£223k**	●
	2018/19		£1,880k	£21k	£46k	£236k	£303k	
CIP delivery (£m) - YTD	*2019/20*	£193k	**£529k**	**£177k**	**£176k**	**£176k**	**£529k**	●
	2018/19		£4.7m	£0.3m	£0.3m	£0.3m	£1.0m	

Income & Expenditure Summary

The Trust's year to date surplus is £0.1m more than budgeted at the end of Quarter 1. Pay costs are £0.1m more than planned, same as last month, non-pay is also running £0.1m overspent, these overspendings are being addressed by an underspending on reserves. The overall position assumes the Provider Sustainability Funding allocation as the forecast 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. Based on current forecast the Trust will need to make £0.5m of additional cost reductions to meet the control total by the end of the financial year. Additional income is expected in respect of the pay award funding for staff working in public health services commissioned by the Local Authority and further contributions to the Trust's fixed costs are anticipated as the year progresses; the required cost reductions are after these have been taken into account. The Director of Finance is confident that the required savings will be achieved or mitigated by changes to the current forecast income and/or expenditure as the year progresses; the situation is monitored closely and it should be noted that the Trust has no funds available for un-planned, ad-hoc expenditure.

Income

Contract income continues to be marginally less than planned as a penalty has been incurred for police custody contract in respect of missed shifts in April and May, it is assumed that some missed shifts will continue throughout the year. The value of the penalty has reduced as management continue to review staffing levels and deployment of staffing resources to maximise shift coverage. Non-contract income is in line with plan. The income this month includes additional funding for the First Contact Practitioners following agreement reached with Commissioners in June.

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; at this early stage in the year the biggest CQUIN risk is achievement of the flu vaccination target which has increased to 80% of staff. Based on last year's performance there is circa £13k at risk. CQUIN performance will be monitored closely and income risks will be report as they arise.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure is £0.1m overspent at the end of the first quarter; as this position now includes the funding for the first contact practitioners it is an improvement on last month. The Children's business unit is £188k overspent on pay £115k of this is in respect of paediatric locum medical staff, £27k for Speech & Language Therapy services and £21k for Children's management team. Pay costs overall are slightly more than in May due to a reduction in the number of vacancies.

There are a net 76 WTE vacancies this month (85 last month), 33 of these are in the Adult BU with 24 being in the Neighbourhood Teams, 5 in the Community Care Beds Service and 5 in the Night's service. There are 39 vacancies in the Corporate and Estates Directorates; the biggest area being 8 for admin support to clinical teams and 4 in the domestic service. Of the net 22 Corporate Support vacancies 2 are in the safeguarding team, 2 in the infection control team and 3 in the Community Informatics service. The Specialist BU has 14 vacancies; 7 are in Stroke services, 5 for Police Custody services, 5 for dietetics and Wetherby YOI have 7. The Children's BU has 9 staff more than planned mostly in Speech and Language Therapy services.

At the end of Quarter 1 the Corporate Directorate is £150k overspent in total; this is because historic cost savings plans in respect of the roadmap contribution (£500k) and corporate CIPs (£300k) along with new savings requirements of £180k for procurement and £200k unidentified savings from the 2019/20 planning round are reported here. The procurement savings target should be delivered as the year progresses; the others remain a significant risk.

Reserves for the year are £0.1m overcommitted at the end of June and the Trust has anticipated £0.3m additional income for pay awards and contribution which has mitigated this; 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 has increased in month but is 29% under the cap set by NHS Improvement and 13% less than planned.

The forecast outturn requires £1.7m of savings or additional funding based on current expenditure levels. Of this £0.4m is within the Children's BU. The most material area to address is the general savings requirements within the Corporate Directorate where the current forecast is £1.1m overspend
.
Non-pay is a net £60k overspent at the end of the month 3 the improvement being due to less expenditure on continence products than expected. The overspending is mainly in respect of the "other" category where the savings requirements are reported.

Delivery of Cost Improvement Plans

Delivery of the identified CIPs is strong. The £0.2m unidentified savings agreed through the planning process is not being achieved and overall savings remain 8% less than planned at the end of June.

Business Unit Budget Performance

The Business Units have a net total of 37 WTE vacancies for June (43 in May) as detailed above.

The Specialist Business Unit continues to be at breakeven at the end of Quarter 1 and currently forecast to be £0.2m underspent at the end of the year following the funding of the First Contact Practitioners being agreed. This net position masks some large variances particularly in weight management, respiratory, stroke, IAPT, Dental, Community Gynaecology and TB services that are underspending and CIVAS, Adult SLT, Police Custody and Sexual Health that are currently overspending.

The Children's Business Unit is £0.1m overspent overall at the end of June and continues to forecast to be a net £0.4m overspent at the year end; with a pay overspending of £0.8m in respect of locums being offset by £0.4m of underspending on non pay. Main areas of pay overspending for the year to date are Paediatricians, Hannah House, Management Team, Sickle Cell and Speech and Language Therapy; these are being partially offset by underspending on Doctors in Training, CAMHS inpatient Unit, Children's Continuing Care and Respite Services and 0-19 Services.

The Adult Business Unit continues to be at breakeven at the end of Quarter 1 and is forecasting £0.1m underspend at the end of the year. The forecast outturn is for £0.3m overspending on pay which is offset by underspending on non-pay. At the end of June Continence services, Neighbourhood Teams, Health Case Management, Geriatricians and the Leeds Integrated Discharge services are underspending whilst the Management Team and the Nights Nursing service are overspending.

Capital Expenditure

The Trust has an initial planned capital resource limit (CRL) of £2.0m for the year; the Trust has offered to reduce its planned capital expenditure for 2019/20 by £250k given the national over commitment of capital resources. NHS Improvement has requested a further £52k reduction which will take the capital resource limit to £1.698m. The Trust will adjust the timing of the planned expenditure to ensure there is no breach of the CRL.

Capital expenditure overall is running £0.1m more than plan at the end of June. This is a timing issue where expenditure has started earlier than anticipated on estates projects the position will correct as the year progresses.

Cash

The Trust's cash position remains very strong at £25.8m; this is £1.2m less than was planned and is due to net current assets position.

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code has exceeded the 95% target for paying invoices for all measures. The underperformance reported last month has been recovered as significantly more NHS invoices were paid in month and all were within the 30 days deadline.

Use of Resources Risk Rating

The Trust's risk rating at the end of Quarter 1 is 1 overall, which is the lowest risk. All metrics score 1 now the Trust is achieving its planned surplus.

Appendix 1 – June 2019

Safe Highlight Report

Leeds Community Healthcare NHS Trust

Highlight Report: LCH Patient Safety July 2019 (June Data)

NHS Leeds Community Healthcare NHS Trust

Outstanding from April

Rate of PSI's per 1000 contacts: Although the trend-line for the SPC chart appears to have dropped to the upper control level this month, a further 36 records have been identified as being incorrectly marked as not patient safety incidents These records have been amended but we will not get an updated SPC until next month. We expect the SPC chart to show a figure similar to the previous month for June.

Avoidable Pressure Ulcers - There have been a further 2 cat 3 PUs this month along with a cat 3 from Dec 18 that has just been recorded on STIES. There has also been a cat 4 avoidable PU that is a deterioration from a previous. Themes remain similar to previous reports and are

- Record keeping; Assessments not completed or delayed / Documentation not updated
- Poor care / case management
- Staff skills/knowledge
- Failure to identify risks

Full pressure ulcer report will be presented at PSEGG

Risks / Red Flags / Assurance

- **Little Woodhouse Hall -** 48 incidents reported but all related to only 5 patients (40 incidents) and 8 regarding staffing or security. Although less incidents than last month, it is the highest incident reporting team in the organisation.
- **Increased checking of incidents for data validity by CG team** – 36 incidents incorrectly marked as not patient safety.
- **Major harm incidents.** A review of the 6 highlighted in the quarter data has shown 2 to be incorrectly recorded unstageable pressure ulcer incidents. These have now been downgraded and will show in next months figure update.
- **Overdue incidents increased -** This is despite extra scrutiny implemented by Senior Ops ABU which continues to be circulated every week. 207 incidents were overdue at 10/07/19, an increase of 49

PSI's per 1000 contacts

Quarter LCH Patient Safety Data

	Apr-19	May-19	Jun-19
No injury	153	178	140
Minimal Harm	83	111	103
Moderate Harm	40	48	45
Major Harm	9	5	6
Total	285	342	294
Ratio:	1:4.8	1:5.5	1:4.8

LCH PSI's Causing Harm

Incident Category	Moderate Harm	Major Harm
Abuse, violece, disruption or self-harm	5	0
Appointment, Admission or Discharge	1	0
Accident that may result in personal injury (falls)	6	3
Implementation of care or ongoing monitoring/review	6	0
Skin Damage	31	3
Total	49	6

May Data Review

- 649 incidents have been reported in Datix in June with 449 (69%) reported as patient safety incidents (PSI)
- 144 (32%) of all PSI's this month originated from other providers
- 44 staff incidents were report – 2 resulted in moderate harm, 1 needle-stick injury , 1 assault.
- 4 (was 6) major harm incidents confirmed – 3x falls resulting in facture neck of femur and 1 report of a patient scalding themselves (not patient safety).

Ongoing Investigation

- Further review of SPC chart data
- Increased checking for data validity by CG team
- Monitor increase in avoidable incidents
- Standardisation of incident themes
- DoC process audit

Appendix 2 – June 2019

Caring Highlight Report

Leeds Community Healthcare NHS Trust

Highlight Report: Patient Experience July (June data)

NHS Leeds Community Healthcare NHS Trust

Follow On

- We continue to trial complaint resolution meeting guidance from NHS England with another meeting booked for July.
- Due to staffing the introduction of Audits within the complaints process has been delayed but will be introduced by end of July 19.

Patient Experience- Friends and family test

	Number of responses received	% of which recommended	% of which would not recommend	Number of comments received	Overall response rate
ABU Services	200	97%	2%	305	5.66%
CBU Services	304	98.03%	0.99%	416	4.17%
CBU Inpatients	4	100%	0%	6	N/A
SBU Services	683	97.07%	1.76%	846	6.50%
SBU Inpatients	0	0	0	0	0

Risks / Red Flags / Assurance

- The complaints caseload is 49; of which 2 are on hold, 5 reopened and 2 with the PHSO.
- Overall, 97.37% of Community patients would recommend the service to family and friends. Of inpatients, 100% would recommend.
- There have been no FFT returns for SBU Inpatient services in June.
- Of % of which would not recommended:

ABU- One negative comment on treatment.
SBU-. Three negative comments on lack of appointments and waiting times.
3 reports are inconsistent with negative tick boxes and positive comments.

CCCs

Feedback	June 2019 Received
Complaints	25
Concerns	31
Clinical Claims	0
Non-clinical Claims	0
Complaints Acknowledged in 3 days	25 (100%)
Complaints Responded within 180 days	15 (100%)
Active PET caseload	49

Narrative

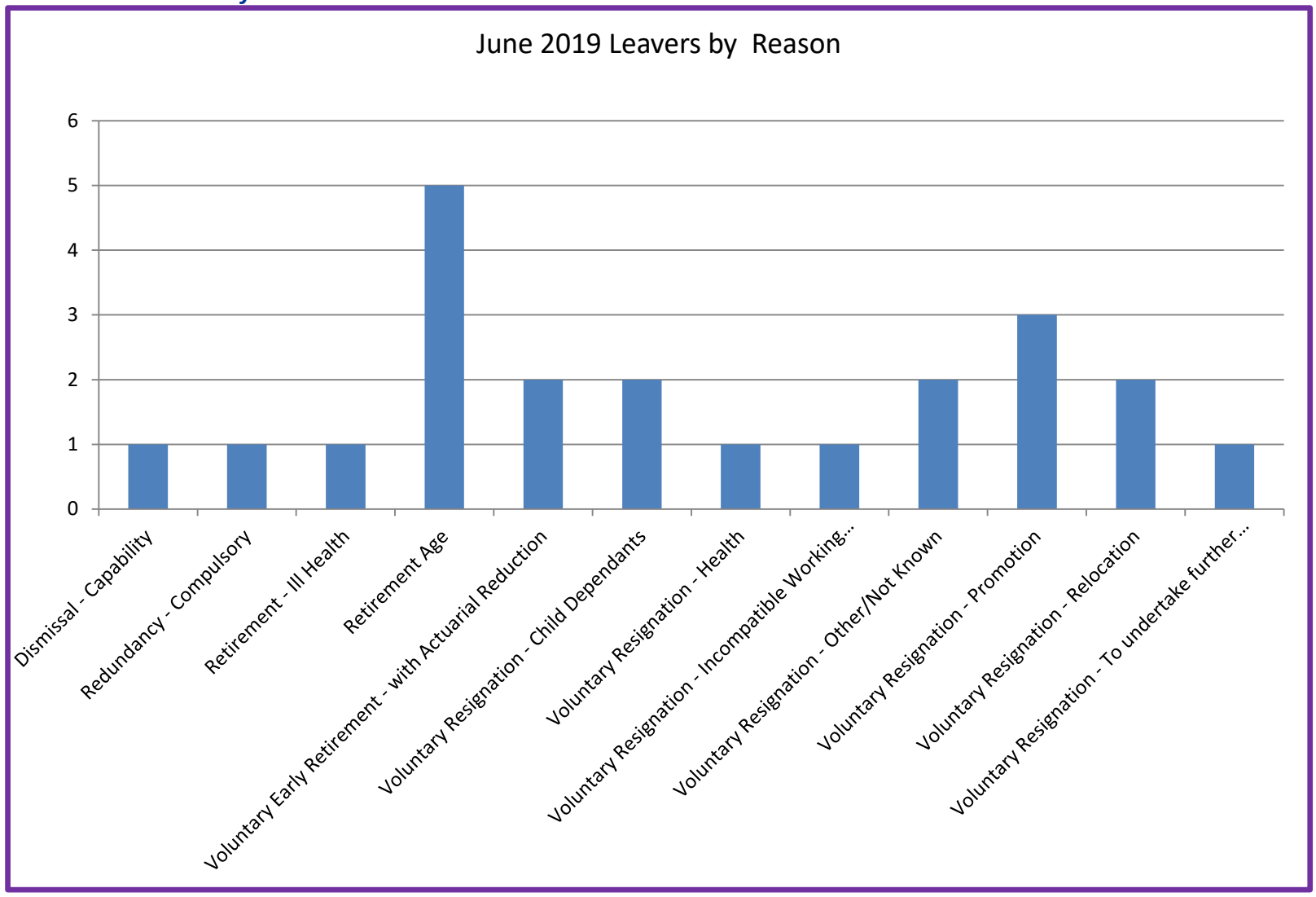
- Updates to the MES system are in progress, including new processes and feedback tools such as Heat Maps, feedback posters and service team FFT summaries.
- The Health & Homeless Inclusion Team are now completing FFT cards with patients seen at SJUH and St George's Crypt. This means we are starting to reach parts of the Gypsy/Traveller community and the homeless, with 100% of respondents so far recommending the service.

Ongoing

- MES (membership experience system) training is taking place on 10th July for designated staff (Patient engagement champions).
- The complaints sub-group meeting (city-wide) is due to meet on 8th August.

Appendix 3 – June 2019

June 2019 Leavers by Reason



Appendix 4 – June 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	£0.0m	£0.1m	£1.7m	G
Remain with EFL of £0.53m			£0.5m	G
Remain within CRL of £2.0m	£0.2m	-£0.1m	£1.7m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	98%	3%	95%	G
BPPC NHS Invoices Value 95%	97%	2%	95%	G
BPPC Non NHS Invoices Number 95%	97%	2%	95%	G
BPPC Non NHS Invoices Value 95%	98%	3%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £1.68m recurrent in year	£0.42m	-	£1.68m	G
CIP Savings £0.64m planned non recurrent in year	£0.11m	-31%	£0.44m	R

Table 2 Income & Expenditure Summary	June Plan WTE	June Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m	Forecast Variance Last Month £m
Income									
Contract Income			(36.7)	(36.7)	0.0	(144.7)	(144.6)	0.1	0.1
Other Income			(2.7)	(2.7)	0.0	(10.3)	(10.2)	0.1	0.1
Total Income			***(39.4)***	***(39.4)***	***0.0***	***(155.0)***	***(154.8)***	***0.2***	***0.2***
Expenditure									
Pay	2,727.7	2,651.3	28.5	28.5	0.1	111.0	111.8	0.9	1.1
Non pay			9.8	9.9	0.1	37.6	37.7	0.1	0.1
Reserves & Non Recurrent			0.5	0.3	(0.2)	1.9	0.7	(1.2)	(1.4)
Total Expenditure	***2,727.7***	***2,651.3***	***38.8***	***38.7***	***(0.1)***	***150.4***	***150.3***	***(0.2)***	***(0.2)***
EBITDA	**2,727.7**	**2,651.3**	**(0.7)**	**(0.7)**	**(0.0)**	**(4.5)**	**(4.5)**	**(0.0)**	**(0.0)**
Depreciation			0.5	0.5	(0.0)	2.0	2.0	0.0	0.0
Public Dividend Capital			0.2	0.2	0.0	0.9	0.9	0.0	0.0
Profit/Loss on Asset Disp			0.0	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	0.0
Retained Net Surplus	**2,727.7**	**2,651.3**	**0.0**	**(0.0)**	**(0.1)**	**(1.7)**	**(1.7)**	**0.0**	**0.0**
	Variance =	**(76.4)**							

Table 3 Month on Month Pay Costs by Category	April £k	May £k	June £k	YTD Actuals £k
Directly employed staff	8,932	8,571	8,546	26,049
Seconded staff costs	229	252	226	707
Bank staff	232	156	211	599
Agency staff	392	306	460	1,158
Total Pay Costs	**9,785**	**9,285**	**9,443**	**28,513**

Table 4 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	208	218	10	6	
Clinical Supplies & Services	2,621	2,459	(162)	(106)	
General Supplies & Services	1,268	1,253	(15)	(5)	
Establishment Expenses	1,454	1,418	(36)	(50)	
Premises	3,582	3,567	(16)	37	
Other non pay	704	982	278	210	
Total Non Pay Costs	**9,837**	**9,897**	**60**	**93**	**124**

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	36	36	0	145	145	0	0%
Non Pay Inflation	86	86	0	345	345	0	0%
MSK Radiology	25	25	0	100	100	0	0%
IAPT - NR vacancies	15	15	0	60	60	0	0%
Dental - M&S Disposables	10	10	0	40	40	0	0%
ABU Non Pay	29	29	0	115	115	(0)	0%
Adults Community Geriatricians	21	21	0	85	85	0	0%
Infection control	4	4	0	15	15	0	0%
Interest received on cash at bank	15	15	0	60	60	0	0%
Contribution from new investments	225	225	0	900	900	0	0%
IT Kit	63	62	0	250	250	0	0%
Un-identified CIP agreed by SMT	50	0	(50)	200	0	(200)	-100%
Total Efficiency Savings Delivery	**579**	**529**	**(49)**	**2,315**	**2,115**	**(200)**	**-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	39.5	711.8	698.1	(13.7)	10.4	10.3	(0.0)
Childrens Services	30.5	700.9	709.7	8.8	7.7	7.8	0.1
Adults Services	42.4	887.7	854.5	(33.2)	10.7	10.6	(0.0)
Ops Management & Equipment	1.7	50.2	51.3	1.2	0.4	0.4	0.0
Service Line Totals	**114.0**	**2,350.6**	**2,313.6**	**(36.9)**	**29.2**	**29.2**	**0.0**
Corporate Support & Estates	28.0	377.2	337.7	(39.5)	7.2	7.3	0.1
Total All Services	**141.9**	**2,727.7**	**2,651.3**	**(76.4)**	**36.4**	**36.5**	**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	0.2	0.2	0.6	0.6	0.0
Equipment/IT	0.0	(0.0)	(0.0)	0.6	0.6	0.0
Electronic Patient Records	0.1	0.1	(0.0)	0.5	0.5	0.0
Totals	**0.1**	**0.2**	**0.1**	**1.7**	**1.7**	**0.0**

Table 8 Statement of Financial Position	Plan 30/06/2019 £m	Actual 30/06/2019 £m	Variance 30/06/2019 £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	28.8	29.1	0.3	*29.3*	29.2	29.2	0.0
Intangible Assets	0.0	0.0	(0.0)	*0.1*	0.0	0.0	0.0
Total Non Current Assets	**28.8**	**29.1**	**0.3**	***29.4***	**29.2**	**29.2**	**0.0**
Current Assets							
Trade and Other Receivables	9.6	10.3	0.7	*8.8*	9.2	9.2	0.0
Cash and Cash Equivalents	27.0	25.8	(1.2)	*23.2*	26.8	28.5	1.7
Total Current Assets	**36.7**	**36.1**	**(0.6)**	*32.1*	**36.0**	**37.7**	**1.7**
TOTAL ASSETS	**65.5**	**65.2**	**(0.3)**	***61.5***	**65.2**	**66.9**	**1.7**
Current Liabilities							
Trade and Other Payables	(12.4)	(10.4)	2.1	*(12.1)*	(10.9)	(10.9)	0.0
Provisions	(0.4)	(0.5)	(0.1)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.8)**	**(10.8)**	**2.0**	***(13.4)***	**(11.3)**	**(11.3)**	**0.0**
Net Current Assets/(Liabilities)	**23.8**	**25.2**	**1.4**	***18.7***	**24.7**	**26.4**	**1.7**
TOTAL ASSETS LESS CURRENT LIABILITIES	**52.6**	**54.3**	**1.7**	***48.0***	**53.9**	**55.6**	**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	**52.6**	**54.3**	**1.7**	**48.0**	**53.9**	**55.6**	**1.7**
TAXPAYERS EQUITY							
Public Dividend Capital	0.4	0.4	(0.0)	*0.3*	0.4	0.4	0.0
Retained Earnings Reserve	21.7	23.3	1.7	*17.2*	23.0	24.7	1.7
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	**52.6**	**54.3**	**1.7**	**48.0**	**53.9**	**55.6**	**1.7**

Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	98%	95%	G
By Value	97%	95%	G
Non NHS Invoices			
By Number	97%	95%	G
By Value	98%	95%	G

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	59	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	5.2	1	20%	0.2
Underlying performance	I&E margin	1%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-29%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (35)

Meeting: Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title: Significant Risks and Board Assurance Framework (BAF) Summary 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 summary report is part of the governance processes supporting risk management in that it provides the Board with updated information about the effectiveness of the risk management processes and that adequate controls are in place to manage risks.

The summary report provides the Board with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received in May 2019

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:

This summary report shows changes to the risk register (for risks scoring 15 or above) since May 2019

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

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

Recommendations

The Board is recommended to:

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

SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

1.0 Introduction

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

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks). This report provides a description of risk movement since the last register report was received by the Board (24 May 2019), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk.

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

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

2.0 Summary of current risks scoring 15 or above

2.1 There are no risks with a current score of 15 (extreme) or above on the Trust risk register as at 5 July 2019

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

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

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

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

3.0 Risks scoring 12 (high)

3.1 There are two new risks scoring 12 reported since May 2019

Risk 975 **(This risk has evolved from Risk 939)**	Initial risk score **15** (high)	Current risk score **12** (high)	Target risk score **6** (medium)

Title: Capital affordability and Business case approval of CAMHS Tier 4 Development

The cost of the CAMHS development is estimated at £19.3m (31/5/19). The original bid for a smaller scheme was £13m which was agreed by the Department of Health. The partnership between LCH and LYPFT has identified funding sources for the additional £6.3m. However, the estimated cost of the core scheme is over the NHSI threshold of £15m above which the Business Case approval process for the scheme can be significantly longer with consequent delay to the scheme.

Controls in place:

- Project Board established
- Regular updates provided to the Business Committee and Board

Planned actions include:

- Explore all options in the Business case to describe the core scheme costs as under £15m to avoid the potential delay from being above this threshold.
- Work closely with NHSE/I colleagues to navigate a smooth path for the business case.

Risk 976	Initial risk score **16** (high)	Current risk score **12** (high)	Target risk score **3** (low)

Title: Affordability of revenue costs of new CAMHS Tier 4 service in new building

The modelling of the revenue costs of the service model for CAMHS Tier 4 in the new building being developed has resulted in a total cost significantly in excess of expected current NHS England funding levels. This potentially will adversely impact the sign off of the capital scheme and/or the view of LCH's ability to run an effective and efficient service.

Controls in place:

- Project Board established
- In principle agreement at the New Care Models Project Board that the full CAMHS Tier 4 budget currently delegated to LCH under the New Care Models pilot, is available to fund costs agreed as reasonable across the collaborative.

Planned actions include:

- Project Board to monitor the situation

4.0 Risks escalated to a score of 12 (high)

4.1 One risk has been escalated to a score of 12 since May 2019

Risk 957	Current risk score **12** (high)	Previous risk score **10** (high)
Title: Increase in demand for the adult speech and language therapy service. Reason for escalation: • Potential negative impact on waiting times identified as there is a delay between the date when the locums leave the service and when new staff will have been inducted. • Clinical staff have been covering some of the administration tasks prior to new admin staff taking on their roles, this means that clinicians capacity for addressing waiting times is reduced		

5.0 Risks de-escalated from a score of 12 (high)

5.1 One risk has been deescalated from a score of 12 since May 2019

Risk 949	Current risk score **9** (high)	Previous risk score **12** (high)
Title: High Turnover of Staff in Neighbourhood Teams Reason for de-escalation: • Risk rating adjusted to reflect improved fill rate in Neighbourhood Teams		

6.0 Closed risks previously scoring 12

6.1 One risk has been closed, which previously scored 12

Risk 939 **(see new risk 975)**	Initial risk score **16** (extreme)	Current risk score **12** (high)	Target risk score **4** (medium)
Title: New CAMHS Tier 4 Building. The Trust has been allocated £13m of public sector capital to deliver a new CAMHS Unit for 22 beds on the St Mary's Hospital site. There is a risk that the cost of the Unit cannot be contained within the £13m risking delivery of the Unit in the required			

timescale and requiring the Trust to identify other sources of funding that could compromise other plans.

Reason for closure:

- Since being included on the risk register, this risk has evolved, a new risk which better describes the specific current risks has been raised (risk 975, see section 3.1)

7.0 Risks with an out of date review date

7.1 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.

7.2 There is one risk which is out of date by one month or more:

Risk ID	Risk description	Risk owner	Review Date
Risk 902	Incompatibility of shelving system, manoeuvring space, stored items and available lifting equipment at Assisted Living Leeds (Leeds Community Equipment Store)	Claire Firth	31/05/2019

8.0 Risk Themes

8.1 Further analysis has been undertaken of the four escalating themes identified in the report provided to Trust Board on 24 May 2019. The themes were as follows:

Table 1. List of live themes (as at 26.06.2019)

Theme	Year entered onto the register				Total
	2016/17	2017/18	2018/19	2019/20 (year to date)	
Information Technology	5	4	8	2	**19**
Patient safety	3	1	6	4	**14**
Retention	2	1	4	1	**8**
Governance	0	1	3	2	**6**

8.1.1 It should be noted that risks can have more than one theme.

8.2 Main findings from theme analysis

8.2.1 Information Technology

LCH computer systems are becoming increasingly incompatible with those of other organisations; when other organisations change their IT systems, often the impact on LCH is not realised or acted upon in a timely manner. There is a risk that data sharing, updating patient records and the requesting of tests is becoming increasingly difficult, leading to inefficient work arounds and increasing the likelihood of human error.

8.2.2 Patient Safety

There are a number of different factors which lead to patient safety being compromised. These include:

- Increased demands on services, resulting in reduced staff capacity, leading to increasing waiting times and requiring prioritisation of patient treatment
- Staff turnover, resulting in reduced staff capacity within services, leading to increased waiting times and the need to prioritise patient treatment
- Management of change; risks are not being identified at the time of change.
    - Risks may be internal to the organisation such as:
        - (Internal)changes in policy or processes e.g. a change in building use which led to the decision not to have receptionists at specific buildings, resulting in a risk for coordinating emergency response (first aid and fire evacuation)
        - Staff leave the organisation leaving a gaps in competency.
    - Some risks are external to the organisation, for example manufacturers change their medication specifications requiring LCH's intervention to ensure patients are aware of changes and associated risks.
- Governance processes are not robust enough to ensure that other parties and/or contractors fulfil their obligations (timely repairs, sufficient provision of competent persons, standards of service).
- Premises (including 3rd party buildings) do not meet LCH requirements including alarm systems, cleanliness, fixtures and fittings, sufficient building capacity for activities.

8.2.3 Retention

A high turnover of staff in some services is resulting in insufficient staff capacity to meet the day to day demands of their work flow which could lead to not meeting contractual requirements and increased patient waiting times. Anecdotally, staff leave due to increased work pressures within their service and because other Trust's offer similar roles at a higher banding.

8.2.4 Governance

Insufficient arrangements are in place to ensure that other parties who work with the Trust (other NHS trusts, contractors and subcontractors) deliver what is required in order to meet contractual obligations and provide outstanding care. This could result in poor patient care, poor CQC rating and loss of contract.

9.0 Board Assurance Framework Summary

9.1 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.

9.2 Definitions:

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

9.3 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.

9.4 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.

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

9.6 Since the last BAF report in May 2019, the current level of assurance for the following BAF risks has been adjusted as follows:

Positive assurance movement (indicating an improved situation)

- BAF risk 3.1 (suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) has seen a positive movement due to the Neighbourhood teams report (capacity and delivery) and Performance Brief (staff turnover figures) both receiving reasonable assurance at Business Committee.

Negative assurance movement (indicating a worsening situation)

- There has been no negative assurance movement

9.7 The attached BAF summary reflects the amended assurance levels.

10.0 Recommendation

10.1 The Board is recommended to:

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

Appendix One: Board Assurance Framework Summary

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 ◆). No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Provide high quality services	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	SL	QC	3	4	12				◆			
	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				◆		Patient Safety and Engagement Report received reasonable assurance at Quality Committee	
	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				◆			
	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				◆		Healthwatch engagement in complaints review received reasonable assurance at Quality Committee	
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				◆		Administration review project update received reasonable assurance at Business Committee	
	RISK 2.2 If the Trust does not deliver contractual 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				◆			
	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						Neighbourhood teams report (capacity and delivery) and Performance Brief - staff turnover figures both received reasonable assurance at Business Committee	→
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	4	3	12						Performance Brief: Sickness absence received reasonable assurance at Business Committee	
	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						Freedom to Speak Up Guardian report received reasonable assurance at Quality 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 presentation - learning and development received reasonable assurance at Business Committee	
Work in partnership to deliver integrated care and care closer to home	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (Health and Care Partnership (ex STP) implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	BC	3	3	9							
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	2	4	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							
	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 Two: Glossary- BAF risk assurance levels

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

NHS
Leeds Community Healthcare
NHS Trust

Agenda Item 2019-20 (36)

Meeting: Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title: Working with Primary Care Networks	**For approval**	✓
Responsible director: Chief Executive **Report author:** Senior Management Team	**For assurance**	
Previously considered by N/A	**For information**	

Purpose of the report: This paper sets out for Trust Board the progress to date on our developing relationships with the 19 newly formed Primary Care Networks (PCNs) in Leeds.

It sets out the four options considered in respect of PCNs employing the new roles mandated under the workforce additionality reimbursement scheme and describes in more detail the proposed offer that Leeds Community Healthcare (LCH) has made to PCNs.

Main issues for consideration:

The offer of LCH as an employer on behalf of PCNs is proposed in the context of the strategic and ongoing partnership between LCH and the Leeds GP Confederation.

PCNs are currently unable to employ staff although they may seek to do so in future.

The proposed offer is that LCH would act as an employer hosting the employment of key roles on behalf of PCNs but with clarity that the staff in question would be deployed to PCNs.

Hill Dickinson have been engaged by the Trust to develop a Service Level Agreement.

There are four key areas in which there is some risk to LCH of offering this hosted employment model to PCNs as follows:

i. Clinical Governance issues.
ii. VAT liability and costs;
iii. NHS Pension Scheme Access;
iv. Financial liability;
v. Employment liability

Mitigation of these risks is described in this paper.

Recommendations
The Board is recommended to:

- Note the detail provided in this paper and approve, in principle, the proposal that LCH offer to employ the community pharmacy mandated roles on behalf of PCNs.
- Agree in principle to use the same model to employ and deploy other PCN staff as they become commissioned.
- Continue to keep the model under review and to assess against the risks outlined.

Working with Primary Care Networks

1. Introduction:

This paper sets out for the Board progress to date on our developing relationships with the newly formed 19 Primary Care Networks (PCNs) in Leeds. It also sets out in more detail the proposed offer to employ staff that Leeds Community Healthcare (LCH) has made to PCNs. Additionally the paper seeks Board approval to progress this offer in the first instance with Community Pharmacists (the first of the mandated additional roles that PCNs are tasked with recruiting) as well as the use of the employment offer in future with other groups of staff as appropriate and needed.

This has been discussed at Business Committee with updates given to the last two meetings and formed part of the conversation at the July workshop and the late July workshop between the confederation and LCH. It is a clear part of starting to operationalise the under arching organisation spanning community and primary care services which has formed a central plank of LCH strategy over several years.

2. Background:

A number of options are available and have been considered in respect of PCNs employing the new roles mandated under the workforce additionality reimbursement scheme now established for primary care. These are set out below:

i. The GP Confederation (GPC) is currently unable to employ staff and should it continue to pursue establishing itself as an employer, the timescales for this do not fit with the requirements placed upon PCNs for mandated roles;
ii. A lead practice could employ on behalf of the PCN and the GPC has provided some legal advice and templates to PCNs to facilitate this option;
iii. Another organisation could act as the host employer;
iv. LCH could act as a central employer, hosting employment with staff deployed and managed within their respective PCNs.

PCNs are currently unable to employ staff although they may seek to do so in future.

The offer of LCH as an employer on behalf of PCNs is proposed in the context of the strategic and ongoing partnership between LCH and the Leeds GPC consolidated through a Committees in Common between the two organisations. The GP Confederation is recognised as the voice of primary care in Leeds and the collective grouping of the three GP Federations and therefore of the 99 GP practices in Leeds from which the 19 PCNs have been formed. The Confederation is working hard to support the development of PCNs and as a key partner in the integration of primary and community care, LCH's strategic direction is to support the GPC in this work.

Additionally in the context of the national direction of travel on efficiency and the prevention of the creation of additional infrastructure, LCH as employer on behalf of PCNs would seem to be an attractive option.

3. What is Involved in Establishing any organisation as an Employer?

There are a significant number of required pre requisites that any prospective employer must comply with prior to establishing itself as an employer and what it must have in place immediately following doing so. In summary the pre employer requirements fall under the following headings:

- Access to a pension scheme;
- Terms and conditions of employment;
- People management policies;
- Pay and reward;
- Resourcing considerations;
- Employee communication, engagement and consultation;
- Employee infrastructure.

The post employer requirements are as follows:

- Employee Relations;
- Learning and Development;
- Performance management.

LCH have all of the above as well as much more in place – the above requirements are, it is suggested, the minimum stipulations in terms of setting any organisational entity up as an employer.

4. Proposed LCH Employment Model:

In summary in terms of this option, LCH would act as an employer hosting the employment of key roles on behalf of PCNs but with clarity that the staff in question would be deployed to PCNs and under their day to day direction in terms of the work and priorities to be undertaken. We have a similar model in place with the recovery hubs working with social care.

In terms of defining this model of employment, it is proposed that the following be included as part of the 'employ and deploy' or hosted offer of employment from LCH to PCNs:

- Access to the NHS Pension scheme;
- Employment on Agenda for Change (AfC) terms and conditions of employment;
- Recruitment vacancy administration; 1
- Induction offering at a corporate or central level;
- Provision of statutory and mandatory training;2
- Provision (at cost) and management of IT Kit;
- Contractual change work / employee data administration;
- Employment infrastructure.

The above offer in terms of hosted employment attempts to distinguish between the bare minimum that LCH would need to offer and the provision of an HR or workforce service to PCNs. As part of the overall service offer LCH will need to provide certain assurances of the sort employment agencies provide to LCH:

[1] Please note that as our employee it is assumed that the same standards in terms of CQC and NHS Employers pre-employment checks should be attained.

[2] Please note that again as our employee it is assumed statutory and mandatory training will be subject to the same standards as required by CQC and so ongoing statutory and mandatory training is included within this hosted employment model.

- That the individual member of staff is competent and qualified to carry out the role;
- That they are DBS checked (if appropriate);
- That they have undertaken the necessary statutory and mandatory training;
- That they are paid for the work they undertake etc.

4. Progress on Proposed Employment Model:

This offer has been scoped and costed in more detail and would be delivered on a Service Level Agreement basis to PCNs. In terms of pricing, the proposed figure is 2% of gross salary in addition to PCNs funding employer on-costs (NI and NHS Pension Scheme employer contribution). The intention is to co-develop the model and to this end, a workshop session was held between LCH, the GPC and individuals representing five PCNs at the end of June. At this workshop a detailed slide deck was considered which covered the employment lifecycle and various steps within it as well as importantly both Clinical Governance and VAT considerations in terms of making this offer to PCNs.

The PCNs represented remain keen to pursue the offer and subsequently two further PCNs have expressed their interest. Hill Dickinson have been engaged by the Trust to develop a Service Level Agreement (SLA) with legal standing and as discussed and agreed as the next step at the workshop. Once this SLA has been developed, it will be shared with the representatives of the interested PCNs for further review and discussion.

It is anticipated that in August the work will be completed in order that this offer can be formally utilised by PCNs recruiting to the first of the mandated roles i.e. Community Pharmacists. It is further anticipated that this offer will prove increasingly attractive to other PCNs as the concept is tested and proved in terms of the 'employ and deploy' model with LCH. It is therefore likely that over time the model will be rolled out to other mandated roles PCNs are tasked with recruiting to, as well as to other groups of staff as required and appropriate.

5. Potential Risks to LCH of Offering this Employment Model:

There are four key areas in which there is some risk to LCH of offering this hosted employment model to PCNs as follows:

vi. Clinical Governance issues.
vii. VAT liability and costs;
viii. NHS Pension Scheme Access;
ix. Financial liability;
x. Employment liability.

Each one is explored in further detail below:

i. Clinical Governance:

The clinical governance risk for this model is currently assessed as minimal; we have examples already in the organisation where this type of model is utilised. For example, the recovery hubs where we employ staff who then work under the day to day management of the local authority home manager. Clear processes have been established to ensure the risk around this is minimal and there is clarity as to who is responsible for what in terms of complaints, incidents, professional issues etc.

This model should be operated in a similar manner and the key areas will be to ensure that staff employed have the correct qualifications/registration and the necessary training and induction, all of which would be for LCH to ensure are in place at the point of employment. It will also be necessary to ensure that staff employed via this model understand and utilise the correct lines of escalation, for example, if they are asked by the practice they are working for to do something that they know is outside their scope of practice, they will need to be clear that this is not possible and to ensure it is escalated to the Medical/Nursing Director as appropriate and also to the local practice manager.

In terms of dealing with complaints or incidents where a member of staff employed by LCH is involved, this will be managed by the local service with input from LCH as required as this will be in relation to the service delivered.

ii. VAT Liability:

In order for the Trust's proposed offer to PCNs to be a financially viable one our working hypothesis is that it cannot introduce a VAT liability to PCNs. Alongside the work with Hill Dickinson mentioned previously we are seeking specialist VAT advice to ensure that any SLA does not inadvertently introduce a VAT liability.

ii. NHS Pension Scheme Access:

LCH is an NHS employer and therefore has full and open access for all staff who wish to be a member of the NHS Pension Scheme. In terms of the other employment options for PCNs, GP Practices can also NHS Pension Scheme access.

Within this context and the longer term primary and community care integration direction of travel nationally as well as the strategic partnership between LCH and the GP Confederation / primary care, it is deemed unlikely that the proposed LCH host employer arrangements would be viewed as a means by which to retain NHS employment and secure NHS Pension Scheme access for those staff working as part of PCNs. Therefore this risk is one that whilst acknowledged is unlikely to materialise.

iii. Financial Liability:

It is anticipated that if LCH were to host the employment of staff on behalf of PCNs that many of these staff would previously have been employed within the NHS and therefore have continuity of service preserved notably for the purposes of any redundancy payment. Where funding flows may cease or reduce in the future, LCH would become liable for redundancy costs where suitable alternative employment was not on offer.

This is a risk which appears across hosted employer arrangements within the NHS at both a national and local level and is one that can be resolved through and within the set up between host employer in this case LCH and PCNs i.e. the SLA would need to acknowledge this risk and plan for it.

There are well established relationships within Leeds to avoid redundancy situations for any clinical staff and we would not expect this to ever become a significant issue given the need for clinicians across the Leeds health care system whatever the changes in strategic direction.

iv. Employment Liability:

There are of course many advantages to NHS employment but also some issues to be addressed which include employment liability. All employers are required to have employment liability insurance to provide coverage to employers against any claims made by employees. In reality, it is likely that any claims in terms of how employees are treated would arise from the day to day management and interactions within the PCN space i.e. not those relating to the LCH hosted employer arrangement.

Similar to financial liability above, this is an issue that arises in hosted employer arrangements throughout the NHS and should be resolvable through the contractual and other agreements struck between LCH and PCNs to ensure that PCNs are indemnifying LCH against any potential employment claims.

6. Recommendations and Next Steps:

It is recommended that the LCH Board note the detail provided in this paper and approve, in principle, the proposal that LCH offer to employ the community pharmacy mandated roles on behalf of PCNs.

To agree, in principle to use the same model to employ and deploy other PCN staff as they become commissioned.

To continue to keep the model under review and to assess against the risks outlined.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (37)

Meeting Trust Board 2 August 2019	**Category of paper**	
Report title Safe Staffing	**For approval**	
Responsible director Executive Director of Nursing and AHPs **Report author** Executive Director of Nursing and AHPs	**For assurance**	√
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

The paper describes the background to the expectations of boards in relation to nurse staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report is written in the context of the current system and local pressures.

MAIN ISSUES FOR CONSIDERATION

The report sets out progress in relation to maintaining safe staffing over the last six months. The statutory requirements and data is contained in an appendix with the main body of the paper being used to provide assurance to the Board in relation to the effect of staffing pressures on services and how these are being mitigated.

Safe staffing has been maintained across all inpatient units for the time period, however, this has meant that on a small number of occasions stays in Hannah House have had to be cancelled to maintain and ensure patient safety. There continue to be pressures in a number of the neighbourhood teams. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this is possible.

RECOMMENDATIONS

The Board is recommended to:

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

1.0 Background

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

1.2 In addition to reporting on the in-patient areas the paper also provides information on some of the other keys services, in particular the neighbourhood teams and the Health Visiting service. Although it should be noted that since the 1st April 2019 the Health Visiting service is now a combined 0-19 service with School Nursing.

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

2.0 Safe staffing

2.1 We continue to use a set of principles as set in Appendix1 below to monitor safe staffing in our in-patient beds and wider teams in the absence of a national definition of community safe staffing. This is also underpinned by the national Quality Board good characteristics (Appendix 2).

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

3.0 Community Neurological Rehabilitation Unit

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

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

3.3 There was deterioration in the Friends and Family Test (FFT) data for this unit in April/May 2019. Whilst numbers of returns are very small, two people said they would not recommend care on the unit. This was scrutinised in more detail and it is felt that one was completed incorrectly as whilst it said care would not be recommended all the comments were good. The other one had no comments but stated they would not recommend care, as these returns are anonymous it is impossible to follow this up.

4.0 Hannah House

4.1 The unit has maintained safe staffing levels throughout the reporting period (See appendix 3). Hannah House has maintained safe staffing levels to children staying at all times. This has been achieved due to late cancellation of stays by parents due to family reasons and on three occasions in Q1

2019/20 cancellations by the unit of a child's stay. Hannah House apologised to the families and have accommodated the children on a future date. Cancelling stays remains the last resort for the unit with team members rearranging off duty, and additional provision sought from colleagues in other services, CLASS or private agency first but occasionally it becomes the only option to ensure safe care. The Business Unit Clinical Lead, supported by the Director of Nursing and AHP's and the Head of Service are currently reviewing how safe staffing levels are determined and whether the criteria is correct.

4.2 There is one Band 5 Registered Nurse vacancy, with all other posts filled with staff coming into post in July 2019. There is a recruitment programme in place for the Band 5 post. Absence, both long and short continue to be actively managed by the Team Manager, with an absence rate of 14%, with short term absence at 3% and long term absence at 11% (June 2019).

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

4.4 There have been no complaints about Hannah House reported during this time.

5.0 Little Woodhouse Hall

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

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

5.3 There has been one complaint about care during this time and this has been resolved satisfactorily for the family involved and was a communication issue. This complaint was not related to staffing issues.

6.0 0-19 Public Health Integrated Nursing Service (previously reported as Health Visiting)

6.1 In April 2019 the health visiting and school nursing service became one service known as the 0-19 Public Health Integrated Nursing Service. The service is delivered by six integrated 0-19 teams working across Leeds. The team is skill mixed to meet the health needs of each geographical area and consists of Health Visitors School Nurses, Staff Nurses and Family Support Workers (formerly known as Community Nursery Nurses). While school nurses are geographically based in the new teams they also continue with some citywide service delivery.

6.2 The number of Health Visitors working in each geographical team is determined by a weighting tool. The tool takes account of the Income Deprivation Affecting Children Index (IDACI) of each geographical area, alongside the number of families living in the top 3%, 5%, and 10% super output areas (SOA). The caseload size per WTE health visitor is determined by the number of health visitors within each team and whether there are vacancies within that team. The service also takes account of caseload size

recommendations described in Lord Laming reports (2009 and 2016), following the deaths of Victoria Climbie and reviewed following Baby P's death. Safe staffing in the service has been maintained throughout the reporting period and the detail related to caseload size etc. can be seen in Appendix 3.

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

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

Two were in relation to communication between the Health Visitor and the families. These were not related to staffing issues and both have been investigated fully with learning implemented to prevent future occurrence.

One was in relation to access to baby clinics and the changes around this due to the new contract and unrelated to staffing.

One was in relation to school nursing and a letter that had been received from the service to parents stating that the child was overweight and offering advice etc. The family were not happy with the letter.

7.0 Neighbourhood Teams

7.1 As previously stated there are no nationally agreed staffing levels for community teams or evidence based tools. The Trust continues to develop the work to set safe staffing levels in community teams. There is information in Appendix 3 in relation to staff turnover and sickness rates.

7.2 Staffing is monitored and manged on a daily basis through the Capacity and Demand reporting tool with senior clinical and operational oversight seven days a week. Actions are initiated to ensure patient and staff safety is maximised. Following recommendations from Internal Audit and discussions with colleagues in Neighbourhood Teams, the Capacity and Demand tool has been updated and relaunched in October 2018. The revised version is simpler to complete and addresses some inconsistencies in the previous version.

7.3 The main recruitment challenges in Neighbourhood Teams are registered nursing and therapy roles. Close working with CLaSS (the LCH temporary staff service) ensures that available bank and agency staff are targeted at teams with the greatest staffing challenges. A Trust wide Short Term Resourcing Group has now concluded the focussed work over the winter period and ongoing work will be picked up through the trust wide Resourcing Steering Group chaired by the Director of Workforce. In addition the contract continues with a local provider to support care home work in a number of teams.

7.4 Staff experience remains variable and is influenced by a number of factors Staff engagement discussions have been held in all teams and a range of

local initiatives continue to be implemented to improve staff experience and engagement.

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

7.6 There are a number of routes for staff to share their feedback and discuss solutions to local and citywide issues including:

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

7.7 There have been a total of 14 complaints in relation to the Neighbourhood Teams during the reporting period. One of these on initial review appeared to be linked to staffing levels as the complaint was in relation to relatives feeling that there was not enough staff to provide appropriate input to their relative in a care home. On investigation the care home had not referred to the team. None of the other complaints appear to have been related to staffing concerns or issues. This will continue to be monitored closely and any issues related to staffing will be escalated for immediate attention to SMT.

8.0 Conclusion

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

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

9.0 Recommendations

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

Appendix 1

- Patients can be treated with care and compassion.
- The determination of safe staffing levels is not a single process but rather an on-going review taking into account clinical experience in running the wards or team.
- The quality of service as determined by outcomes, including patient experience and national guidance and development of further tools. All patients have a thorough and holistic assessment of their needs.
- All patients have a care plan which sets out how the goals for their admission, care plan or treatment episode will be set.
- Staffing numbers allow full and timely implementation of the care plan.
- Staff numbers are sufficiently robust to allow the team or unit to function safely when faced with expected fluctuations and with the inevitable occurrence of short term sickness of staff.
- Operational Managers and Unit Managers are able to call upon additional resources if this is required by the particular needs of the inpatient group on a particular shift.
- A clear system of outcomes focussed on patient experience, patient safety and patient outcomes are in place and the information from these measures informs how the Operational and Clinical Leads run services.
- There is not an undue reliance on temporary staff to fill nursing rotas.

The agreed processes for clinical prioritisation are followed in periods of escalation

Appendix 2

National Guidance

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

Appendix 3

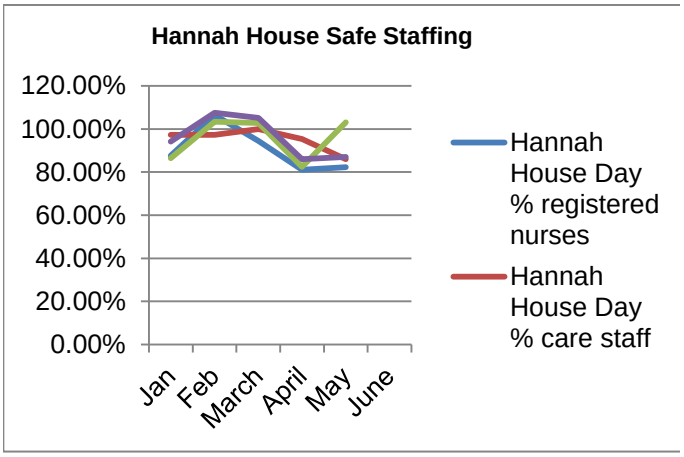
Data:

Community Neurological Rehabilitation Centre

This regional unit consists of five inpatient beds and up to five day case places with additional community based services. Patients are typically admitted to the unit for two week episodes of care and assessment. The unit has reviewed its staffing model in line with the model of care. Safe staffing levels are maintained as set out below for the last 6 months:

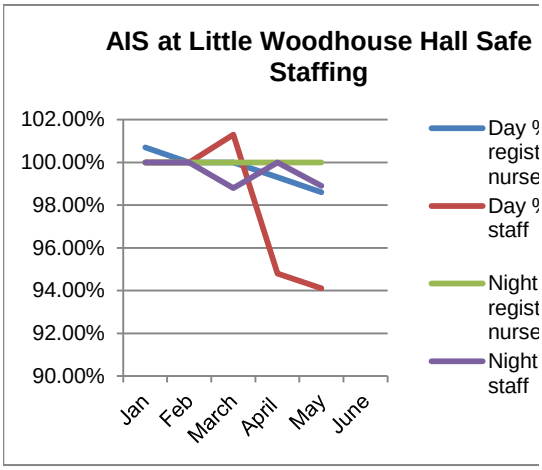
	Community Rehabilitation Unit			
	Day		Night	
	% registered nurses	% care staff	% registered nurses	% care staff
Jan 19	100%	100%	100%	100%
Feb	100%	97.4%	100%	100%
March	100%	100%	100%	100%
April	100%	98.7%	100%	100%
May	100%	100%	100%	100%
June	100%	100%	100%	100%

Hannah House



Month 2019	Hannah House			
	Day		Night	
	% registered nurses	% care staff	% registered nurses	% care staff
Jan	87.6%	97.3%	86.4%	94.2%
Feb	106.5%	97.3%	103.3%	107.5%
March	94.5%	100.0%	102.7%	105.1%
April	81.1%	95.3%	82.4%	86.0%
May	82.3%	86.0%	103.0%	87.0%
June	93.4%	96%	103.3%	92.2%

Little Woodhouse Hall



2019	Day		Night	
	% registered nurses	% care staff	% registered nurses	% care staff
Jan	100.7%	100.0 %	100.0%	100.0%
Feb	100.0%	100.0 %	100.0%	100.0%
March	100.0%	101.3 %	100.0%	98.8%
April	99.3%	94.8 %	100.0%	100.0%
May	98.6%	94.1 %	100.0%	98.9%
June	100.0%	100.0 %	100.0%	100.0%

Health Visiting Service

The service is commissioned for 125 whole time equivalent (WTE) Health Visitors to be in post. Table 1 illustrates the caseload size per whole time equivalent (WTE) Health Visitor for each geographical area, using the number of resident children under 5 years of age. In June 2019 the service reported a 2.05 WTE Health Visitor vacancy.

Table 1: Current Staffing in Integrated 0-19 Teams 2019 based on 125 WTE HVs

Team	No's of under 5's	No. of current HVs in post	% achieved	Vacancy	Average caseload based on current HVs in post
South	11829	30.40	98	0.62	389
Outer West	11300	23.24	100	0.06	486
Inner West	6430	18.31	102	-0.28	351
Inner East	5112	15.40	95	0.81	332
Outer East	7298	15.20	96	0.63	480
North East	8774	20.40	99	0.21	430
Total	50743	122.95	98	2.05	413
					Date: 17 June 2019

Table 2 demonstrates the improvement in health visitor numbers Quarter 1 2019/20. Vacancies and capacity issues are discussed weekly at team meetings and the services leadership management meetings.

Additionally there have been creative steps taken to market the service and recruit, including use of social media (YouTube and FaceBook)

Table 2: Health visiting total number staff in post Jan – June 2019

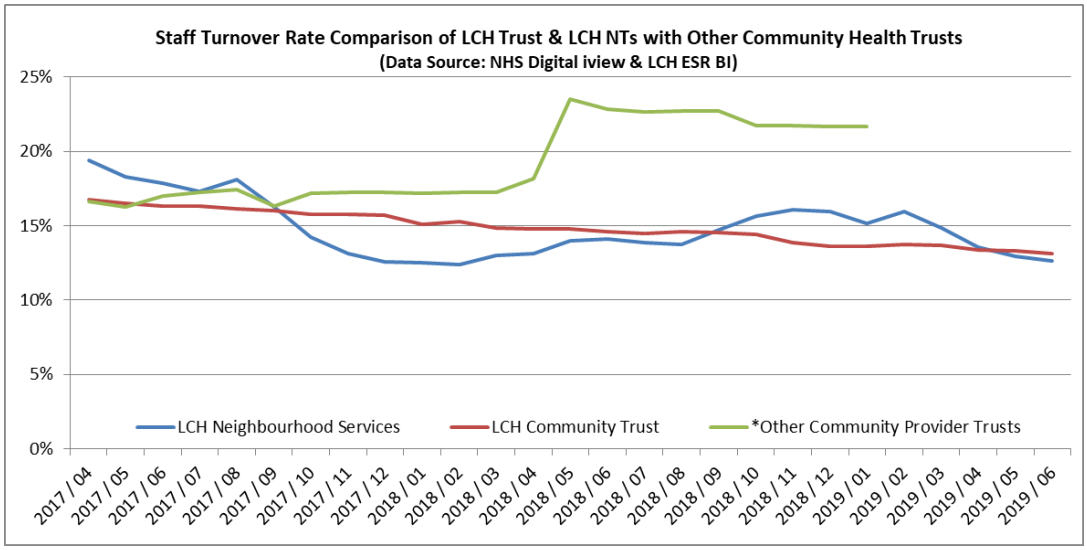
	Quarter 4			Quarter 1		
	Jan-19	**Feb-19**	**Mar-19**	**Apr-19**	**May-19**	**Jun-19**
Health Visitor (WTE) in post	117.30	116.90	118.90	124.05	123.45	124.45

Neighbourhood Teams

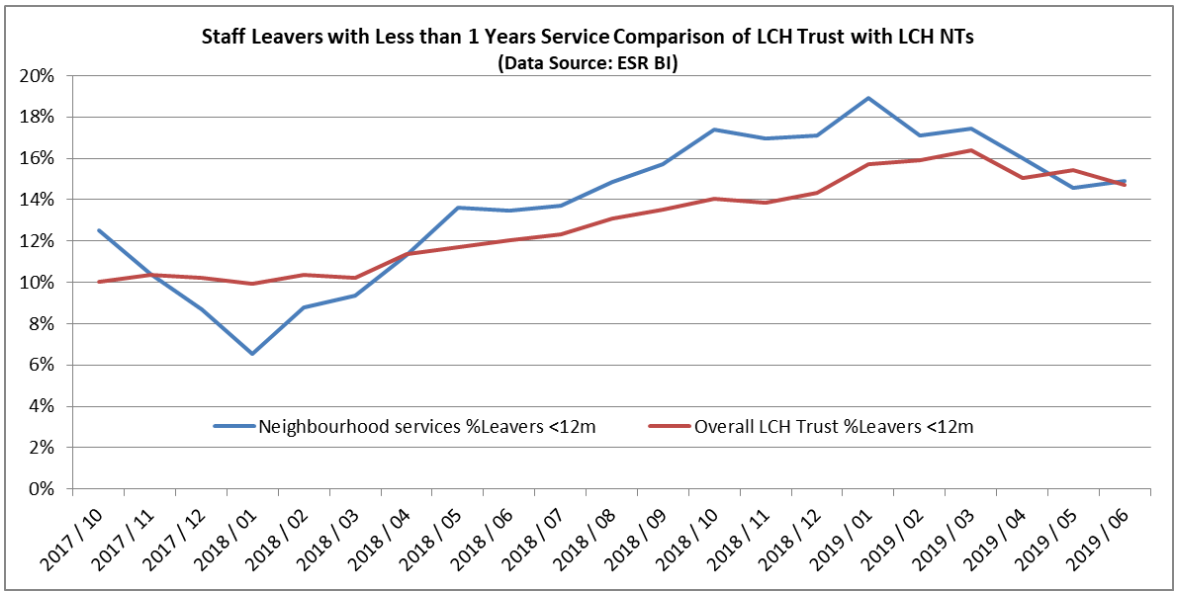
Neighbourhood Team face to face activity. The chart below shows the pattern of face to face contacts for the period April 2017 to March 2019, with the impact of seasonal variation and the altered commissioner profile marked. Work continues to develop a broader measure of Neighbourhood Team activity to encompass productivity and outcome measures.

Staff Turnover:

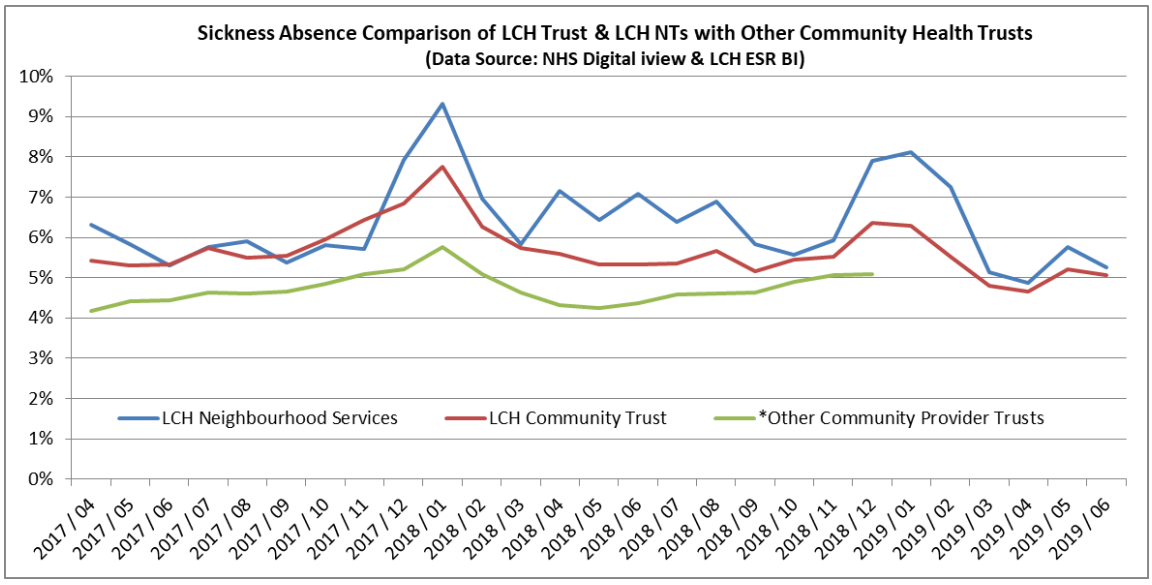
As shown in the chart below Neighbourhood Team staff turnover has returned to a level below the trust total. Neighbourhood Team turnover has decreased in the last 3 months and it compares favourably with 2017 levels.

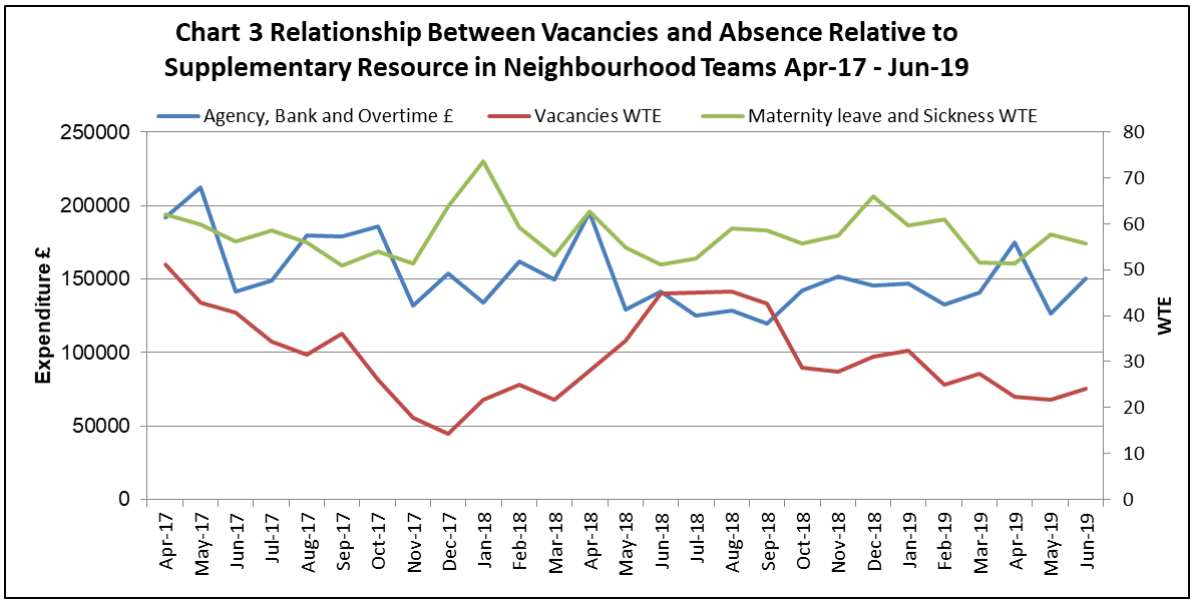


Number of leavers in their first 12 months of employment in Neighbourhood Teams has decreased over the last period and is now at a similar level to the overall trust position



Sickness levels. There is an ongoing focus on staff health and wellbeing and staff sickness. Neighbourhood Team sickness rates have remained stable, with a seasonal reduction in sickness from a peak in December 2018.





Quality, safety and patient experience continue to be monitored through:

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (38)

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

Purpose of the report

This report provides the Board with an update and assurance in relation to the management of Serious Incidents (SI's). It summarises the outcomes, themes, actions and learning from SI investigations closed within the organisation during 1 April 2019 to 30th June 2019.

Main issues for consideration

A total of fourteen (14) new Serious Incidents were reported and verified from April through to June 2019.

These consisted of 8 pressure ulcers (4 unstageable, 3 category 3 and 1 category 4), 2 self-harm in 24 hour care, 1 delay in the referral process, 1 fall resulting in fractured hip and 1 treatment issue.

1 de-log request was made and granted by the CCG for an incident reported in the previous quarter that following investigation, had already been logged as an SI with LYPFT and it was agreed that a joint investigation was the appropriate way to investigate.

Outcomes of serious incident investigations completed in this reporting period are included along with any themes identified through investigations. This now does not include pressure ulcer incidents as this is covered in the separate pressure ulcer report.

The main body of the report will consider the quarters reported incidents, learning and any other pertinent issues to bring to the Boards attention.

Recommendations

The Board is recommended to:

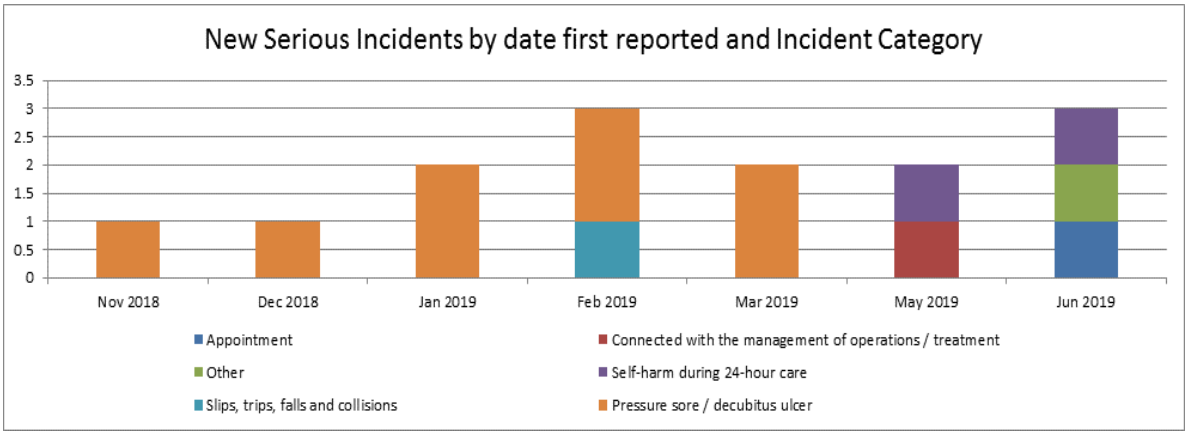
- receive this report and note the current position with regards action plans and learning
- receive assurance regarding the management of Serious Incidents and handling of inquests

1.0 New Serious Incidents in Quarter 1

Fourteen incidents were reported to the commissioners via STEIS between 1st April and 30th June 2019.

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

	Apr 2019	May 2019	Jun 2019	Total
Failure in referral process	0	0	1	1
Pressure Ulcers	2	2	4	8
Self-harm	0	1	1	2
Treatment, procedure	0	0	1	1
Unexpected Death in the Community	0	0	1	1
Suspected fall	0	0	1	1
Total	2	3	9	14



Synopsis of the serious incidents (not falls or ulcers) from the original reports.

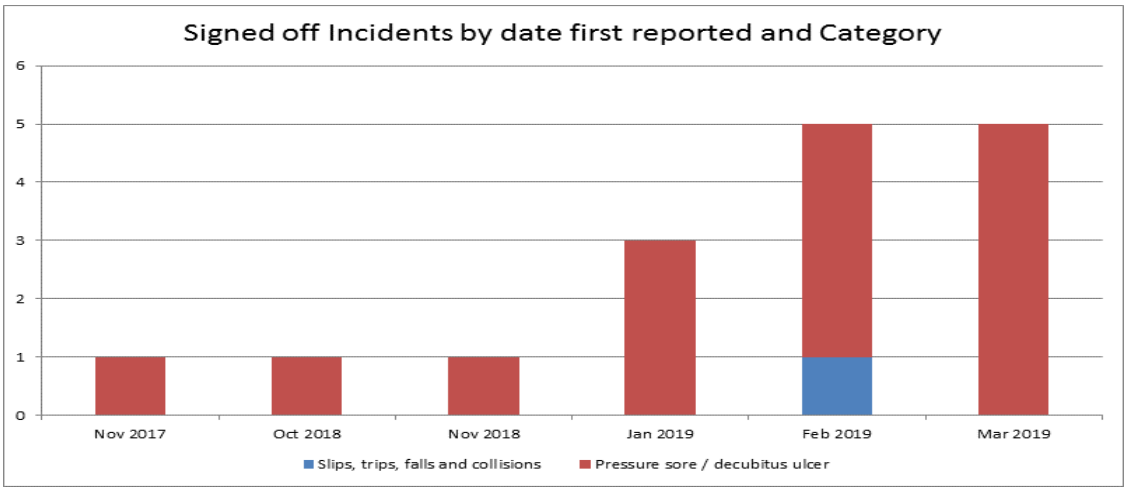
- A young person in Wetherby YOI had inflicted multiple lacerations to arms and legs whilst on constant watch after being given a razor to shave with that he had managed to dismantle and conceal.
- A young person in Wetherby YOI who required constant watch had inserted objects into his penis. This required hospital visit and surgical intervention for removal.
- A patient of the Homeless & Health Inclusion Team and occupying a HALP bed at St Georges Crypt was found dead in the community.
- A pre-adopted child was referred to Paediatric Neurodisability. Post adoption health visitor enquired what had happed to referral and found discharged although parent/carer had opted in. Delay in referral and diagnosis.

- A patient re-attended and reported severe pain and restriction of arm following removal and insertion of contraceptive implant, re-removal was undertaken by a senior clinician and symptoms resolved

Completed Investigations

Sixteen SI's were signed off by the Director of Nursing in Quarter 1.

	Apr 2019	May 2019	Jun 2019	Total
Pressure Ulcer acquired during LCH NHS Care	4	4	7	12
Suspected fall (Patient)	1	0	0	1
Total	5	4	4	13



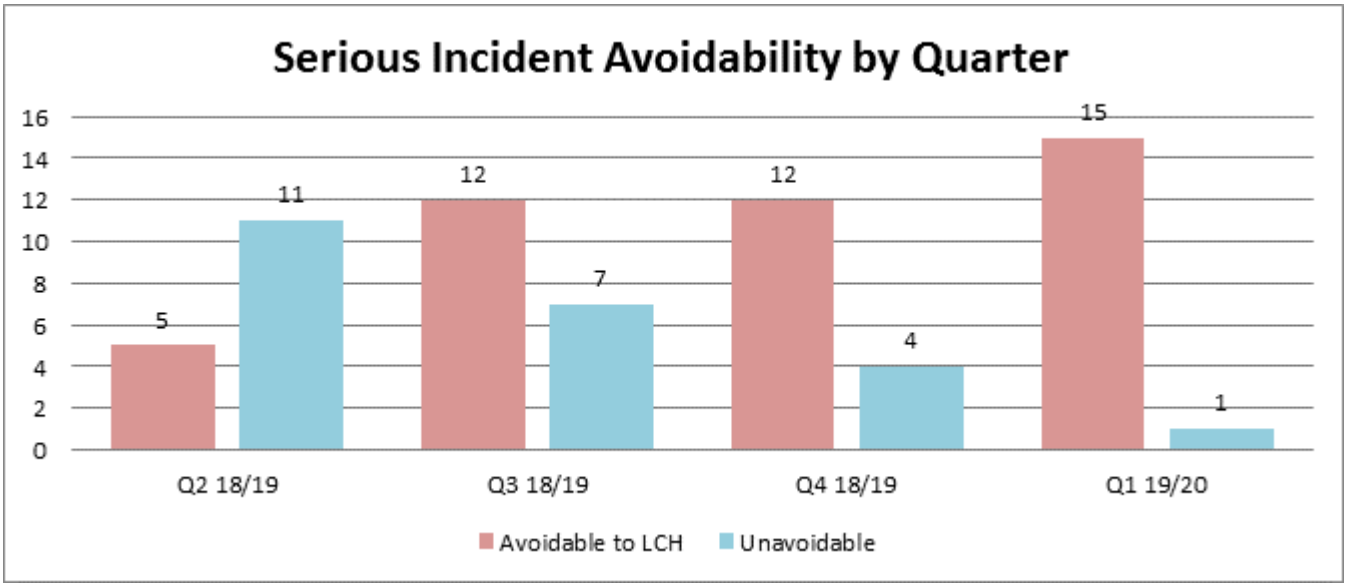
Fourteen were signed off before the due date. Two were subject to delays which resulted in the due date being passed. The report from November 17 was heard at panel and closed in January 2018, however the report was not signed off by a Director or submitted to the CCG. This was noted at a recent audit and the omission rectified.

There were only pressure ulcer incidents and a fall serious incident signed off in the quarter. The learning from the pressure ulcer investigations is now being collated into one action plan which will be overseen by PSEG.

The one fall which was found to be avoidable was closed in April 2019. The Root cause identified: • Failure to respond to known risk factors. • Failure to complete accurate timely assessments. This learning has been picked up in the team involved and also disseminated across the other neighbourhood teams.

Outcomes and Themes

Of the sixteen SI records closed in the quarter, fifteen were found to be avoidable with only one being unavoidable. Compared to previous quarters it is evident that there is now a consistent number of avoidable incidents occurring. The unavoidable figure continues to drop; this is as a result of only marking records as STEIS reportable at the review meeting.



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 April to June identify assessments not completed correctly, a failure to identify risks, communication and poor care/case management.

These themes are shared with the Director of Nursing and AHPs and discussed at the pressure ulcer steering group and PSEG to identify any key areas of work across the organisation with the support of the clinical leads.

The adult business unit have taken an in-depth look at the pressure ulcers and developed an action plan that will be considered and monitored at the PSEG.

4.0 Coroners Inquests

Two inquests were heard between April and June, only one required LCH representation.

One was a report of a death following release from a Custody Suite; following the inquest an open conclusion was given.

The other was a death following admission to hospital for a necrotic foot ulcer and cellulitis. A statement was provided to the coroner by a WPMS specialist, no witnesses were called.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (39)

Meeting: Trust Board 2 August 2019	**Category of paper**	
Report title: Freedom To Speak Up Guardian Report	**For approval**	
Responsible director: Chief Executive **Report author:** Freedom To Speak Up Guardian	**For assurance**	✓
Previously considered by N/A	**For information**	

Purpose of the paper

This paper provides an overview of the Freedom To Speak Up Guardian (FTSUG) work, basic activity data and the future direction on this stream of work. The report covers the period from 1 April 2018 to 31 March 2019.

Main issues for consideration

- This report addresses matters relating to working in the FTSUG role: the work, its spread and its links to other areas of work in the Trust.
- The FTSUG role is working well in the Trust and receives strong support from the chief executive, directors and the wider organisation
- During 2018/19 40 LCH staff members have met directly with the FTSUG and raised concerns
- A peer review of the LCH FTSUG service by the FTSUG at Locala has been undertaken and offers us areas to celebrate and to develop
- Emerging themes are leadership and culture, process, carers, and service changes

Recommendation

The Board is recommended to:

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

Freedom to Speak Up Guardian Report

1.0 Introduction

1.1 This paper provides an overview of the work of the FTSUG, basic activity data and recommendations on the role and its development.

2.0 Background

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

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

2.3 Following a competitive recruitment process, the Trust appointed its FTSUG in November 2016 and the appointee took up post on 1 December 2016.

3.0 Current position

3.1 The FTSUG role is working well in the Trust and receives strong support from the chief executive, directors and the wider organisation. A clear form of work has been established which aligns with the CQC well-led domain's aspect of LCH's work. The FTSUG was interviewed by the CQC in the recent inspection.

3.2 Communication of the role across the Trust and a positive relationship with Staffside has been accomplished. The LCH FTSUG is now the FTSUG for the staff at the Leeds GP Confederation. Regular supervision meetings with the FTSUG from Locala are in place. A peer review of the LCH FTSUG service by the FTSUG at Locala has been undertaken and offers us areas to celebrate and to develop. Leeds has been asked by the National Guardian Office to lead a national vanguard site for developing Speaking Up across general practice in Leeds. The LCH FTSUG is leading this and attended the National Guardian Conference in March 2019 to speak about the Speaking Up work in primary care in Leeds.

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

4.0 Activity data

4.1 The table below shows the volume and type of activity with which the FTSUG has been engaged between April 2018 and 31 March 2019. The table also indicates the nature of the issues raised with the FTSUG.

Business Unit	Method of contact	Numbers of staff	Issue
Adults	Phone, emails	7	culture, leadership, staff behaviours
Children's	Emails, telephone and face to face	11	service changes, culture, service pressures
Corporate	Face to face and emails	12	service changes, culture, behaviours, process
Specialist	Emails, telephone calls	8	culture, leadership.

4.2 40 LCH staff members have met directly with the FTSUG and raised concerns. One concern was directed to the whole of LCH and another pertained to an external organisation where a LCH staff member was on secondment. These figures do not include work with whole teams or staff who met with but did not raised a concern via the FTSUG. The FTSUG saw 9 staff members from BAME communities. One of these staff directly raised a concern regarding race.

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5.0 Themes

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

- ***Leadership and culture.*** There is a recurrent theme around compassionate leadership and supportive culture in the concerns. Staff not feeling valued and listened to is a key aspect of this.
- ***Process.*** Staff raised concerns over process and how this impacted them. This was partly the nature of the process itself and the lack of support through the process.
- ***Carers*** The issue of how we support staff who are carers has been a concern for some staff.
- ***Service Changes.*** Staff raised concerns over changes in their service and how they have felt not supported or included in the ongoing changes. Aligned to this are service pressures.

6.0 Conclusions

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

- The Freedom to Speak Up Guardian role has had a positive impact with strong support from the Trust.
- The Freedom to Speak Up Guardian role raises the issue of working outside of formal routes. Most people seen could not or did not wish to raise issues through a formal route although nearly all had spoken to their manager about the issue before speaking to the Freedom Guardian.
- The role illustrates the centrality of workplace culture. It validates the Trust's commitment to a person-centred vision.
- The work reflects the importance of safe spaces, empathic listening and inclusion of the staff voice in the organisation – it offers an actualisation of the values of LCH for its staff and services.
- This FTSUG work is now three-fold – LCH, Leeds GP Confederation and supporting safe and effective Speaking Up in Leeds general practice.
- There is the question of how to balance the role with national and regional meetings. There is a need to keep connected to national work but focus energy and work primarily on our staff and their voice.
- There seems a correlation between morale, sickness, staff wellbeing and the work of the Freedom to Speak Up Guardian. A significant number of staff express their appreciation and thanks for someone to listen to their concerns, support them and feedback to the organisation their concerns.
- The feedback to and work with managers has been a constructive experience and the concerns have been shared via managers into the services.
- The role links well with the other mechanisms we have for staff to share concerns. As a Trust we have a rich variety of options for our staff to share concerns and ideas.

7.1 Recommendation

7.1 The Board is recommended to:

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (40)

Meeting Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title Guardian of Safe Working Hours Quarterly Report	**For approval**	
Responsible director Executive Medical Director **Report author** Dr Turlough Mills, Guardian of Safe Working Hours	**For assurance**	x
Previously considered by Quality Committee 22 July 2019	**For information**	

Purpose of the report

To provide assurance that doctors and dentists in training within LCH NHS Trust are safely rostered and that their working hours are consistent with the Junior Doctors Contract 2016 Terms & Conditions of Service (TCS)

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

Main issues for consideration

- Work has been conducted since the last report to ensure an accurate database is held centrally of doctors and dentists on training placements within the Trust
- Work underway within the Trust to increase the centralised support available for new doctors and dentists on training rotations within LCH NHS Trust
- No issues identified in the last quarter via exception reporting or the Junior Doctors Forum (JDF).
- Work continues to facilitate improved engagement with trainees across all specialities across the Trust, in conjunction with the JNC Staffside Chair and Executive Medical Director.

Recommendations

- The Board is recommended to receive assurance that trainee doctors and dentists within LCH NHS Trust are working safely and in a manner compliant with the 2016 Junior Doctors contract TCS (2016)
- Recognise the work underway to engage trainee doctors and dentists within LCH NHS Trust and to promote the role of the GfSWH
- Receive the update from the BMA regarding the implications of the most recent changes to the Junior Doctors' Contract.

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

1.1 To provide the Board with assurance that trainee doctors and dentists within LCH NHS Trust are working safely and in a manner complaint with the 2016 Terms & Conditions of Service (TCS).

1.2 To escalate any identified issues affecting trainee doctors and dentists such as working hours, quality of training and morale.

2.0 Background

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

In June 2016, the BMA concluded negotiations on proposed improvements to the Junior Doctors' Contract, details of which are included in this paper.

3.0 Quarterly Report of Guardian of Safe Working Hours

3.1 There are 20 Junior Doctors and Dentists employed throughout the Trust (in different specialities) as detailed in the table below.

Service	No.	Grade	Status
CAMHS	3	Speciality Trainees	Employed
	4	Core Trainees	Honorary
Community Paediatrics	3	Speciality Trainees	Employed
	3	Speciality Trainees	Honorary
Sexual Health	1	Speciality Trainees	Employed
	1	Speciality Trainees	Honorary
Dental Service	5	n/a	Honorary

3.2 Overview April to June 2019

Rota Gaps		**Second on call rota (CAMHS):**		
(number of nights uncovered)		April	May	June
	Gaps	13	14	21
	Internal Cover	7	5	5
	External cover	6	9	16
	Unfilled	-	-	-
Exception reports		None received		
Fines		None		
Patient Safety Issues		None		
Junior Doctor Forum		26 April 2019		

3.3 Rota gaps

LCH produce and populate a Speciality Trainee second on call rota in CAMHS. This rota is not fully recruited to. There are 2 FTE post unfilled. One CAMHS Speciality Trainee went on sick leave in June 2019, further contributing to rota gaps.

The CAMHS Clinical Lead and Workforce Department are developing a CAMHS second on call locum bank; locums are now predominantly sourced internally. This increases the consistency of care provided and ensures familiarity with Trust policy and procedure. The locum consultant working in the South also works on the second on call rota; this recorded as 'external cover' as they are employed through an agency.

4.0 Implementing the role of GfSWH

4.1 Feedback from trainees

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

4.2 Update from the BMA

Negotiations to improve the Junior Doctors' Contract have now concluded and the proposed changes are as follows:

The deal agreed with NHS Employers and the Department of Health and Social Care brings a £90 million investment for junior doctors over the next four years. The deal includes:

- Increases to pay for weekend and night shift (shifts ending after midnight and by 4am)
- £1,000 a year extra for all less than full time trainees
- A fifth nodal point on the payscale at the level of ST6
- 'Section 2' transitional pay protection extended until 2025
- Improved GP trainee mileage and confirmed supernumerary status

- Improvements in rest and safety entitlements, with no more pay-to-stay when too tired to drive
- Contractualised NROC/LTFT (non-resident on call/less than full time) rostering guidance
- Exception reporting for all Annual Review of Competence Progression (ARCP)/portfolio requirements
- Guaranteed annual pay uplift of 2 per cent each year for the next four years.

These changes are not expected to have a significant impact on the Trust, but JNC continue to consider any likely impact or proposed changes regularly.

4.3 Fatigue and facilities charter

LCH have received a payment of £60,000 from Health Education England to improve working conditions for junior doctors. Proposals for the use of these funds are being considered at the JNC and the Junior Doctors Forum.

5.0 Developments

5.1 Engagement

An inaugural medical and dental engagement session was held in June 2019, with invites extended to the whole LCH medical and dental workforce. The GfSWH and the JNC chair introduced attendees to the GfSWH role and were encouraged to review exceptions reports (and situations that may give rise to exception reports) with their trainees.

The addition of exception reporting review in the Annual Review of Competence Progression (the formal and structured examination of evidence to ensure a trainee's satisfactory progression through each stage of training, from the foundation programme onwards) is expected to aid with this.

Further engagement sessions are planned with the Community Paediatric Team.

5.2 Administrative support

Since the last Guardian report, work has taken place to consolidate an accurate database of junior doctors in training at LCH. Work is underway to centralise the recording and administrative functions associated with induction and monitoring of trainee doctors and dentists within LCH which we hope will provide increased consistency of support functions (Smartcard access, ESR, statutory and mandatory training etc) for new starters on rotation to the Trust. Local inductions will continue with the relevant speciality.

6.0 Impact

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

7.0 Recommendations

7.1 The Board is recommended to:

- Receive assurance that trainee doctors and dentists within LCH NHS Trust are working safely and in a manner compliant with the 2016 Junior Doctors contract TCS (2016).
- Recognise the work underway to engage trainee doctors and dentists within LCH NHS Trust and to promote the role of the GfSWH.
- Receive the update from the BMA regarding the implications of the most recent changes to the Junior Doctors' Contract.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (41)

Meeting: Trust Board 2 August 2019	**Category of paper**	
Report title: Workforce Strategy 2019-2021: Progress & Delivery - Resourcing	**For approval**	
Responsible director: Director of Workforce	**For assurance**	✓
Previously considered by: Business Committee 24 July 2019	**For information**	

Purpose of the report

To provide the Board with an update on progress and delivery on the Resourcing priority within the Workforce Strategy.

Main issues for consideration

Key Resourcing headlines from the last 6 months are:

- Retention rates have consistently improved and remain better than target
- The Recruitment team has been nominated for a Nursing Times Award for Best Recruitment Experience
- Operational recruitment challenges have led to a requirement for a recovery plan, which is now in place. This has led to the overall rating for the Resourcing priority being Amber at Q1
- The e-Rostering project has successfully completed its pilot phase and entered its implementation phase

Recommendation

The Board is recommended to:

- Note the progress made on Resourcing in the last 6 months
- Note the Amber rating of the Resourcing priority, linked to operational recruitment challenges which are currently subject to a recovery plan

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, and regular updates on Resourcing would be provided to Business Committee,

This report provides the Business Committee with an update on the progress made on the delivery of the **Resourcing** priority during the period January 2019 – June 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. Resourcing

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

At the end of Quarter 1, there has been good progress in a number of areas associated with the Resourcing priority, particularly in the areas of retention and e-Rostering. However the overall Resourcing priority has been rated as Amber, "below target" at present.

This rating is linked to operational challenges within the LCH recruitment service. The recovery plan being implemented in this service should enable the rating to revert to being Green, "on target", by the end of Q2.

Progress against resourcing objectives has been delivered by a number of functions within the Workforce Directorate, including the e-Rostering team, the Workforce Information team, and the Resourcing team itself.

A full summary of the 2019-21 objectives associated with the Resourcing priority is at ***Appendix 2***.

3. Progress: Recruitment & Retention

3.1 Recruitment summary

Over the past 6 months, LCH has experienced an increased rate of recruitment, at approximately 60 vacancies per month compared with approximately 50 vacancies per month during the 2017 and 2018 calendar years. Much of this increase has been planned, including for example the bulk recruitment associated with the mobilisation of the 0-19 PHIN Service.

Whilst the majority of recruitment activity has been successful, the LCH recruitment service itself has experienced unplanned high turnover and absences during the period. This, during the period of heightened recruitment volume, has affected the service's capacity and capability, with the overall quality of the service provided to Business Units and candidates falling short of expectations in a number of instances.

A recovery plan is now in place within the recruitment service, which includes temporary resource and process improvements. Regular monitoring of progress is taking place, with weekly updates provided to the Business Units and SMT. The LCH risk register has been updated.

3.2 Innovative recruitment

Well-received recruitment initiatives continue, including the now-annual LCH Bus Tour, which is part of the annual LCH campaign to attract newly qualified nurses to the organisation. It took place in May to take second and third year students around 3 of our neighbourhood teams.

The Bus Tour and its accompanying assessment centre have been nominated during Q1 for a Nursing Times award for Best Recruitment Experience; the results will be known towards the end of September 2019.

"Just thought I would let you know that I have had an email from 2nd year nurse student. She loved the bus tour and on the basis of her experience has decided to go for a career in the community. She was really inspired. Thank-you so much for getting her a place."

(University Course Tutor, May 2019)

With funding for a dedicated digital recruitment post ceasing at the end of 2018/19, alternative means of maintaining the well-received and sought after social media recruitment campaigns have been trialled.

An initial attempt to retain a small number of hours each week of the previous digital recruitment resource, working remotely, has been unsuccessful due to technical issues in the country in which the individual is currently residing. With forthcoming campaigns for CAMHs vacancies and others in the pipeline, work is currently underway to procure campaign materials and expertise externally.

Links continue with the Leeds citywide “One Leeds Workforce” programme of work, which includes intent in due course to consistently brand and advertise health and care roles in Leeds via a single portal. In May, as part of the same programme of work, a Health and Care Careers event was held , with LCH taking part alongside citywide partner organisations (Fig 2).

To support this work approx. 30 “Health and Care Ambassadors” from health and care organisations across Leeds have been trained to promote careers across the system, particularly in schools and colleges. LCH has 2 trained ambassadors.

3.3 Retention

Organisational stability rates and turnover have continued to improve over the past 6 months, with turnover at 13.5% in Q4 of 2018/19 against a target of 14.5%, falling further to 13.2% at the end of Q1 2019/20. LCH has received praise on its progress from NHS Improvement, whose retention programme we took part in during 2018/19.

There are a range of factors which may correlate with and / or contribute to the positive turnover trajectory, including but not limited to the improvements in staff engagement and morale evidenced by the 2018 Staff Survey; and the enrichment of leadership skills supported by the Leading by Example Programme.

Specific recent retention initiatives include the expansion of the **Refer a Friend** scheme, which now applies to school nurses, nursing and HCP's; an internal transfer scheme aimed at band 5 nurses; and the introduction in the Adult Business Unit of developmental band 6 nursing posts.

4. Progress: Workforce Planning (including E-Rostering)

The e-Rostering project is on track, with significant progress made over the past 6 months. 3 services successfully went live with the new system during the pilot phase, and the first services subsequently went live during Q1. A further 6 services are scheduled to go live during Q2.

A recent e-Rostering business case has secured project resource for the implementation / rollout phase of the project, which will last until March 2021. Rollout focuses on the Adult Business Unit in 2019/20, moving on to the Children's and Specialist Business Units in 2020/21. Planning has also commenced for the transition from implementation to Business as Usual.

Work on the development of a new LCH approach to workforce planning has commenced; the Head of Workforce Systems & Intelligence is currently investigating which methodology which will provide the most value for the organisation. Our approach will recognise three planning 'lenses': Tactical Resourcing, Operational Planning and Strategic Planning.

5. Progress: New Roles

LCH was delighted to support 8 people to graduate as Nursing Associates in January 2019, offering graduates guaranteed roles in the organisation. Meanwhile, recruitment to the 4 year nurse apprenticeship is underway. These learners will have a structure support programme during this period.

6. Recommendations

The Business Committee and Board are recommended to note the progress which has been made in the area of **Resourcing,** as well as the operational recruitment service challenges and recovery plan.

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 Complete**
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: Resourcing Objectives (from the LCH Workforce Strategy 2019-21)

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

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

This priority aligns with the following organisational behaviours

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019/20 (41ii)

Meeting: Trust Board, 2 August 2019	**Category of paper** *(please tick)*	
Report title: Interim NHS People Plan: implications for LCH	**For approval**	
Responsible director Director of Workforce **Report author** Director of Workforce	**For assurance**	
Previously considered by SMT, 26 June 2019 JNC, 8 July 2019 JNCF, 10 July 2019	**For information**	√

Purpose of the report

This paper draws colleagues' attention to the key themes of the Interim NHS People Plan ("the Interim Plan"), which was published in early June 2019.

Overall, the content of the Interim Plan is aligned with LCH's current organisational strategic objectives and priorities, Workforce Strategy and cultural direction of travel.

Recommendations

Colleagues are recommended to:

- Note the content of this paper and the Interim NHS People Plan itself;
- Note that a whole-NHS engagement exercise is expected to take place "over the summer"; further details are expected
- Note that conversations about the Interim Plan have taken place within LCH at SMT, JNC and JNCF; and are additionally expected to take place at the LCH / GP Confederation CIC.
- Note that a substantive version of the Interim Plan is expected to be published before the end of the 2019 calendar year.

Interim NHS People Plan: implications for LCH

1. Introduction

1.1 The Interim NHS People Plan ("the Interim Plan") was published on 3 June 2019.

1.2 This paper provides headline information about the Interim Plan, highlighting its key themes for SMT's attention.

2. Background

2.1 The NHS Interim People Plan ("the Interim Plan") has been developed with involvement from NHS Employers and a wide range of other stakeholders to set out an initial approach to tackling a range of workforce challenges.

2.2 Workforce supply is acknowledged as the biggest challenge facing the NHS.

2.3 The substantive People Plan will be published following the Spending Review. Key financial commitments will be decided as part of the Spending Review.

2.4 The substantive People Plan will be a five year plan, underpinning the NHS Long Term Plan.

2.5 There are almost 80 in-year actions mandated by the Interim Plan; other than the two exceptions below these actions are to be undertaken by NHS national bodies. The two actions below are described as actions for "STPs/ICSs":

2.5.1 All local NHS systems and organisations to set out plans to make the NHS the best place to work as part of their *NHS Long Term Plan* implementation plans, to be updated to reflect the people offer published as part of the full People Plan

[by November 2019]

2.5.2 Agree development plans to improve STP/ICS workforce planning capability and capacity.

[*by April 2020, with NHS England, NHS Improvement and Health Education England].*

2.6 NHS organisations will be expected to undertake further action following the publication of the substantive People Plan.

2.7 A new "balanced scorecard" is being developed to inform the future development of the Care Quality Commission's Well-Led assessments.

3. Key themes

There are 5 themes in the Interim Plan, set out below:

3.1 **Make the NHS the best place to work**: We must make the NHS an employer of excellence – valuing, supporting, developing and investing in our people.

3.2 **Improve our leadership culture**: Positive, compassionate and improvement focused leadership creates the culture that delivers better care. We need to improve our leadership culture nationally and locally.

3.3 **Prioritise urgent action on nursing shortages:** There are shortages across a wide range of NHS staff groups, However, the most urgent challenge is the current shortage of nurses. We need to act now to address this.

3.4 **Develop a workforce to deliver 21st century care:** We will need to grow our overall workforce, but growth alone will not be enough. We need a transformed workforce with a more varied and richer skill mix, new types of roles and different ways of working, ready to exploit the opportunities offered by technology and scientific innovation to transform care and release more time for care.

3.5 **Develop a new operating model for workforce:** We need to continue to work collaboratively and to be clear what needs to be done locally, regionally and nationally, with more people planning activities undertaken by local integrated care systems (ICSs).

3.6 The full, 76 page version of the Interim Plan is available online at https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf

4. Interim NHS People Plan and LCH

4.1 Overall, the content of the Interim Plan is aligned with LCH's current organisational strategic objectives and priorities, Workforce Strategy and cultural direction of travel.

4.2 Resourcing, leadership & skills, engagement and a positive organisational culture are all already high priorities here. The Interim Plan endorses these priorities in its first 3 priorities.

4.3 The 4th theme of the Interim Plan, *Develop a workforce to deliver 21st century care*, references a range of roles and initiatives, including nursing associates, flexible working and apprenticeships, with which LCH is already actively engaged.

4.4 The 5th theme of the Interim Plan, *Develop a new operating model for workforce* argues that [workforce planning] functions should be undertaken at the best level to meet the needs of the services. In particular it commits to devolution of responsibility to the Integrated Care Systems (ICSs).' The substantive plan is therefore likely to have some implications for workforce planning at LCH. The West Yorkshire & Harrogate ICS is working with its member organisations to ascertain and influence the substantive national position.

4.4 LCH has directly engaged with authors of the Interim Plan, both during its formulation and afterwards.

4.5 The Interim Plan describes a process of engagement "over the summer" which LCH will wish to be involved with. It is expected that all NHS staff will be enabled to participate in the engagement exercise. Further information is expected from NHS Improvement / NHS England imminently.

4.5 To ensure Board engagement and oversight in relation to the Interim Plan and the substantive plan; it is envisaged that the Business Committee and Board will receive this paper, with opportunities for more detailed presentation and discussion as required.

5. Conclusion

5.1 The Interim NHS People Plan, published earlier this month, intends to underpin the NHS Long Term Plan, and will be superseded by a substantive People Plan before the end of 2019.

5.2 The Interim Plan above all recognises the workforce resourcing challenges facing the NHS and its five themes are broadly aligned with LCH's existing organisational strategies and priorities.

6. Recommendations

Colleagues are recommended to:

6.1 Note the content of this paper and the Interim NHS People Plan itself;

6.2 Note that a whole-NHS engagement exercise is expected to take place over the summer

6.3 Note that further conversations about the Interim Plan are proposed to take place at Business Committee (July 2019) and Board (August 2019).

6.4 Note that a substantive version of the Interim Plan is expected to be published before the end of the 2019 calendar year.

Jenny Allen & Laura Smith
Director of Workforce, OD & System Development
24 June 2019
(minor updates 9 July 2019)

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (43i)

Meeting Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title **Quality Improvement Strategy**	**For approval**	✓
Responsible director Executive Director of Operations **Report author** Quality Improvement Team	**For assurance**	
Previously considered by • Quality Committee – 22 July 2019 • SMT – 26 June 2019 • Quality Improvement Steering Group - 03 June 2019 • Senior Operations Strategy Group – 07 May 2019	**For information**	

Purpose of the report

The Quality Improvement Strategy sets out the context, ambitions, approach and actions for the QI work across the organisation.

There is a specific focus on the next 12 months as the second year of a five year approach.

Main issues for consideration

There are three QI Priorities as a focus within the Strategy for 2019/20:

1. **We can all Make Stuff Better**
   Develop and embed continuous quality improvement which engages staff and service users to undertake small or large scale change
2. **Enabling & supporting all staff to Make Stuff Better**
   Provide tools, training and resources to staff and other teams that help them improve their area of work; involving patients and service users
3. **Recognising Good Stuff happens and sharing our learning**

   Enable all staff and service users to access QI tools, QI team members and shared learning and improvement stories.

A number of specific actions, with measures, are identified under each category to achieve impact during 2019/20.

Recommendations

The Board is recommended to:

- Approve the Quality Improvement Strategy

Leeds Community Healthcare NHS Trust

The Leeds Community Healthcare Quality Improvement (QI) Strategy 2019-2020 (Year Two)

Making Stuff Better

Contents

1. Foreword

Dear colleagues and partners,

Welcome to the Leeds Community Healthcare NHS Trust Quality Improvement (QI) Strategy. This is Year two of a Five Year Progression Plan.

The QI Strategy describes our QI approach and aspiration, and feeds into both the Workforce Strategy, and the Quality Strategy

It is important to note that this is a strategy and not a detailed operational plan, and sets the direction for Quality Improvement work in Leeds Community Healthcare

Our vision is to develop an organisational culture of continuous quality improvement (QI); where improvement is everyone's business, with all staff feeling skilled, confident and empowered to make changes and improvements at work.

What we achieved in Year One:

- Set out our methodology and approach to QI.
- Established a partnership with the Improvement Academy who supported us in determining how to embed the approach.
- Developed a comprehensive training package which is integral to the LCH leadership offer.
- Facilitated board workshops in partnership with our Improvement Academy partners to secure board support
- Commenced four learning projects to test the approach
- Established action learning set for Improvement coaches to potentiate learning.

Definition of QI:

There are many different definitions of QI, we have adopted this definition by the Kings Fund, which we feel best reflects our QI aspirations:

"Quality improvement refers to the use of systematic tools and methods to continuously improve the quality of care and outcomes for patients. It requires a systematic approach based on iterative change, continuous testing and measurement, and the empowerment of frontline teams"

Quality Improvement is a broad, overarching concept which encompasses specific improvement work as well as clinical audit, outcomes and research in our overall ambition to make stuff better.

When developing the QI Strategy we believed it was important for the document to be as useful and informative to you, the reader, as possible. To this end, *we have embedded as many links and references in the document as possible which will not be accessible in paper versions.*

Debbie Flintham, Lisa Falkingham, Mark Simpson, Roger Wood and Anne McGee
The Organisational Development and Improvement (ODI) Team

2. Vision, Values & Behaviours

The LCH Vision, Values and Behaviours, **"Our Eleven"**, permeate this Strategy. Our belief is that all QI work demonstrates our one **vision** and operates in line with our three **values** and our **magnificent seven behaviours**.

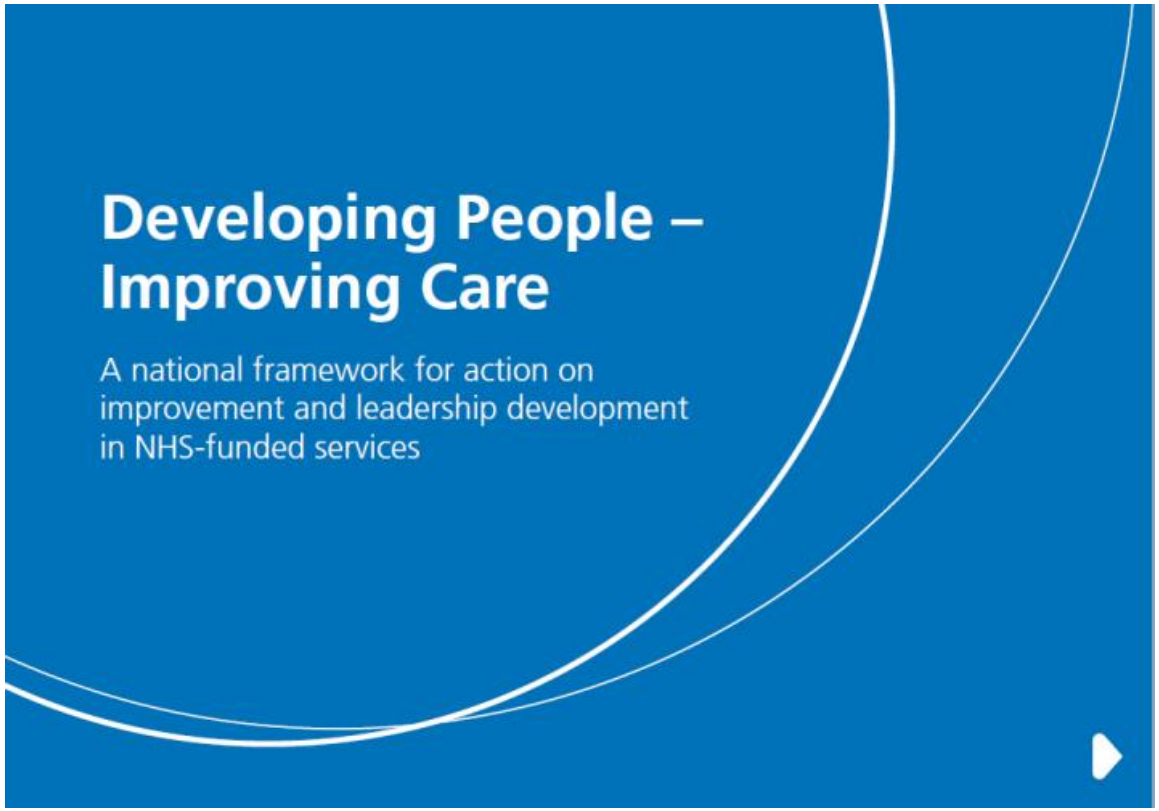
In **Section 7** we list out priorities, and indicate with of these **magnificent seven behaviours** are demonstrated by each priority's achivement with their icons.

3. Context:

The aim of this QI Strategy is to stimulate, inform and guide QI thinking in LCH, leading to the empowerment of all staff to initiate and lead QI work in their services. This will then in turn drive the development of the culture of continuous quality improvement in LCH.

In designing the Strategy we have considered in detail the context within which LCH works now, and will work in the future. We recognise the external and internal context which has influenced our priorities. We have broken this context down into internal, external and cultural factors:

3.1 National Context & QI Rationale



Developing People – Improving Care is a national framework for action on improvement and leadership development in NHS-funded services:

What is the framework's purpose?

To equip and encourage people in NHS-funded roles to deliver continuous improvement in local health and care systems and gain pride and joy from their work to develop a critical set of improvement and leadership capabilities among their staff

Why?

Evidence and experience from high performing health and care systems shows that having these capabilities enables teams to continuously improve population health, patient care, and value for money

The framework emphasises compassionate and inclusive leadership. Compassionate and inclusive leadership is embedded in high quality, high performing systems because it is the right way to behave evidence shows it is also the right way to unleash people's full potential to improve care working with patients and service users, improve population health and well-being, and improve value for money.

The framework identifies five conditions common to high quality systems that interact to produce a culture of continuous learning and improvement. **The five conditions are**:

Of particular focus is **Condition 3** - Knowledge of improvement methods and how to use them at all levels

“Chief executives of the majority of provider trusts rated ‘outstanding’ by the Care Quality Commission (CQC) have stated their commitment to quality improvement methods and continuous learning. The aim is for continuous improvement to be core to everyday work for everyone working in NHS-funded services.

Research into the factors driving high quality health systems shows that board and executive teams’ understanding of leading for improvement is crucial. Leading for improvement includes allocating adequate resources, giving teams time for improvement activities (reducing less value-adding activities where possible), role-modelling improvement principles in leaders own behaviour and celebrating successes.

Patients, service users, families and communities should always be involved as equal partners with professionals in re-designing and improving processes and systems.”

3.2 Local Context: QI in Leeds

The city of Leeds has an exciting and vibrant approach to partnership working across all agencies, with the aim of improving the health and wellbeing of everyone in the city. The key strategy underpinning this is the Leeds Health and Wellbeing Strategy 2016-2021, supported by the Leeds and Health Care Academy, and Leeds Health and Care Plan.

We are also fortunate to be supported in this work by other QI specialist agencies such as the Improvement Academy (part of the YHAHSN) and the NHS Leadership academy, which is based in Leeds. They all encourage and support QI thinking, providing resources, training and expert advice.

There is an aspiration to build a shared QI capability across the whole city of Leeds. As joint work and the ‘whole system approach’ become more prevalent, QI teams in different organisations have the opportunity to work together more to ensure the patient’s journey is the best it can be at every step. Adopting a QI approach will enable us to meet this challenging new agenda.

3.3 Internal Context: QI in LCH

We have reviewed the national and international evidence base on quality improvement and are developing an approach that will fit our organisational identity and culture. Features of our proposed quality improvement approach include:

A clear and structured methodology
for undertaking quality improvement that will become our way of doing things. This is based on the Model for Improvement (Institute for Health Improvement) and adapted from the approach successfully implemented in East London NHS Foundation Trust.

A focus on engaging frontline staff
in undertaking quality improvements. We are clear that quality improvement is everybody's business and recognise that those closest to complex quality problems are often the best placed to find solutions for them. We will continue to move from staff collecting data to them being enthusiastic about using data to inform and shape practice. We must celebrate success and ensure staff are able to take ownership and feel proud of their achievements. We will build a culture where each and every person executes their own personal responsibility in the delivery of quality services

Patient, service users and their carers
remain integral to our ongoing improvement work

Leadership development
will include approaches to quality improvement. By developing our leaders we can foster a quality improvement culture and environment where improvement and engagement can flourish. Delivery of this strategy is highly dependent on having the right organisational culture and leadership.

Working with the Improvement Academy
as our improvement partner to support the training of staff in improvement science, including data and measurement

4. Our Organisational Culture and QI

LCH aspires to developing an organisational culture of continuous quality improvement (CQI) where QI is 'the way we do things', and all staff feel empowered and supported to **'Make Stuff Better'**. This is underpinned by our organisations vision, values and behaviours, highlighted above. Our value of **'continuously listening, learning and improving'** embodies the CQI culture we strive for.

Why is this cultural change important, and what are we doing to achieve this?

In Embedding a Culture of QI, research by the Kings Fund finds:

'Adopting a quality improvement approach involves significant and sustained cultural change within organisations, which will require time and resource'.

Attention needs to be paid to the following areas:

- A recognised clear rationale and shared vision
- Leaders need to ensure that staff are engaged and actively involved
- Leaders need to commit to a shift from 'problem-solving' to being enablers of change.

Kings Fund 2017

A culture of CQI is a common, defining factor in recognised high performing NHS organisations, such as ELNHST. Their success lies in the integration of quality and safety culture, as these are interdependent, and share common traits:

- Employee involvement and engagement in QI
- Compassionate and consistent leadership
- Organisational support for learning

This integration of safety and QI is essential as it is widely acknowledged that if staff are happy and feel involved, quality of care and patient safety improves.

So for LCH culture of CQI to thrive we are committed to a broad and integrated approach, including:

- Enabling a bottom-up approach to QI
- QI training for all staff
- Integrating our QI training into our new leadership development programme
- Compassionate leadership and effective decision making training also integrated into our leadership development training
- Better aligning QI with our quality assurance systems and processes, e.g. audit, outcome measures, research and service evaluation
- Increased capacity to lead QI by upskilling improvement resource across BU business and corporate teams
- Understanding our QI capability and capacity across all services in the organisation

5. Making the Connections

Quality Improvement as a way of working is an enabler for various other priorities & strategies in LCH. Below are some examples of this:

Workforce Strategy

- Goal: to ensure LCH's workforce is able to deliver the best possible care in all our communities
- Priorities: Engagement, Resourcing, Leadership, Integration

Quality Strategy

- Goals: Prevention & Proactive Care, Shared decision making & personalised care, Patient experience and engagement, New models of care, Workforce

Business Plans

- Goal: To support the development and implementation of the Business Unit Improvement Plans

Digital Strategy

- Digital Strategy (currently under review for update, held by Systems Teams): QI to supporting the thinking and implementation

Future

- System-wide QI: fostering better relationships both internally and externally. Emphasis on linking up and sharing knowledge across the Leeds QI/CQI system.

6. QI Priorities

We want to ensure QI is relatable and achievable for all staff. Ultimately, Quality Improvement is about **Making Stuff Better**.

The QI Strategy has 3 key priorities, responding to Leeds Community Healthcare's current objectives. These are:

1) We can all Make Stuff Better

Develop and embed continuous quality improvement which engages staff and service users to undertake small or large scale change

2) Enabling and supporting all staff to Make Stuff Better

Provide tools, training and resources to staff and other teams that help them improve their area of work

3) Recognising good stuff happens and sharing our learning

Enable all staff and service users to access QI tools, QI team members and shared learning and improvement stories.

The aims, objectives, initiatives and outcomes of each of these are set out in **Section 7.**

7. Delivering our Priorities

The subsequent pages set out how each of the QI Strategy's 3 priorities will be delivered.

Key:

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

7.1 We can all Make Stuff Better

Priority's Aim:	Develop and embed continuous quality improvement which engages staff and service users	
What do we plan to achieve? (Objectives)	**How will we achieve it? (Initiatives)**	**How will we know that we've achieved it? (Outcomes)**
Further develop the culture of Continuous Quality Improvement	1) Delivery of QI training and evaluation training. Providing Effective Decision Making and Compassionate Leadership sessions (as part of LCH Leadership Development Programme) 2) Develop the QI Hub and Huddles to support staff with QI queries.	1) Quantitative data - number of attendees and feedback ratings 1) Qualitative data - examples of where staff used QI methodology to improve care/work 2) Increasing opportunities for staff to attend huddles, indicating interest 2) Quantitative data: page hits and downloads
Increase in numbers of staff attending training both In-House and with Improvement Partners (IA)	1) Identify needs and wants from partnership with Improvement Academy 2) Increase comms around what opportunities are available	1) Have new partnership with IA agreed by Financial Year 2020 2) Quantitative data - number of; attendees; feedback ratings & QI Bronze completed
Measure of the impact of QI	1) Develop measures which provide baseline data 2) Increasing number of Improvement Stories through any mechanism for sharing	1) Implementation of Culture questionnaire 1) Review team performance 6 months after close of QI project 2) Rise in numbers

This priority aligns with the following organisational behaviours:

7.2 Enabling and supporting all staff to Make Stuff Better

Priority's Aim:	***Provide tools, training and resources to staff and other teams that help them improve their area of work***	
What do we plan to achieve? (Objectives)	**How will we achieve it? (Initiatives)**	**How will we know that we've achieved it? (Outcomes)**
Develop the interface with QPD, Business teams, Research & Development team, and outcome measures project team, in pursuit of alignment of all developed in CQI	1) Contribute to review of audit process and Quality Challenge+, ensuring alignment with QI 2) Work with the Business Units to deliver their joint 'obsession' with enabling staff to influence change	1) Increased number of QI Projects based on audit findings & increased articulation of positive impact of clinical audit to board. 2) Link BU teams into ongoing and new pieces of QI work to ensure visibility of areas where staff are improving teams
Promoting QI approach within key forums	1) Commitment to attend CEG, PSGE, Always event oversight group	1) Schedule attendance and two way communication and feedback loops, leading to QI approach utilisation

This priority aligns with the following organisational behaviours

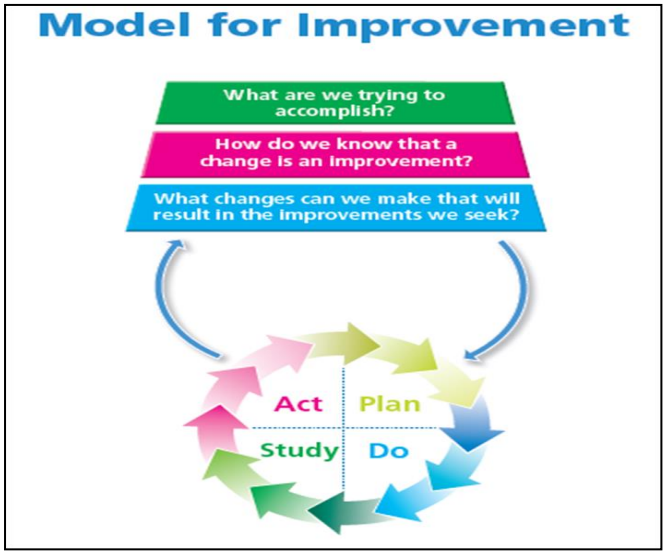
7.3 Good stuff happens and we share our learning

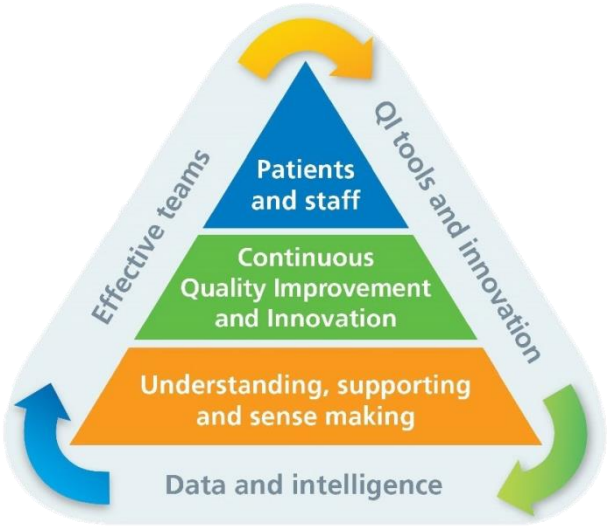
Priority's Aim:	**Enabling all staff and service users to access QI tools, QI team members and shared learning and improvement stories.**	
What do we plan to achieve? (Objectives)	**How will we achieve it? (Initiatives)**	**How will we know that we've achieved it? (Outcomes)**
Raise the profile of QI within LCH	1) Develop and begin robust Communications plan with support from Comms colleagues. 2) Create a one-stop-shop for all staff needing QI support in the Quality Improvement Hub	1) Implementation of Communications plan timed with strategy release 2) QI Hub hosts QI resources, training details, and learning stories.
Facilitate the learning from both internal and external improvement projects	1) Identify and share the learning from all QI projects 2) Increase the collation and sharing of Improvement Stories 3) Develop relationships with QI colleagues across the city and in other organisations, through site visits, conference attendance, and share learning	1) Stories shared in improvement newsletter, Elsie and other media 2) Improvement stories through all avenues increase, Improvement story template completion, Fab-U-Leeds, Award nominations and submissions 3) Collaborative working, replicating and adopting learning from other organisations

This priority aligns with the following organisational behaviours

8. How we make stuff better (Delivery)

The LCH QI Team use the Model for Improvement as their key methodology





There are several approaches to improvement methods but all share the same basic principles. As the Berwick review identified, not everyone needs to be expert in an approach, but all staff and teams should understand the principles and all organisations should have enough staff with the leadership and expert analytical skills to lead and sustain improvement work through coaching teams. All teams should have the opportunity and time to apply improvement skills in their daily work, as well as access to on-going support and shared knowledge.

Our Ambition:

To develop and implement a systematic, organisation-wide programme to ensure Quality Improvement happens at scale

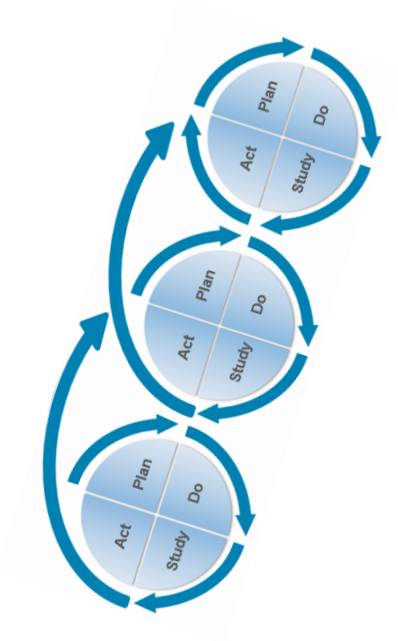
Our training packages and resources are all found on the QI Hub on ELSIE

Training Packages		QI Resources	
The LCH Leadership Development Offer	3 leadership development courses, delivered in conjunction with the Organisational Development Team	Innovation Huddles	Meet with the Quality Improvement team and improvement ambassadors within LCH to discuss ideas, new projects and how we 'Make things better'.
Bronze Quality Improvement Training	Online intro to QI, delivered in conjunction with the Improvement Academy	Evaluation Training	Do you need help evaluating your project? Join our Evaluation Workshops
Continuous Quality Improvement training	A closer look at the QI methodology we use in LCH, and how to use data to measure and improve	Learning From Incidents	Incident reporting of huge benefit from those who want to improve and avoid mistakes already made. The QPD team keep incident reports for this purpose
Trust Induction	The QI team attend Induction for all new starters to introduce them to QI principles and encourage them to use fresh eyes to make improvements	Improvement Stories	To encourage learning from past projects, the QI team keep a log of improvement journeys from across the Trust
		One Minute Guide to QI	A short introduction to QI

9. Risks to Delivery:

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

Risk 1) Lack of Capacity & buy in from frontline teams



Plan (Mitigation): Leadership of frontline teams attending QI training or Leadership Development Programme to highlight the important of CQI

Do: Already underway

Study: Collect feedback from sessions and review themes

Act: Improve content of offer based on feedback, and approach new cohort of leaders/attendees to begin the updated training

Risk 2) Capacity in the QI Team

Plan (Mitigation): Action from QI Steering Group: Work is underway to determine capacity/capability across LCH in Business Teams, QPD, R&D, BI and Clinical & Quality Leads

Do: Already underway with Emma Heeson & Lisa Falkingham

Study: Collect data and review

Act: Based on Study

Risk 3) Alignment of QI with other internal and external teams

Plan (Mitigation): Continuous working towards the alignment. Raising this with services we are working with and meeting with our stakeholder teams

Do: Already underway

Study: Collect feedback & data, reflect on improvements made and what has not worked

Act: Celebrate and share improvements and focus team working on areas marked for improvement

10. Conclusion

All evidence around Quality Improvement shows that at Trusts which embed QI at every level, empower staff to make changes, and share learning, good stuff happens. The QI Strategy's aims and priorities are vital for LCH to **Make Stuff Better** and achieve the same successes.

West Sussex Hospitals NHS Trust:
Best Organisation at Patient Safety
Awards 2017
Outstanding - CQC

East London NHS Foundation Trust:
Outstanding - CQC
HSJ Provider of the Year – 2016

When there is organisational commitment to improvement culture and QI….

Salford Royal NHS Foundation Trust
Outstanding – CQC
Best Place to Work –
NHS Staff Survey 2014

Northumbria Healthcare NHS Trust:
Best Place to Work – Nursing Times
Outstanding – CQC; 2015

If you do what you've always done, you'll get what you've always gotten

References and Associated Documents:

Quality Strategy

Workforce Strategy

LCH Vision & Values

Developing People – Improving Care

Leeds Health and Wellbeing Strategy

The Leeds Community Healthcare Innovation Line

Acknowledgements

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Maria Ashraf and Hannah Davison for their tireless efforts in keeping the service running.

All staff who contributed to the development of this strategy through review and feedback.

All readers of this document, we hope you found it useful and welcome your thoughts and questions.

Glossary

Cultures of continuous improvement: in health organisations, these exist where people 'have a rational understanding of how small improvements compound to make big differences; they love improving –both because they are passionate about the importance of their work and because it feels so good to move to a new level of performance; and they have enough confidence in their colleagues to believe the organization is capable of making progress.' (from George C. Halvorson, Chairman and CEO of Kaiser Permanente, the largest U.S. non-profit health plan and hospital system, at https://hbr.org/2013/07/the-culture-to-cultivate)

Measurement for improvement: shows whether work to improve a process or system is achieving its intended results. Measurement for improvement comprises measures that demonstrate current (baseline)performance in terms of quality and cost, performance goals for the process or system and the impact of improvement work on progress towards those goals. In health care, measurements are often used for reporting aggregate quality and cost results to oversight and regulatory bodies that "judge" the data against specific standards or rules. Measurements for judgement generally differ from measurements for improvement, although both types of measurement are important.

Improvement: designing and redesigning work processes and systems that deliver healthcare with better outcomes and lower cost, wherever this can be achieved. Established improvement methods can be used to improve single processes and systems within organisations and also multiple processes and systems that may cross organisational boundaries, as in transformational change programmes and service reconfigurations across local health systems.

Organisational culture: the 'way we do things around here', influenced in particular by how leaders do six things: communicate the organisation's vision; translate the vision into practical objectives; manage people; make sure the organisation is just and fair; work in teams; and express core human values. (From the work of Professor Michael West, Head of Thought Leadership at the King's Fund see https://www.kingsfund.org.uk/blog/2016/01/if-it%E2%80%99s-aboutculture-it%E2%80%99s-about-leadership).

Review

Review of Year Two is due by the end of March 2020

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (44i)

Meeting Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title Workforce Disability Equality Standard	**For approval**	√
Responsible director Director of Workforce **Report author** Assistant Director of Workforce, Equality and Diversity Manager	**For assurance**	
Previously considered by SMT Trust Board Development Workshop 5 July 2019 Business Committee 24 July 2019	**For information**	

Purpose of this report

- To brief the Trust Board on the Workforce Disability Equality Standard (WDES) and associated WDES Metrics outlined within Appendix A.
- To seek approval of the WDES Action Plan, Appendix B.

The Trust Board is recommended to:

- Approve the Trust WDES action plan

Workforce Disability Equality Standard

1.0 Purpose of this report

1.1 To brief the Trust Board on the Workforce Disability Equality Standard (WDES) and associated WDES Metrics outlined within Appendix A.

1.2 To seek approval of the WDES Action Plan, Appendix B.

2.0 Background

2.1 The Trust recognises the importance of treating each member of staff as an individual, with particular regard to advancing equality regardless of their protected characteristic's, which is reflected within the Workforce Strategy as a key priority.

2.2 The results from the NHS annual staff survey show that Disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities.

2.3 The WDES is mandated by the NHS Standard Contract and is a data-based standard that uses a series of ten evidence-based measures (Metrics), detailed in Appendix A. These will enable NHS organisations to compare the reported outcomes and experiences of Disabled and non-disabled staff. Three of the metrics focus on workforce data; five are based on questions from the national NHS Staff Survey, one around disability representation on Boards and one on the voices of Disabled staff.

2.4 The WDES was considered by the SMT on the 26th June 2019, Trust Board Development workshop on the 2nd July 2019 and the Business Committee on the 24th July 2019.

3.0 Overview

3.1.1 Disability equality is rooted in the fundamental values, pledges and responsibilities of the NHS Constitution. The NHS Constitution reiterates the rights of people using NHS services to healthcare that is free from discrimination; it also includes the rights of staff to a workplace that is free of discrimination, and the commitment of the NHS to putting this into practice. High quality care requires high quality workplaces, with commissioners and providers aiming to be 'employers of choice'.

3.1.2 The WDES is a crucial NHS initiative that seeks to improve, as part of a wider cultural change, the experience of Disabled staff working in the NHS and contribute to improving the number of Disabled people employed in the NHS.

3.1.3 The historically poorer employment rates for Disabled people were one of the drivers that led to the introduction of the Disability Discrimination Act (DDA) 1995. The DDA was replaced by the Equality Act 2010, which sought to harmonise and simplify previous equalities legislation; disability is one of the Equality Act's nine (9) protected characteristics. Section 149 of the Equality Act sets out the Public Sector Equality Duty (PSED), offers protection in relation to employment, as well as access to goods and services. The PSED strengthens the duty on employers to eliminate discrimination and advance equality of opportunity for Disabled employees. Implementing the WDES will assist NHS organisations to ensure that they are complying with the provisions of the Equality Act 2010, and the aims of the PSED. The WDES will encourage the development of a more diverse, empowered and valued workforce and a better understanding across the NHS workforce of disability equality.

3.1.4 Research by Michael West (2015) links improved staff experiences with better patient care, the higher the levels of satisfaction and commitment that staff report, the higher the levels of satisfaction that patients report. The creation of positive, supportive environments for staff will in turn create caring, supportive environments and deliver high-quality care for patients.

3.2 **Governance**

3.2.1 The WDES Action Plan is monitored through the Business Committee as part the quarterly workforce report.

3.2.2 Progress of the WDES will be included in the annual E&D report to the Trust Board presented at the December Trust Board meeting.

4.0 Next steps

4.1 The Trust WDES Metrics and action plan will be published on the external website on the 9th August 2019 and shared with the lead commissioner at Leeds NHS.

5.0 Recommendations

5.1 The Trust Board is recommended to:

- Approve the Trust WDES action plan

Appendix A - Workforce Disability Equality Standard (WDES) Metrics

WDES Metrics	Criteria	LCH Position (based on reporting period 1/4/18 – 31/3/19)
Metric 1	***Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce****. Organisations should undertake this calculation separately for non-clinical and for clinical staff.* *Cluster 1: AfC Band 1, 2, 3 and 4* *Cluster 2: AfC Band 5, 6 and 7* *Cluster 3: AfC Band 8a and 8b* *Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members)* *Cluster 5: Medical and Dental staff, Consultants* *Cluster 6: Medical and Dental staff, Non-consultant career grade* *Cluster 7: Medical and Dental staff, Medical and dental trainee grades*	*D 4% v ND 81.9% U 14.1%* *D 4.3% v ND 85.8% U 9.9%* *D 3.6% v ND 91% U 5.4%* *D 8.3% v ND 83.3% U 8.3%* *D 0% v ND 81.3% U 18.8%* *D 5% v ND 60% U 35%* *D 0% v ND 80% U 2*
Metric 2	*Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.* *Note:* *i) This refers to both external and internal posts.* *ii) If your organisation implements a guaranteed interview scheme, the data may not be comparable with organisations that do not operate such a scheme. This information will be collected on the WDES online reporting form to ensure comparability between organisations.*	*D 142 shortlisted* *19 hired* *ND 2552 shortlisted* *469 hired*

Metric 3	*Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note:* *i. This Metric will be based on data from a two-year rolling average of the current year and the previous year.* *ii. This Metric is voluntary in year one.*	*D 2 v ND 9*
Metric 4 *Staff Survey Q13*	*a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:* *i. Patients/service users, their relatives or other members of the public* *ii. Managers* *iii. Other colleagues* *b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.*	*D 34.2% v ND 22.3%* *D 11% v ND 6.7%* *D 21.1% v ND 10.6%* *D 56% v ND 56%*
Metric 5 *Staff Survey Q14*	*Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.*	*D 81.1% v ND 88.1%*
Metric 6 *Staff Survey Q11*	*Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.*	*D 23.7% v ND 14.4%*
Metric 7 *Staff Survey Q5*	*Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.*	*D 43.7% v ND 54.7%*

The following NHS Staff Survey Metric only includes the responses of Disabled staff		
Metric 8 *Staff Survey Q28b*	*Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.*	*D 82.5%*
NHS Staff Survey and the engagement of Disabled staff **For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall trust's score** **For part b) Add evidence to the Trust's WDES Annual Report**		
Metric 9	*a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.* *b) Has your trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)* *Note: For your Trust's response to b)* *If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report.*	*D 7.0 v ND 7.3* *Overall Trust Score 7.2* *Yes* *The Trust has an established Health and Wellbeing Engagement Group, reporting to the Health and Wellbeing Steering Group, which meets every two months and consists of staff, managers and trade union representatives, who have a passion to make a difference. Whilst our recent Staff Survey results have shown an overall improvement around health and wellbeing, there is more we can do.* *The Equality, Diversity & Inclusion Officer explored the appetite for establishing a Disability staff network group, where a group of staff are interested in exploring further at a meeting 5/8/19.*

Metric 10	*Percentage difference between the organisation's Board voting membership and its organisation's overall workforce disaggregated:* • *By Voting membership of the Board* • *By Executive membership of the Board* • *Headcount Board = 12* • *Headcount Staff = 2978* • *Disabled Staff = 138*	*Disabled Staff on Board 8.3%* *Disabled Staff in Overall Organisation 4.63%* *Difference 3.7%*

D = Disabled
N = non-disabled
U = unknown/undeclared

Appendix B – Proposed WDES Action Plan

	Initiative/action	Lead	Desired outcome (s)	Delivery Date
1	Conduct analysis of the Trust WDES indicators data	E & D Facilitator and EDI (Disability) Officer	Understand the WDES data in order to identify actions to be included in the WDES action plan to create a level playing field where the treatment of staff is not unfairly affected by their disability	End of Q1 19/20
2	Deliver monthly Reasonable Adjustment Awareness Sessions for Managers	EDI (Disability Officer)	Ensuring Managers have sufficient disability equality awareness training.	To commence end of Q1 19/20
3	Design and implement a WDES Comms Plan	EDI (Disability) Officer	Increase awareness of the WDES and its purpose Highlight key messages of the WDES Engage with colleagues Promote good practice and processes Increase awareness of the role of the EDI (Disability) officer	End of Q2 19/20
4	Plan and deliver a disability focused event	E &D Facilitator	The target audience is aware of the good work that has already happened in the areas of Disability Raise supervisor/managers awareness of the inequality of experience by disabled staff compared to non-disabled staff A commitment by the target audience to improve the disabled staff experience and subsequently the Trusts WDES performance	End of Q3 19/20
5	Engage with staff to test the appetite for a Disability Network	Asst. Director of Workforce	Meet the requirements of the WDES	End of Q3 19/20
6	Identify key stakeholders	E & D Facilitator	To share best practice and provide mutual support.	End of Q3 19/20

	Initiative/action	Lead	Desired outcome (s)	Delivery Date
7	Implement a Disability Talent Management strategy	ODI Lead and Asst. Director of Workforce	An increase in disabled staff employed in Senior and Board level roles Disabled staff feel valued	End of Q4 19/20
8	Implement the Disability Confident Leaders action plan	E&D Facilitator	The Trust achieves and retains the Disability Confident Leaders accreditation	End of Q4 19/20
9	Design and implement a Reverse mentoring programme for Board members and disabled staff.	EDI (Disability) Officer	Educate leaders about diversity issues, by exposing them to challenging dialogue, which they might otherwise never encounter. Facilitate disabled staff access to Board Members to provide an understanding of their role and responsibilities in the Trust	End of Q1 20/21

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (45)

Meeting Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title Executive Medical Director's Annual Revalidation Report	**For approval**	✓
Responsible director Executive Medical Director **Report author** Executive Medical Director	**For assurance**	
Previously considered by: Quality Committee (22 July 2019)	**For information**	

Purpose of the report

An annual Executive Medical Director's report is a requirement for Revalidation of doctors (and dentists in the future) to provide assurance of the appraisal process to the Trust Board.

Main issues for consideration

This Executive Medical Director's report covers the period of 01/04/18 to 31/03/19 and includes information and activity relating to medical and dental staffing appraisal and medical revalidation.

NHS England has provided guidance: 'Framework of Quality Assurance for Responsible Officers and Revalidation, June 2015' with a Board template to be completed and a Statement of Compliance from the Board. This report follows the guidance and the 2018/19 template format.

Recommendations
The Board is recommended to:

- Note the contents of the 2018/19 Annual Executive Medical Director's Report
- Note the addition of Section 24 'Planned Actions for 2019/20' which was not considered by Quality Committee
- Approve the Statement of Compliance

Executive Medical Director's Annual Revalidation Report

1. Executive summary

An annual Medical Director's report is a requirement for Revalidation of doctors (and dentists in the future) to provide assurance of the appraisal process to the Trust Board. This report covers the period of 01/04/18 - 31/03/19 and includes the Annual Organisational Audit (AOA) submitted to NHS England on 08/05/2019 (**separate attachment**). Designated Bodies are required to submit a 'Statement of Compliance' to be signed by the Chief Executive or Chairman of the Board (**Appendix C)**.

The numbers of doctors with whom the designated body has a prescribed connection at 31 March 2019 who had a completed appraisal between 01/04/2018 and 31/03/2019 was **36/38** (**95%**). This was due to 2 deferments (one ill health, one adoption leave).

The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2018 – 2019 was **37/39** (**95%**). This was lower than the 2017/18 figure of **96%**, again due to the two deferments and changes in personnel.

The number of Police Custody self-employed doctors who confirmed that they had been appraised by 31/03/18 was **13/13 (100%)**.

The total number of doctors who were revalidated in this time period was **9**.

2. Purpose of the report

Medical appraisal has been a requirement for consultants since 2001, for General Practitioners (GPs) since 2002 and for salaried dentists since 2008. The purpose of this report is to provide assurance to Quality Committee (QC) and LCH Board that LCH as a designated body has effective systems in place which comply with the requirements of the Responsible Officer regulations

3. Responsible Officer Regulations

The Medical Profession (Responsible Officers) regulations 2010 and the Medical Profession (Responsible Officers) (Amendment) regulations 2013 require each body designated under the regulation to appoint a Responsible Officer who must monitor and evaluate the fitness to practise of doctors.

4. Medical and Dental Appraisal and Revalidation

Medical appraisal is the appraisal of a doctor by a trained appraiser, informed by supporting information defined by the GMC, in which the doctor demonstrates that they are practising in accordance with the GMC *Good Medical Practice Framework for appraisal and revalidation* across the whole of their scope of practice.
Dental appraisal has been a requirement for salaried dentists since 2008. There is currently no revalidation process for salaried dentists; however, salaried dentists employed by LCH are required to have an annual appraisal that meets the required standards set by the BDA and NHS Employers, 2008.

Every Doctor or Dentist in LCH is responsible for collection, preparation and presentation of their annual appraisal and should ensure that they record the full scope and nature of their work (including private practice and work outside of LCH). The portfolio must show evidence of appropriate personal reflection by the doctor/dentist.

Appraisers are responsible to the RO for the quality of appraisals, and submission of the completed summaries of the appraisal discussion, PDPs and appraisal outputs to the RO. As part of the Quality Assurance process the RO office undertake an annual sample of appraisal output forms to check standards against the NHS England matrix.

Revalidation is the process by which licensed doctors demonstrate to the GMC that they are up to date and fit to practise. The cornerstone of the revalidation process is that doctors will participate in annual medical appraisal. On the basis of this and other information available to the Responsible Officer from local clinical governance systems, the Responsible Officer will make a recommendation to the GMC, normally every five years, about the doctor's revalidation. The GMC will consider the Responsible Officer's recommendation and decide whether to renew the doctor's licence to practise.

LCH hold regular Revalidation Recommendation Panels. This will normally be the RO, Deputy Medical Director for Professional Standards and the Responsible Officer Manager, input from an Appraiser may be requested if there are concerns. The panel meet as needed to ensure recommendations are submitted on or before the Revalidation submission due date.

The Revalidation Recommendation Panel will review the outcome of all appraisals within the five year revalidation cycle and consider the alongside other relevant information regarding the individual doctor when making a revalidation recommendation to the GMC, which includes 360 patient and colleague feedback, and any complaints or concerns that are held on file by LCH's HR or Complaints Teams. The final decision on the recommendation remains with the RO as they hold the statutory duty.

5. Revalidation Recommendations 01/04/18 – 31/03/19

The RO made **9** positive recommendations to the GMC **(Appendix B** Audit of revalidation recommendations). One doctor was deferred into the 2019/20 cycle due to being on parental leave.

6. Background of Revalidation

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

7. Appraisal and Revalidation Performance Data

7.1. General

Under The Medical Profession (Responsible Officers) Regulations 2010 [Guidance, 4.5], the Responsible Officer (RO) is required to keep an accurate record of all doctors with whom the Designated Body has a prescribed connection. The prescribed connection for the LCH RO does not include:

- General Practitioners who are on the performers list in Leeds
- Trainees who have a prescribed connection to the Deanery.
- Forensic Medical Examiners (FME's) who are not directly employed by LCH.
- Secondary care locums employed by locum agencies with their own RO.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (License to Practice and Revalidation) Regulations Order of Council 2012'

Academics with honorary clinical contracts will usually have their RO in the NHS Trust where they perform their main clinical work. LCH has **1** practitioner in this category.

7.2 Numbers of Doctors and Dentists

As of the 31st March 2019, LCH as a Designated Body had a prescribed connection (and reported on for the purposes of the AOA) for **38** doctors:

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

Not reported on the AOA:

- **9** salaried Dentists,
- **1** Consultant Dentist,

Non Designated Body doctors employed by included:

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

Self-employed non designated body doctors included:

- **13** Forensic Medical Examiners in Police Custody Suites.

Staffing has not been static throughout the year with retirements, resignations and some recruitment to vacancies.

7.3 Appraisal activity

The Annual Organisational Audit (AOA) was submitted to NHS England on 08/05/2019. This self-assessment covered the final end of year period to 31/03/19 and the report is attached separately.

The numbers of doctors with a prescribed connection to LCH who had a completed appraisal between 01/04/2018 and 31/03/2019 was **36/38** (**95%**).

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

The audit highlighted:

- Almost all doctors completed appraisals between 01/04/2018 and 31/03/2019; the exception report shows a return of 2 doctors.
- All Service Level Agreement (SLA) and contracted sessional doctors are all compliant within their own designated body with the exception of the Self-Employed FME doctors within the Police Custody Suites who were compliant in **13/13 (100%)**.

- The number of dentists to include the consultant dentist who completed an annual appraisal between 01/04/2018 and 31/03/2019 was **9/10** (**90%**). One appraisal was deferred into 2019/20 due to Maternity Leave.
- The total number of completed appraisals for doctors and dentists in LCH (to exclude Police Custody Suite self-employed doctors) during 2018 – 2019 was **37/39** (**95%**).

7.4 Doctors in Remediation and Disciplinary Processes

LCH does not have any doctors in a remediation process but had one doctor who had undertakings imposed by the GMC.

8. Appraisers

8.1 Appraiser Numbers

LCH had **9** appraisers for designated body doctors between 31/03/2018 and 01/04/2019. The ratio of medical appraisers to doctors being appraised remains between 1:5 -1:20 in keeping with national guidance (1.5-1.20).

8.2 Appraiser training

All LCH designated body appraisers received an enhanced appraisal training update on 12th April 2018. On 27th February 2019 LCH arranged for a full day of 'Appraiser Training' in conjunction with Leeds Teaching Hospitals NHS Trust, one doctor and two dentists attended, becoming new appraisers and carrying out appraisals within the cycle.

The RO and RO manager have attended the relevant appraiser/RO network meetings.

8.3 Dentists

The Trust had three Dental Appraisers. The Consultant Dentist had their appraisal undertaken by the former Associate Medical Director (AMD). the AMD assisted in completing any additional dental appraisals. Two new appraisers were trained by LTHT to undertake appraisals for the 19/20 cycle.

9. Governance Arrangements

The RO is supported by a Deputy Medical Director for Professional Standards, an RO Manager and a part time RO Administrator. The Trust has implemented the PReP system for medical appraisal for doctors with a prescribed connection and has

a robust system for assurance of annual appraisal for non-designated body doctors and salaried dentists.

The RO Manager and Administrator upload the completed appraisal data to ESR on a monthly basis to maintain an accurate list of medical and dental employees, locums and trainees. Each Medical Lead has a responsibility of notifying the RO team for new medical and dental staff starters and leavers.

The RO and RO Manager regularly check GMC connect and the appraisal database for an accurate list of designated body doctors and those who are under notice for revalidation or on hold pending GMC investigations. The RO has the responsibility for making timely revalidation recommendations to the GMC. The RO Manager downloads portfolio information for any doctors due to revalidate, which includes appraisal input, output, 360 patient and colleague feedback, CPD and complaints and concerns, this information is reviewed by the RO and used to make a decision on positive recommendations or deferrals where necessary.

The RO provides quarterly returns with regard to appraisal activity to NHS England. In July 2015 NHS England reviewed its processes in the north region and decided that for certain designated bodies assurance could be provided on a quarterly basis by email that satisfactory achievement of appraisal rates was being achieved and the organisation was on track to achieve their trajectory, provided that they had met certain criteria to include:

1. The DB has achieved > 90% appraisal uptake in the previous year as stated in the 2018/19 AOA
2. The DB has confirmed in question 2.2 that all missed or incomplete appraisals were managed by the programme
3. The DB engages with the RO and appraisal networks
4. No concerns have been evidenced from an independent verification visit or any other source.

LCH met the criteria and were exempt from quarterly returns and provided assurance as statement in an email return.

The RO also provides assurance to the TDA through the Integrated Planning Checklist – Supporting a Well Led Organisation on Quality.

10. Policy and Guidance

The Appraisal Policy and Guidance, the Job Plan Policy and the Remediation, Reskilling and Rehabilitation Policy for Consultants, SAS Doctors and Dentists in LCH were rewritten and ratified by SMT in September 2016 and issued on 30th November 2016, they are currently being revised into one policy document with supplementary guidance.

11. Quality Assurance

11.1 PReP system

LCH re-procured the PReP IT system to assist with revalidation, appraisal and job planning for three years. The system went live in August 2013 and was re-procured in 2016 and 2019. It has been used for all doctors with a prescribed connection to LCH for the appraisal years 2013/14, 2014/15, 2015/16, 2016/17, 2017/18 and 2018/19.

There is currently work underway; looking at recommendations to move away from a paper based appraisal system; and instead implement a more streamlined annual appraisal process for community dentists by introducing the PReP system for all dentists working for the trust.

The PReP system contains an RO dashboard and enables storage of appraisal portfolios, output forms, PDPs, a multi-system feedback tool, an appraiser evaluation form and a job planning facility. The system provides automatic prompts and restricted access for the RO admin team, appraisees, appraisers and the RO.
All designated body doctors were provided with group and individual training for the PReP system. In addition the RO team provided individual administration support to doctors on request.

11.2 Quality Assurance Process

All appraisers participated in a quality assurance exercise in 2018 which included a sample of output forms which were critiqued and 360 feedback from doctors for each individual appraiser.

As part of the NHS England Independent Verification process introduced during 2014/15 there is an expectation that the RO office will undertake a sample of appraisal output forms to check standards against evidence and identify any appraiser training needs. In 2018 the RO Office (Dr Florence McDonagh (Associate Medical Director for Job Planning and Appraisals) and Leanne Wilson RO Manager) undertook a Quality assurance exercise using an NHS England approved monitoring tool, The EXCELLENCE QA tool (Improving and Quality Assuring appraisal output documentation) for the 2017/18 cycle.

Samples of appraisals were randomly selected, and in total 18 appraiser output forms were reviewed. Where there were low scored output forms, the Associate Medical Director then examined the appraisal input form and the appraise feedback forms to triangulate the information. Scores and comments were fed individually to appraisers, and aggregated information was provided in a quality assurance feedback session.

There were no complaints or appeals and appraisers all received positive feedback.
Work is currently underway to undertake the same exercise for the 2018/19 cycle.

11.3 RO Quality Assurance

The RO reviewed portfolios of all doctors with revalidation due dates within the 18/19 cycle. Those doctors who have been positively recommended have met the national standards for inputs and outputs.

12. Access, security and confidentiality

The PReP system allows restricted access for appraisees and appraisers. The RO admin team can access appraisee's portfolios to input data, to collect data and enable anonymous sampling exercises for quality assurance. The RO has full access if required to the portfolios, PDPs and output forms. The Associate Medical Director for Job Planning and Appraisals has full access to enable completion of the Quality assurance exercise. Appraisees can directly view an evidence trail of access by their appraiser and RO. Appraisees can request the evidence trail for admin access.

13. Clinical Governance

LCH is able to populate designated body doctor's appraisal portfolios with audits, incidents and complaints. Incidents and complaints information is dependent on the corporate services recognising when a doctor or dentist is involved and providing the relevant information to the RO team prior to an appraisal date. Where services are on SystmOne data activity can also be provided. The clinical governance process continues to be refined.

14. Recruitment and engagement background checks

All designated body doctors who joined the Trust had the appropriate pre-engagement checks undertaken and appraisal information was obtained from their previous designated body via the RO.

15. Monitoring of practice

Monitoring of practice is currently devolved to the services; work is underway with the Medical and Dental Leads to establish what of this can be standardised and what can be held centrally. LCH conducts a documentation audit as part of the standard annual audit schedule and this is expected to be fed back to each clinician and incorporated into personal feedback and development, as well as annual appraisal.

16. Handling of concerns

LCH has five policies relating to concerns and remediation for doctors and dentists to include:

- Appraisal Policy and Guidance for Consultants, SAS Doctors, and Dentists in Leeds Community Healthcare NHS Trust (November 2016)
- Job Planning Policy for Consultants, SAS Doctors, Salaried GPs and Salaried Dentists, Leeds Community Healthcare NHS Trust (November 2016)
- Remediation, Reskilling and Rehabilitation Policy for Doctors and Dentists in LCH (November 2016)
- Maintaining High Professional Standards in the Modern NHS (May 2016),
- Disciplinary Policy (November 2016)

Section 5.1.4 describes the doctors in Remediation and Disciplinary Processes within the time period of this report.

Any incidents or complaints involving a registered clinician are flagged to the Medical or Dental lead for the service, who will monitor or be involved in the investigation and management as required.

Any member of staff who is the subject of an incident or complaint will be given full details of the complaint by their Line Manager. They will have access to any records they may have made personally in connection with the incident referred to in the complaint. If a complaint alleges negligence or malpractice on the part of an individual member of staff, the investigating manager will obtain advice from Human Resources.

If a complaint is referred to the professional body of a registered clinician, the relevant professional lead is responsible for conducting and documenting the investigation. Where necessary, the Complaints Manager will support this process. The Executive Medical Director has regular meetings with the GMC Employment Liaison Advisor, and through this process discusses any ongoing cases that are, or might become, subject to GMC investigation and processes.

All feedback identifying Doctors or Dentists will be reported into their appraisal and (when applicable) will be considered in the revalidation process.

17. Maintaining High Professional Standards in the Modern NHS *(*MHPS)

The management of performance is a continuous process as set out above, however serious concerns around the performance of medical or dental colleagues are managed under the Trust's *Maintaining High Professional Standards in the Modern NHS* policy.

All serious concerns must be registered with the Chief Executive and he or she must ensure that a case manager is appointed. The Chairman of the Board must

designate a non-executive member "the designated member" to oversee the case and ensure that momentum is maintained.

The Executive Medical Director will act as the case manager in cases involving clinical directors and consultants and may delegate this role to a senior manager to oversee the case on his or her behalf in other cases. The Executive Medial Director or Chief Executive will also approach the NCAS (National Clinical Assessment Service) for advice and guidance on the management of the case.

Having discussed the case with the NCAS, the case manager must decide whether an informal approach can be taken to address the problem, or whether a formal investigation will be needed. Where an informal route is chosen the NCAS can still be involved until the problem is resolved.

Where it is decided that a more formal route needs to be followed the Executive Medical Director (or nominated person) must, after discussion between the Chief Executive and Director of Workforce, appoint an appropriately experienced or trained person as case investigator to conduct the investigation.

18. NCAS Alert Letters

Alert Letters are issued to notify NHS organisations and others about health professionals whose performance or conduct could place patients or staff at serious risk. Employees regulated by both the General Medical Council and the General Dental Council may be subject to alert letters.

Alert Letters are received by the Recruitment Team from NCAS. These details are then entered onto a local alert letter database against which any potential new employees or workers will be checked before an offer of employment is made. If an applicant is identified as being on the alert letter database the Recruitment Team will halt the recruitment process, inform the relevant parties and take action as appropriate.

Work is underway with workforce teams to ensure that alerts can be checked against the current database of bank and employed staff when the notifications are received, in addition to checking new applicants against the list of current alerts.

19. Identity and Language Checks

As part of the selection process for medical and dental colleagues, candidates are asked to present to an interview panel, where English language abilities are tested.

Following the recruitment process pre-employment checks are carried out. These must satisfy the requirements of the NHS Employers pre-employment check standards, and the following checks are made:

- Verification of identity checks
- Right to work checks
- Professional registration and qualification checks
- Employment history and reference checks
- Criminal record checks
- Occupational health checks

All pre-employment checks must meet these requirements before the Recruitment Team will officially write to the candidate to offer them the position. The Trust will withdraw any offer of employment to anyone who fails to meet these requirements.

All Medical appointments also require additional pre-employment checks in line with the Medical Profession (Responsible Officers) Regulations 2010. All candidates for Medical appointments will be required to provide, at interview, details relating to their revalidation. On appointment, the Trust will contact their previous Responsible Officer, requesting confirmation of this information in line with current regulations.

20. Risk and Issues

The system has no financial resource to add newly appointed designated body doctors to the system and is reliant on the movement of doctors leaving the Trust to maintain the 45 licences purchased.

Failure of an appropriate clinical governance, appraisal and revalidation process would be viewed as a significant quality issue by the TDA, CQC and the GMC.
Currently all dental appraisals are completed in a paper format, but work is ongoing to implement the PReP system to bring Dentists in line with Trust Doctors.

21. Corrective Actions, Improvement Plan and Next Steps

- Completion of all breached appraisals.
- To report progress on doctors with concerns, through the Cause for Concern bimonthly private Board report.

22. Medical and Dental Job Plans

Every medical and dental practitioner working in LCH is required to have a fully completed and signed off annual job plan. **37/38 97%** of medical job plans were completed. The incomplete job plan was due to parental leave.
The dentists have 100% completed annual job plans for 18/19, the service have completed a group job plan for 19/20.

23. Annual Medical and Dental Conference

Leeds Community Healthcare Trust's annual 'Medical and Dental Conference' was held on the 6th November 2018 at Weetwood Hall Hotel in Leeds.

The conference was attended by 57 delegates (excluding speakers, stall holders and the RO Team as organisers). The breakdown is shown overleaf.

Service	Total
CAMHS	6
CASH	3
CHILD HEALTH	18
ICT	2
MSK	2
FME Employed	2
Dental	8
Head Office	4
Clinical and General Managers	3
Trainees	6
Directors	3
Total	**57**

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

The morning session was chaired by Thea Stein, Chief Executive of Leeds Community Healthcare NHS Trust, who also presented on system leadership and provided an update on how the healthcare landscape is changing across the city.
The Second session began with an introduction from Dr Ruth Burnett, Executive Medical Director, who updated delegates on the new structure for the Medical Directorate, including the appointment of the two new Deputy Medical Directors.

This was followed by a talk from Dr Robert Arnold, Deputy Medical Director entitled 'From Deviancy to Empowerment' which covered learned optimism calculated risk. Dr Arnold asked delegates to stand up and asked a series of questions based around increasing levels of risk, delegates were invited to sit when the questions reached a level of risk that they hadn't personally experienced. The session highlighted the deviation in people's aversions to risk.

Following the morning coffee break there was a session led by Dr Manoj Sivan, 'Associate Clinical Professor and Consultant in Musculoskeletal Rehabilitation Medicine', who discussed working a split clinical and academic post. Dr Sivan explained how his career path had progressed through multiple degrees and high

profile research projects; and the benefits of working with the Trust's Research team to carry out research.

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

The afternoon began with a break-out session for medics and dentists, the dentists were led in a team building session with Lucy Williams Consultant Paediatric Dentist; whilst the remaining delegates listened to Ian Wilson from the General Medical Council (GMC) talk about the effects of the Dr Bawa Garba case on doctors relationships with the GMC. Mr Wilson also included information on the case and the legal system with a view to dispelling the myths built up by media coverage. The session concluded with information on the new 'Reflective Practitioner' Guidance released by GMC in September 2018.

This was followed by an interactive session led by Dr Ruth Burnett on 'Reflective Practice' using case studies provided by the GMC; delegates were asked to reflect within table groups on any concerns they had identified, any education activities that might be relevant and any evidence of learning implemented into practice. The session concluded with the tables feeding back their thoughts to the wider group.

The final session of the day was led by Laura Smith 'Director of Workforce'. Delegates were provided with information on the proposed approach in terms of the refreshed Workforce Strategy, this was followed by a PowerPoint presentation from members of the 'Organisation Development and Improvement Team', which outlined the redesigned 'Leadership and Management Development' offer and concluded with a round table discussion on delegates key development needs as leaders.

For the first time this year evaluation forms were circulated electronically via a 'Survey Monkey' link in an email accompanying delegates attendance certificates to try to capture feedback from all attendees, unfortunately the return rate was just 6 out of 57 delegates (10.53%)

24. Planned actions for 2019/20

The revised AOA template for 18/19 requires the Responsible Officer to agree an action plan for areas where further development is identified for 19/20.
The following action points have been identified:

1. Completion of review currently underway regarding monitoring of professional practice within services
2. Medical professional assurance audit planned for 19/20 audit cycle (requested by Audit Committee)
3. Annual appraisal assurance audit
4. Ensure process established that enables new NCAS Alerts to be checked against all established employed and bank staff in addition to new recruits

5. Audit Committee have requested an audit of ‘medical professional assurance’ in the 19/20 cycle which we welcome in order to provide assurance regarding current processes, and identify any areas where we could improve.

25. Recommendations

The Committee is recommended to:

- Note the contents of the 2018/19 Medical Director’s Report
- Note the addition of Section 24 ‘Planned Actions for 19/20’ which was not considered by Quality Committee
- Approve Statement of Compliance

Appendix A

Audit report to identify reasons for missed or incomplete appraisals 2018/19 Leeds Community Healthcare NHS Trust

Doctor factors (total)	**38**
Completed appraisals 2018/19 = 36 (95%)	
Maternity leave during the majority of the 'appraisal due window'	1
Sickness absence during the majority of the 'appraisal due window'	1
Prolonged leave during the majority of the 'appraisal due window'	0
Suspension during the majority of the 'appraisal due window'	0
New starter within 3 month of appraisal due date	0
New starter more than 3 months from appraisal due date	0
Postponed due to incomplete portfolio/insufficient supporting information	0
Appraisal outputs not signed off by doctor within 28 days	0
Lack of time of doctor	0
Lack of engagement of doctor	0
Other doctor factors	0
Appraiser factors	**0**
Unplanned absence of appraiser	0
Appraisal outputs not signed off by appraiser within 28 days	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
(describe)	
Organisational factors	**0**
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Recommendations:
Two appraisals were postponed to the next cycle, one due to maternity leave, the other due to long term ill health.

Appendix B

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2018 to 31 March 2019	
Recommendations completed on time (within the GMC recommendation window)	9
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	9
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other	
TOTAL [sum of (late) + (missed)]	0

Appendix C
Designated Body Statement of Compliance

The board of Leeds Community Healthcare NHS Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

Comment: LCH is fully compliant

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

Comments: accurate records of all licenced medical practitioners with a prescribed connection to LCH is maintained

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

Comments: There are sufficient numbers of trained appraisers in LCH

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

Comments: All appraisers have an annual on-going training session and received appraiser feedback

5. All licensed medical practitioners[2] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

Comments: All missed or incomplete appraisals are noted and reported to the RO

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

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

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

are aware of and are compliant with obtaining patient and colleague feedback

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

Comments: The RO is notified of any areas of concern

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

Comments: LCH is compliant

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[3] have qualifications and experience appropriate to the work performed; and

Comments: LCH is complaint

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

Comments: A development plan is in place

Signed on behalf of the designated body

Name: Dr Ruth Burnett Signed: _ _ _ _ _ _ _

[chief executive or chairman a board member (or executive if no board exists)]

Date:

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2018-19 (46)

Meeting Trust Board 2 August 2019	**Category of paper**	
Report title Nursing and Allied Health Professional (AHP) revalidation and registration	**For approval**	
Responsible director Executive Director of Nursing **Report author** Assistant Director of AHPs, Patient Experience and Engagement	**For assurance**	√
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

This report provides an update on nursing and AHP revalidation and registration. The paper describes the current context for regulation for both nurses and AHPs and an overview the current situation within the organisation.

MAIN ISSUES FOR CONSIDERATION

Nurses and AHPs are required to register with the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) respectively in order to be able to practice their professions. The registration status of each employee employed in a nursing or AHP role is recorded on ESR and responsibilities and processes for registration described in the Professional Registration policy.

As of June 2019 there are currently 1043 nurses employed by the trust and 508 AHPs. One nurse who should hold registration does not do so. The Directors of Nursing and AHP's and Workforce are aware of this and are actively engaged with the NMC in supporting this person. All AHPs who should be registered are.

Last year the government consulted on regulatory reform. The results of the consultation are due to be published soon. It is likely that this will include legislation that will enable the regulators to deal with fitness to practice cases more quickly. It is not thought that the changes will impact on the requirements of employers.

RECOMMENDATION

The Board is recommended to:

- Note the positive position of nursing and AHP registration.

Nursing and AHP revalidation and re-registration

1.0 Introduction

1.1 Nurses are regulated by the NMC. They are required to pay an annual subscription and revalidate every 3 years. The process of revalidation is clearly set out and includes confirmation from the individuals line manager that they have met all parts of the revalidation requirements. Staff will receive an email from the NMC and from the Electronic Staff Register (ESR) 3 months prior to their revalidation date.

1.2 AHPs are regulated by the HCPC. HCPC protect the titles that AHPs work to meaning that it is an offence to practice under any of the titles unless you are on the register. Registrants are required to pay an annual fee and re-register every 2 years. They are required to maintain a portfolio of continuing professional development (CPD) which they may be asked to submit at the time of re registering. Staff will receive a notification from ESR 4 months prior to re-registration and a letter from HCPC 2 months prior.

1.3 From January 2019 the NMC have regulated the role of Nursing Associate. The regulation of Nursing Associates is similar to nursing staff in relation to code of conduct and revalidation. What is different to how nurses are regulated is that Nursing Associate has been designated as a protected title in the same way that AHP titles are. It is illegal to practice under this title without being on the register. The revalidation process will be the same as for Nurses.

1.4 The government have recently consulted on changes to health care regulation. The aim is to bring together the nine health and care regulators and make regulation more efficient and effective. The response to this consultation is expected imminently. It is not thought that this will significantly change things for registrants in the near future.

1.5 The LCH Professional Registration policy details the responsibilities and processes currently in place to ensure staff have relevant registration on commencing employment and thereafter. This policy is due for revision in September 2019.

2.0 Current situation

2.1 There are currently 1043 staff identified on ESR in the category “nursing and midwifery registered” of which 1028 are shown to have current NMC registration. Of the 15 without current registration, a check of the NMC online register has confirmed that 12 are registered. Of the 3 remaining, one unregistered member of staff is known to the Directors of Nursing and AHPs and Workforce and we are actively working with the NMC to support re registration. One is an IAPT practitioner and therefore does not require registration for their post. The third member of staff is on the NMC register however her name is spelt differently to the staff record.

2.2 There are 15 members of staff in nursing and midwifery designated roles that are registered with HCPC. This designates an AHP working in a job role that is categorised as a nursing role, for example a physiotherapist undertaking the role of community matron or a paramedic undertaking the role of a custody nurse. It is likely that we will see more roles in the future where ESR categories and regulatory bodies do not align given the development of new roles, extension of scope of practice and cross boundary working. We will need to ensure that our internal processes are able to identify all clinical posts that require statutory registration regardless of the regulating body.

2.3 There are currently 508 staff identified in the ESR category as "Allied Health Professionals" 504 of which have current HCPC registration. The remaining 4 staff members have NMC registration.

2.4 The nursing associate role is not designated on ESR. Staff in these posts are included in the nursing and midwifery ESR staff group. We have currently supported 10 nursing associate apprentices 7 of which have completed their qualification and joined the NMC register.

2.5 The government is due to publish its response to its consultation on the reform of regulation imminently. Whilst the intention is to make regulation more responsive; easier for the public to understand; and efficient, it is not thought that the changes will have any direct implications for employers of registrants. When the response and intended actions are published they will be reviewed by the Director of Nursing and AHP team and the Board appraised of any material impact.

3.0 Main Issues

3.1 The current processes within the trust are effective in logging the registration details of both NMC and HCPC regulated staff. There is a clear process for notifying staff when their registration is due to expire and to ensure that it is updated.

3.2 There is a lack of consistency within the ESR system between job role and regulating body. This has arisen as job roles and the requirements of staff have developed. It is envisaged that this complication will continue as new ways of working is further embedded.

3.3 The professional registration policy is due for renewal in September 2019. This review will need to give consideration to how we identify posts that require professional registration; how we can effectively oversee who is on each register and identify issues regarding registration early enough to ensure staff do not fail to re -register.

4.0 Recommendation

4.1 The Board is recommended to:

- Note the position on nurse and AHP revalidation and re-registration

Leeds Community Healthcare NHS Trust

Agenda Item 2019-20 (47i)

Meeting: Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title: Ratification of Health and Safety Policy	**For approval**	✓
Responsible director: Executive Director of Finance and Resources **Report author: Health and Safety Adviser, Risk Manager**	**For assurance**	
Previously considered by: Corporate and Clinical Policies Group 13 May 2019 (reviewed and agreed) SMT 22 May 2019 (reviewed and approved)	**For information**	

Purpose of the report:
The Health and Safety Policy requires Trust Board ratification. A number of revisions have been made, which are summarised below.

Main issues for consideration:

Section	Detail of each change made
Executive Summary	Amended Executive Summary
Health and Safety Policy Statement	Remove old Health and Safety policy statement add new Health and Safety policy statement
Section 3.8	Added new section - Health and Safety Working Group
Section 3.10	Added bullet point - Dress appropriately and wear suitable footwear for their working environment and where necessary, use safety equipment and personal protective equipment as provided by LCH.
Section 4	Added new section – Health and Safety Arrangements

The draft revised policy has been widely consulted on: a health and safety working group was convened to review and revise the existing policy document on 3 March 2019, the revised draft was scrutinised and further (minor) revision were made at the Corporate and Clinical Policies Group on 13 May 2019. SMT reviewed and approved the policy on 22 May 2019.

Recommendations
The Board is recommended to**:**

- Ratify the revised Health and Safety Policy

Leeds Community Healthcare NHS Trust

Health and Safety Policy	
Author (s)	John Glynn Health and Safety Officer
Corporate Lead	**Leeds Community Healthcare NHS Trust** Executive Director of Finance and Resources
Document Version	4
Document Status	Final
Date approved by Clinical and Corporate Policies Group (CCP)	13 May 2019 (approved by SMT 22 May 2019)
Date ratified by Trust Board	TBC (2 August 2019)
Date issued	
Review date	May 2022
Policy Number	PL282

Executive Summary

Leeds Community Healthcare NHS Trust (LCH) is committed to maintaining a working environment where the health and safety of our staff, patients, visitors, contractors and general public is assured. LCH will not only comply with the relevant legislation, it will continue to take positive action to prevent ill health, injury and loss and promote good health and safety practice.

This policy applies to all temporary, agency, bank, trainee staff, volunteers, contactors, and anyone else who may be affected by our work activities or use our services.

This policy has been produced in accordance with requirements of Health and Safety at Work etc Act 1974 (HASWA). It supports the Care Quality Commission key line of enquiries.

It contains a health and safety policy statement which sets out LCH's commitment and objectives for managing health and safety effectively.

The policy details roles and responsibilities and provides guidance to directors, managers, employees and, where appropriate, independent contractors on the arrangements for managing health and safety throughout the Trust.

This policy is supported by a suite of more detailed policies (see Appendix 1) which must be read in conjunction with this policy.

Changes made to this version:

Section	Detail of each change made
Executive Summary	Change Executive Summary
Health and Safety Policy Statement	Remove old Health and Safety policy statement add new Health and Safety policy statement
Section 3.8	Added new section - Health and Safety Working Group
Section 3.10	Added bullet point - Dress appropriately and wear suitable footwear for their working environment and where necessary, use safety equipment and personal protective equipment as provided by LCH.
Section 4	Added new section – Health and Safety Arrangements

Equality Analysis

Leeds Community Healthcare NHS Trust's vision is to provide the best possible care to every community. In support of the vision, with due regard to the Equality Act 2010 General Duty aims, Equality Analysis has been undertaken on this policy and any outcomes have been considered in the development of this policy.

Contents

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Health and Safety Policy Statement

At Leeds Community Healthcare, we are committed to ensuring the health, safety and welfare of all our employees, and anyone else who may be affected by our work activities. We know that high standards of health and safety are good for our employees, good for our organisation and good for the communities we serve.

We will comply with the requirements of health and safety legislation, find solutions and deliver improvements in order to promote the continual improvement of our health and safety management system and reduce occurrences of occupational injury or ill health.

This policy statement applies to our employees, the contractors who work for us and anyone else who may be affected by our work activities or use our services. To support our health and safety objectives we will:

Leadership

- Provide visible leadership, lead by example and promote health and safety as a priority.
- Work together to develop and maintain a positive health and safety culture based on fairness, trust and cooperation, where all safety incidents are reported and investigated in order to share lessons learnt and prevent reoccurrence.
- Ensure that arrangements are in place to engage with our employees and others in accordance with the principles of partnership working.

Employees

- Provide suitable and sufficient information, advice, statutory and mandatory training, and supervision to ensure that our employees are fully aware of their responsibilities and competent to undertake their work activities.
- Empower all our employees to embrace safe working behaviours, looking after themselves and others.
- Encourage employees to report all accidents, incidents and near misses.

Performance

- Strive to achieve our targets for improvement, develop appropriate action plans and utilise robust measures to monitor performance.
- Establish channels of communication and consultation which encourage and permit our employees, and as appropriate, their representatives, to contribute to improvements in our health and safety performance.
- Undertake audits and inspections to identify areas of weakness and ensure corrective actions are taken.

Responsibilities

- Provide our employees safe working environments, the right equipment, all necessary safety devices, and standard operational procedures, in order for them to be able to work safely.
- Ensure that the level of risk from all significant hazards is assessed, eliminated, reduced or controlled as far as reasonably practicable.
- Provide adequate resources to successfully manage health and safety at work.

The Trust Board has ultimate responsibility for ensuring that risks arising from our work activities are understood and mitigated as so far as reasonably practicable. We will make the best decisions to ensure that Health and Safety is integrated into our strategic plans and working practices.

Signed: _____ Date: 16/4/2019

Thea Stein, Chief Executive

1 Introduction

This policy has been produced in accordance with the requirements of the Health and Safety at Work etc Act 1974 (HASWA) and the five domains of the key lines of enquiry as set out by the Care Quality Commission (CQC).

The Health and Safety at Work etc Act 1974 and Management of Health and Safety at Work Regulations 1999, as amended 2006, requires that employers protect all people at work including contractors and others not at work, including service users and the general public. Employers are required to assess risks and take positive measures to promote health and safety at work.

The Trust's Health and Safety Policy Statement signed by the Chief Executive establishes the organisation's approach to health and safety and provides a formal corporate statement of its approach to health and safety and safety management.

To ensure effective delivery of Health and Safety Policy the roles and responsibilities of all employees are clearly identified and employees must accept personal responsibility for health and safety. Although the main responsibility for compliance with The Health and Safety at Work etc Act 1974 rests with the employer, every employee has a responsibility to ensure that no one is harmed as a result of their acts or omissions during the course of their work.

This policy is underpinned by a suite of policies which sets out the organisational arrangements and provides guidance to enable the Trust and staff to comply with their responsibilities and legal duties under health and safety legislation.

2 Aims and Objectives

The purpose of this policy is to provide a framework around which a safe and healthy working environment can be maintained by promoting good working practise with regard to health, safety and welfare for staff and patients.

The aims of the policy are to:

- Ensure, as far as is reasonably practicable, the health, safety and welfare of all employees at work and of all those visiting LCH premises or using services provided by the organisation.
- Comply with all current health and safety legislation.
- Provide safe and healthy conditions of work, plant and systems.
- Raise the level of staff knowledge and competencies on health and safety through the provision of education and training programmes.
- Assess and manage hazards in all working and patient environments to ensure that all risks are identified and minimise as far as is reasonably practicable.
- Promote behaviour and practices which minimise the risk of harm to all staff, service users, visitors, contractors and the general public through the activities of the Trust.

3 Responsibilities

All staff employed by Leeds Community Healthcare NHS Trust must work in concordance with the Leeds Safeguarding Multi-agency Policies and Procedures and local guidelines in relation to any safeguarding concerns they have for service users and members of the public with whom they are in contact.

3.1 Trust Board

The Board carries ultimate responsibility for health and safety of employees, patients and other individuals whilst on the organisation's premises, and in other areas where they might be affected by LCH activities. Authority is delegated to the Chief Executive.

3.2 Chief Executive

The Chief Executive has the overall statutory responsibility for managing health and safety within the Trust. The Chief Executive will ensure, as far as it is practicable, that there are adequate resources to meet, health and safety requirements.

3.3 Executive Director of Finance and Resources

The Executive Director of Finance and Resources has responsibility for the co-ordination of health and safety actives across the Trust and chairing the Health and Safety Group.

3.4 Executive Directors

All Executive Directors are responsible for ensuring that the requirements of the Trust's Health and Safety Policy and associated policies and procedures are effectively implemented and standards maintained in their areas of responsibility.

3.5 Health and Safety Group

The Health and Safety Group exists to promote co-operation and consultation across the whole organisation in the instigation of measures to ensure the health, safety and welfare at work of its employees, patients, visitors and other person who may be affected by its activities.

The Health and Safety Group reports to Business Committee and is also responsible for ensuring that the Trust is compliant with its statutory health and safety legislation and any other relevant requirements.

3.6 Health and Safety Working Group

The Health and Safety Working Group ensures the development and implementation of the health and safety management system (section 4.1). It reports to the Health and Safety Group.

3.7 Health and Safety Officer

The Health and Safety Officer is responsible for reviewing and monitoring the effectiveness of this policy, advising and assisting managers in meeting their responsibilities, and monitoring measures to ensure identified risks are eliminated or controlled adequately at all times. The Health and Safety Officer:

- Chairs the Health and Safety Working Group.
- Carries out independent risk assessments and provides support and guidance to staff within their own working environment and patient homes.
- Promotes compliance with relevant health and safety legislation.
- Carries out site health and safety inspections.

- Liaises with other risk management functions within the Trust.
- Provides expertise and knowledge pertinent to health and safety, informs and delivers health and safety training.
- Acts as a specialist reviewer of all reported health and safety related incidents.
- Provides assurances of health and safety compliance to the Health and Safety Group.
- Liaises with health and safety union representatives.

3.8 Managers

Managers are responsible for ensuring that:

- All work is conducted in a safe environment, so far as is reasonably practicable, by implementing this Health and Safety Policy.
- Arrangements for local induction and health and safety training of staff are in place and complied with and the contents of this policy are explained at local induction.
- All new employees, agency staff and volunteers are given initial fire, security and health and safety instruction within the first day of employment.
- Health and safety hazards to employees or other persons are assessed within their work area identifying and implementing measures to reduce the level of risk.
- Risks are escalated in accordance with the Risk Management Policy and Procedure.
- All workplaces and associated areas, machinery, equipment and work activities are regularly and systematically examined and reviewed in order to identify hazards.
- Risk assessments are undertaken and safe systems / working practices are in place.
- Health and safety standards are monitored within their area, including the investigation of all accidents and dangerous occurrences, and ensuring that the agreed reporting procedures and learning are complied with.
- Any contractors who are working within a particular area where services are being delivered are compliant with health and safety requirements.
- A positive culture of safety awareness and incident reporting is supported and encouraged.
- RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reportable incidents, due to or in connection with work activities, where incapacitation is 7 days or greater are reported in a timely manner (see Incidents and Serious Incident Management Policy).
- Appropriate referrals are made to Occupational Health where a workers health status affects their ability to carry out specified work and when work duties or environment factors can affect a workers health status.
- Health and safety assessment action plans are implemented.
- Risks to all young persons under 18 years' of age are assessed before they commence employment with LCH and relative actions taken to ensure their health, safety and wellbeing.

3.10 All staff (including temporary, agency, bank, trainee staff, volunteers and visiting staff)

At work, all employees must take reasonable care to ensure the health and safety of themselves and others who will be affected by their acts or omissions. They must also co-operate with management to ensure compliance with statutory requirements.

Employees are required to:

- Report all incidents, accidents, dangerous occurrences and near misses due to or in connection with work using LCH incident reporting systems (Datix®).
- Abide by this policy and comply with lawful instructions given to them to ensure their safety and the safety of others.
- Read and comply with safety notices and alerts.
- Carry out tasks in the way they have been trained.
- Comply with risk assessment in the workplace.
- Bring to the attention of their line manager any defective equipment or potential health or safety hazard, or any practice likely to cause an accident, incident or ill health.
- Keep work equipment in good condition, document all incidents (including near misses), using LCH incident reporting systems (Datix®) and report defects to supervisor or manager.
- Ensure all equipment and devices are used according to manufacturer's guidance and for purposes intended.
- Dress appropriately and wear suitable footwear for their working environment and where necessary, use safety equipment and personal protective equipment as provided by LCH.
- Complete identified statutory or mandatory health and safety training.
- Observe the fire prevention, evacuation and fire drill procedures and be familiar with the position of departmental firefighting equipment, fire exits and fire assembly points.
- Ensure that any items / equipment provided in the interests of health and safety are not interfered with or misused.
- Discuss their health status with line manager, where this affects their ability to carry out specified work.
- Ensure that faults within the buildings, including electrical and mechanical services within, are reported to the relevant estates maintenance contractor's helpdesk as soon as they become apparent.

3.11 LCH Estates

LCH estates are required to:

- Ensure the maintenance of LCH buildings.
- Liaise with Estates from other organisations whose buildings LCH staff use, to ensure any issues with maintenance are followed up and resolved.
- Ensure the maintenance of safety equipment (fire alarms, portable firefighting equipment).
- Ensure the effective control in Legionella.
- Ensure the effective control of asbestos including the provision of an asbestos register to be readily available where asbestos is present.

3.12 Building Managers

Building Managers will ensure that:

- Appropriate action is taken to remedy any issues that have been reported or identified via inspections, including but not exclusively, those related to health and safety, infection control and fire.
- They instigate building user groups to address relevant health and safety, infection control and fire hazards.

3.13 Contractors

Other employers or individuals providing goods or service to LCH are required to employ only competent persons and to comply with all relevant legislation, regulations, codes of practice and other appropriate guidance in relation to health and security matters. They will also be required to co-operate with LCH in the implementation of this policy.

3.14 Occupational Health

Occupational Health is primarily concerned with the prevention, or minimisation, of the impact of ill health in the workplace. This is a two-way relationship of how a worker's health status affects their ability to carry out specified work and how work duties or environment can affect a worker's health. The relationship involves physical, psychological, environmental and sociological aspects.

The Occupational Health service will offer:

- Employment health assessments in order to identify and provide advice on safe and fair employment of those with existing medical problems taking account of Equality Act 2010.
- Advice and support for control of infectious diseases and vaccinations and advice where appropriate, to protect employees and patients health.
- Assessment of those for whom there is concern with regard to health in relation to work. This service is provided by referral request for in service assessment or workplace visit at the request of Health and Safety Officer and line manager.
- Reactive advice and management following potential exposure to blood-borne virus (sharps/splash).
- Advice, when requested, on all aspects of Occupational Health.
- Internet links to a range of guidance and advice relating to health in the workplace.
- Information and guidance to managers prior to them notifying the Health and Safety Executive of any specified reportable diseases which have been professionally diagnosed by a medical practitioner.
- Advice to managers on the completion of RIDDOR documentation for reportable diseases and of other actions which need to be taken.

3.15 Safety Representatives

As in Section 2 (4) of the Health and Safety at Work etc Act 1974, Safety Representatives will be elected by accredited Trade Unions to represent the workforce. LCH will assist in the release, training and support to health and safety representatives.

The Trust recognises its duty to consult with such representatives with a view to initiating and maintaining arrangements which will enable the Trust and employees to co-operate fully and effectively in the promotion of health and safety.

Health and safety union representatives will:

- Encourage and promote a safe and working environment.
- Work collaboratively with employers unions and stakeholders to recognise and influence the management of risk in the workplace.
- Signpost members, staff and organisations to relevant high quality resources relating to Health and Safety.
- Support and/or represent individual member's health and safety needs.
- Be a spokesperson for union membership and advising other rep colleagues on Health and Safety Issues.
- Access and analyse information relating to Health Safety and Wellbeing/Welfare.
- Support and assist in the development of a positive workplace culture.

4 Health and Safety Arrangements

It is a legal requirement that LCH details its health and safety arrangements for delivering the Health and Safety Policy Statement. These are set out in sections 4.1-4.7.

4.1 Health and Safety Management System

LCH will implement a health and safety management system to ensure:

- Compliance with health and safety legislation
- Continual improvement of health and safety performance

4.2 Hazard Identification and Risk Management

Workplace health and safety hazards will be identified.

Risks associated with health and safety hazards will be risk assessed. Action will be taken to prevent, reduce or control risks to an acceptable level and reduce the potential for incidents, accidents and occurrences of ill health.

All relevant staff, temporary, agency, bank, trainee staff, volunteers and contactors will be informed as appropriate of the hazards, associated risks and the relevant control measures.

.Refer to:

- Control of Substances Hazardous to Health (CoSHH) Policy
- Display Screen Equipment Policy
- Driving at Work Policy
- Fire Policy
- Infection, Prevention and Control Overarching Policy
- Lone Workers Policy
- Management of Medical Devices Policy
- Management of Stress in the Workplace Policy
- Management of Slips, Trips and Falls for Staff and Members of the Public
- Management of Estates Policy
- Risk Management Policy and Procedure

- Safer Moving and Handling Policy including Bariatric and Therapeutic Guidance
- Security Policy
- Smoke free Policy
- Violence and Aggression Policy

4.3 Health and Safety Training

Workplace health and safety hazards and risks will be identified. All relevant staff, temporary, agency, bank, trainee staff and volunteers will be adequately instructed and trained on relevant health and safety requirements, and safe working practices must be followed.

Refer to the Statutory and Mandatory Training Policy including Training Needs Analysis.

4.4 Behaviour and Culture

Senior Management will demonstrate leadership in health and safety. Systems will be in place and people will be empowered to raise health and safety concerns.

4.5 Incident Investigation

Accidents, incidents and near misses will be reported and investigated to drive improvement to our health and safety management system. Any lessons learned from such events will be used to take corrective action to prevent reoccurrence.

Refer to the LCH Incident and Serious Incident Management Policy

4.6 Measuring Performance

The Health and Safety Group will actively review and report on LCH health and safety performance and relevant improvement plans will be developed as required.

4.7 Work related health

Action will be taken to prevent, reduce or control occupational health risks to an acceptable level and reduce the potential for ill health. Health surveillance will be conducted to satisfy health and safety legislation.

5 Legislation

Legislation relevant to this policy includes the following:

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Safety Representatives and Safety Committee Regulations 1977
- Equality Act 2010

6 Risk Assessment

The Management of Health and Safety at Work Regulations requires employers to make a suitable and sufficient assessment of:

- The health and safety risks to which their employees are exposed whilst at work.
- The health and safety of persons not in their employment arising out of, or in connection, with the conduct of their undertaking.

The purpose of risk assessment is to plan, introduce and monitor measures to ensure identified risks are eliminated or controlled adequately at all times. This is a continuous process and assessments will be required as changes occur for example the

introduction of new equipment, revised working methods and / or changes in working environment.

For further information about completing a risk assessment, refer to the Risk Management Policy and Procedure.

7 Monitoring Compliance and Effectiveness

Explain how you will monitor compliance with, and effectiveness of, the policy, this may include auditing. Give clarity on who is leading with what and how actions will be implemented.

Complete the table below which needs inserting into your policy

Minimum requirement to be monitored / audited	Process for monitoring / audit	Lead for the monitoring/audit process	Frequency of monitoring / auditing	Lead for reviewing results	Lead for developing / reviewing action plan	Lead for monitoring action plan
Incidents / Accidents	Datix® health and safety specialist reviewer	Health and Safety Officer	Ongoing review and quarterly reports	Health and Safety Officer	Health and Safety Working Group	Business Committee
Staff mandatory /statutory training	Electronic staff record	Workforce	Quarterly	Health and Safety Officer	Health and Safety Group	Business Committee
Health and Safety premises inspections	Annual visual inspection of premises	Health and Safety Officer	Annual programme quarterly reports	Health and Safety Officer	Health and Safety Group	Business Committee
Health and Safety Group compliance with terms of reference	Annual self-assessment	Chair of Health and Safety Group	Annual	Chair of the Health and Safety Group	Chair of the Health and Safety Group	Business Committee
Health and Safety Management System Review	Annual self-assessment	Health and Safety Officer	Annual	Chair of the Health and Safety Group	Chair of the Health and Safety Group	Business Committee

8 Approval and Ratification process

The policy has been approved by the appropriate body and ratified by SMT on behalf of the Board.

9 Dissemination and Implementation

Dissemination of this policy will be via the Clinical and Corporate Policy Group to services and made available to staff via the intranet.
Implementation will require:

- Operational Directors/ Heads of Service/General Managers to ensure staff have access to this policy and understand their responsibilities for health and safety.
- The Health and Safety Officer can provide appropriate support and advice to managers and staff.

10 Review arrangements

This policy will be reviewed in three years following ratification by the author or sooner if there is a local or national requirement.

11 References

- Equality Act 2010
  https://www.legislation.gov.uk/ukpga/2010/15/contents
- The Health and Safety at Work etc Act 1974
  http://www.hse.gov.uk/legislation/hswa.htm
- The Management of Health and Safety at Work Regulations 1999
  http://www.legislation.gov.uk/uksi/1999/3242/contents/made
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013
  http://www.legislation.gov.uk/uksi/2013/1471/contents/made
- The Safety Representatives and Safety Committees Regulations 1977
  http://www.legislation.gov.uk/uksi/1977/500/contents/made
- Care Quality Commission (CQC) Key Lines of Enquiry (KLOE)
  https://www.cqc.org.uk/what-we-do/how-we-do-our-job/five-key-questions-we-ask?

External Regulators

- Health and Safety Executive
  https://www.hse.gov.uk/
- Care Quality Commission
  https://www.cqc.org.uk/

12 Related Policies

Control of Substances Hazardous to Health (CoSHH) Policy
Dress and Appearance Policy
Display Screen Equipment Policy
Driving at Work Policy
Fire Policy
Incident and Serious Incident Management Policy
Infection Prevention and Control Overarching Policy
Lone Workers Policy

Management of Medical Devices Policy
Management of Stress in the Workplace Policy
Management of Slips, Trips and Falls for Staff and Members of the Public.
Management of Estates Policies
Prevention of Patients Slips, Trips and Falls Policy
Risk Management Policy and Procedure
Safer Moving and Handling Policy including Bariatric and Therapeutic Guidance
Security Policy
Smokefree Policy
Violence and Aggression Policy

Policy Consultation Responses

Complete this template when receiving comments at various draft stages of the Policy.

Responder (including job titles and organisation)	Version, Comment and Date	Response from Author
Ann Hobson, Asst. Director of Workforce	Policy Statement looks good – just wondered whether you need to include statutory training under the People section as well as mandatory?	Accepted
Catherine Duff, Interim Quality Lead for Children's Business Unit	Do we need the Health and Safety Statement isn't it already covered in the body of the policy? Or does it the legislation say we need Health and Safety Statement. Section 4.2 Risks associated with health and safety hazards will be risk assessed – This confusing are risks and hazards different?	Health and Safety legislation requires a Health and Safety Statement Yes Small grammatical changes accepted
Philip Boynes, Quality Lead for Specialist Services	Policy Statement – Not sure about use of word people. May be more appropriate to refer to them as staff not employees Section 3.9 Why have young people been singled out? 4.2 This is the same as Appendix 1 not need twice	It to remind managers to complete the young people's risk assessment, they are aware of the other risks assessments that need carrying out e.g. lone working but not aware of the young people's risk assessment. Not accepted. Small grammatical changes accepted

Debbie Hammill Sarah Still Staff Side Health and Safety reps	Section 3.15 We wander if it might be worth adding a brief statement about the role of H&S reps	Accepted.

Policy Consultation Process

Title of Document	Health and Safety Policy
Author (s)	John Glynn, Health and Safety Officer
New / Revised Document	Revised
Lists of persons involved in developing the policy	Cara McQuire , Risk Manager
List of persons involved in the consultation process	Thea Stein- Chief Executive Bryan Machin –Executive Director of Finance and Resources Steph Executive Director of Nursing Andrea North – General Manager, Specialist Business unit Megan Rowlands – General Manager, Adult Business unit Caroline McNamara – Clinical Lead Adult Services Helen Rowlands – Clinical Lead Children's and Families Julie Mountain – Clinical Head of Service, Adults Health and Safety Group: • Peter Ainsworth – Operational Support Manager • Dominic Mullan – LSMS Security Manager • Paul Howarth Fire Safety Advisor • Stuart Verry – Estates Manager • Debbie Hammill – RCN H&S rep • Joanne Reynard – Infection Prevention and Control • Debbie Lowe –Operational Lead • Kellie Mcloughlin – Operational Manager

	• Sarah Still – Staff Side H&S rep • Liz Grogan - Infection Prevention and Control • Sara Clarke Service Manager • Ann Hobson – Ass Director of Workforce • Cara McQuire – Risk Manager Philip Boynes – Quality Lead, Specialist Services Health and Justice Catherine Duff, Interim Quality Lead for Children's Business Unit Jacquie Walker – Operational / Clinic Manager Gill Lockwood – Service Manager Gill Whitehead – Clinical Service Manager for Long Term Conditions Liz Ward, Service Manager LSH Lisa Mincke – Children's Service Manager Lisa Mclnerney - Clinical Team Manager CNRU, St Mary's Hospital Susan Carr – Teamleader Inclusion Nursing Service. Helen Swales – Library Service Manager Maria Jose' Simoes – Assistant Librarian Kezia Prince – Incident and Assurance Manager George Peareth – Staff Side rep

Appendix: 2 – Authors Guide for writing/Review and Approval of Procedural Documents

	Title of new/reviewed Document	Yes/No/ Unsure	Comments
1.	**TITLE**		
	Is the title clear and unambiguous?	**Yes**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Yes**	
2.	**RATIONALE**		
	Are there defined reasons for document development?	**Yes**	
3.	**REVIEW PROCESS**		
	Is the method described in brief?	**Yes**	
	Are individuals involved in the development identified?	**Yes**	
	Has a rational attempt been made to ensure the relevant expertise has been used?	**Yes**	
	Is there evidence of a consultation with stakeholders and users?	**Yes**	
4.	**CONTENT**		
	Is the objective of the document clear?	**Yes**	
	Is the target population clear and unambiguous?	**Yes**	
	Are the intended outcomes described?	**Yes**	
	Are the statements clear and unambiguous?	**Yes**	
5.	**EVIDENCE BASE**		
	Is the type of evidence to support the document identified explicitly?	**Yes**	
	Are key references cited?	**Yes**	
	Are the references cited in full?	**Yes**	
	Are all supporting documents referenced?	**Yes**	
6.	**APPROVAL**		
	Has the named Director had sight of the document?	**Yes**	
	Does the document identify which committee/ group will approve it?	**Yes**	
	If applicable have the joint Human Resources/staff side committee (or equivalent) approved the document?	**Yes**	
7.	**DISSEMINATION and IMPLEMENTATION**		
	Is there an outline/plan to identify how this will be done?	**Yes**	
	Does the plan include the necessary training/support to ensure compliance?	**Yes**	
8.	**DOCUMENT CONTROL**		
	Does the document identify where it will be held?	**Yes**	
	Have archiving arrangements for superseded	**Yes**	

	documents being addressed?		
9.	**PROCESS to MONITOR COMPLIANCE and EFFECTIVENESS**		
	Are there measurable standards or KPI's to support the monitoring compliance with and effectiveness of the document?	**Yes**	
	Is there a plan to review or audit compliance with the document?	**Yes**	
10.	**REVIEW DATE**		
	Is the review date identified?	**Yes**	
	Is the frequency identified? Recommend every 2/3 years or sooner if required.	**Yes**	
	Is this an acceptable time frame?	**Yes**	
11.	**OVERALLRESPONIBLITY for the DOCUMENT**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	**Yes**	
12.	**FORMAT and CONTENT**		
	Arial font	**Yes**	
	Font size 12	**Yes**	
	Trust Logo on front page	**Yes**	
	Title of policy on front page	**Yes**	
	Policy control page completed	**Yes**	
	Is this a review of an existing document, if so have all changes/amendments been recorded in the table provided	**Yes**	
	Footer of each page details: name of policy, author and date of publication	**Yes**	
	Numbered sequentially	**Yes**	
	Appendices present (where required)	**Yes**	
	Impact assessment carried out	**Yes**	
	Glossary included as appropriate	**N/A**	
	Proof read the document	**Yes**	

Author			
If you are satisfied and want to approve this document please sign and date it			
NAME	John Glynn	**DATE**	19 /03/2019
SIGNATURE	John Glynn		
FINAL APPROVAL			

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (48)

Meeting: Trust Board 2 August 2019	**Category of paper** *(please tick)*	
Report title: Draft revised procedure for emergency powers and urgent decisions (Board and Committee)	**For approval**	✓
Responsible director: Chief Executive **Report author:** Company Secretary	**For assurance**	
Previously considered by N/A	**For information**	

Purpose of the report

The procedure for emergency powers and urgent decisions ('Chief Executive and Chair's actions') and Committee urgent matters was last reviewed in March 2013. Whilst this is a procedure, rather than a policy, and does not require regular review, there are a number of amendments required to be made to this document.

Any amendments need to be approved by the Trust Board.

Main issues for consideration

The amendments and rationale are listed on the version history (page 3 of this document). The main issues to note are:

- The front cover of the procedure now includes an executive summary
- In addition to emergency situations, 'time-critical situations' has also been included (for example the need for action when compliance documents need urgent Board approval).
- The previous version combined and confused the procedures required for Board emergency powers and urgent decisions, and Committee urgent matters. These have now been separated.
- The previous template forms did not require the reason for the urgency of a decision and the actual decision made to be documented, this has been added.

Recommendations
The Board is recommended to:

- Approve the amendments made to the procedural document

Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

Executive Summary:
The procedure relating to urgent Board decisions is referred to as 'Chief Executive and Chair's action'. Chief Executive and Chair's action should only be used in "emergency" situations and time-critical situations. Similarly, Committees may also act on urgent matters arising between meetings of the Committee, in accordance with their terms of reference. This procedure outlines how requests for Chief Executive and Chair's action, and Committee's urgent matters should be managed.

Document History:

Version:	2
Date:	TBC
Last version received by:	Trust Board
Date received:	1 March 2013
Ratified by:	Leeds Community Healthcare NHS Trust Board
Date ratified:	1 March 2013
Name of author:	Company Secretary
Name of responsible committee:	N/A
Date issued:	Version 4: TBC
Review date:	June 2022
Target audience:	Leeds Community Healthcare NHS Trust Board members, senior managers, and Board and Committee administrative support

Version history

The table below logs the history of the steps in development and amendment of the document.

Version	Date	Author	Status	Comment
0.1	1 March 2013	Vicky Pickles Director of Corporate Affairs	Draft	Presented to Board for review
1	1 March 2013	Vicky Pickles Director of Corporate Affairs	Final	Approved by Board on 1 March 2013
2	13 June 2019	Diane Allison, Company Secretary	Draft	Updated roles, 'Chief Executive and Chair's action' defined for purposes of procedural document, Added 'time-critical situations' in addition to emergency situations to include for example the need for action when compliance documents need urgent Board approval. Added paragraphs to the introduction section to acknowledge the requirement for Committee's urgent matters. Added a section 6 'Committee's urgent matters' which had previously been confused within section 5 (which is about Board urgent decisions). Dissemination section - role descriptions have been amended to include senior managers, rather than General Managers. Added a requirement to document the reason for the urgency of a decision and the actual decision made - included on the Chief Executive and Chair's action form (appendix A) and on the Committee's urgent matters form (appendix B). Added a 'Committee's urgent matters' form (appendix B) – which was previously confused within appendix A, which was multi-use

Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

Contents

Appendices

Procedure for emergency powers and urgent decisions (Chief Executive and Chair's actions and Committee urgent matters)

1. Introduction

1.1 Under Leeds Community Healthcare's Standing Orders, Board committees and other groups undertake work on behalf of the Board. At times it may be necessary for urgent matters that the Board, Board Committees and other groups would normally consider at meetings to be dealt with between meetings. These matters would then be formally reported at subsequent meetings for ratification. For the purposes of this document, the procedure relating to such actions is referred to as 'Chief Executive and Chair's action'.

1.2 Chief Executive and Chair's action should only be used in "emergency" situations and time-critical situations. This procedure outlines how requests for Chief Executive and Chair's action should be managed.

1.3 The way in which the Board makes urgent decisions between meetings is set out in section 5.2 of the organisation's Standing Orders. This states:

'Emergency Powers and Urgent Decisions
The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.8) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-officer members. The exercise of such powers and decisions by the Chief Executive and Chair shall be reported to the next formal meeting of the Trust Board in public session for formal ratification.'

1.4 To ensure there is a clear audit trail of any such decisions, the form contained at Appendix A should be used for urgent decisions by the Board.

1.5 Similarly, there are occasionally urgent matters requiring a Committee's consideration and action which arise between meetings of the Committee. The way in which a Committee takes urgent action between meetings is set out in its terms of reference, which are in accordance with the Trust's scheme of delegation.

1.6 To ensure there is a clear audit trail of any such actions, the form contained at Appendix B should be used for a Committee's urgent matters.

2. Aims and Objectives

2.1 This document clearly sets out the procedure that should be followed when requesting Chief Executive and Chair's action and that such requests are dealt with in a consistent and traceable manner.

3. Scope of the Procedure

3.1 This procedure must be followed by all Leeds Community Healthcare NHS Trust staff including those on temporary or honorary contracts, secondments, pool staff and students.

3.2 It applies to the Board, Board Committees and all groups within Leeds Community Healthcare NHS Trust.

4. Accountability

4.1 The Company Secretary will be responsible for monitoring compliance with and use of this procedure.

4.2 Directors will be responsible for ensuring that their staff make appropriate requests for Chief Executive and Chair's action and for Committee Chair's urgent matters and that these are reported to the next formal meeting of the Board / Committee.

4.3 The Company Secretary will be responsible for offering advice and support to staff.

5. Procedure for Chief Executive and Chair's Action

5.1 If a member of staff has an item that they consider is appropriate and sufficiently urgent to warrant requesting Chief Executive and Chair's action they should, in the first instance, obtain the approval of their Director.

5.2 A 'Request for Chief Executive and Chair's action form (see Appendix A) should be completed by the requester, including obtaining the signature of the responsible Director.

5.3 The completed form, together with a copy of the appropriate document/s should be submitted to the Company Secretary.

5.4 The Company Secretary will confirm that Chief Executive and Chair's action is appropriate.

5.5 If Chief Executive and Chair's action is not considered appropriate all the documentation will be returned to the originator with an explanation of why it is considered inappropriate.

5.6 The Company Secretary will contact the relevant people as described in the Standing Orders (section 5.2). to obtain their support for Chief Executive and Chair's action being taken. This will be the Chair, the Chief Executive and at least two non-officer members. Details of other members contacted, including Non-officer Members, will be recorded on the 'Request for Chief Executive and Chair's

Action' form together with details of the next formal Board meeting that the Chief Executive and Chair's action will be reported to, for formal ratification.

5.7 Once a decision is made, the Company Secretary will advise the responsible officer of the approval of Chief Executive and Chair's action. The Company Secretary will then ensure that the item is presented for ratification at the next formal Board meeting.

5.8 The Company Secretary will retain a record of all Chief Executive and Chair's actions.

6 Committees' urgent matters

6.1 The Chair of a Committee in consultation with at least one other member may act on urgent matters arising between meetings of the Committee. Any such action will be reported to the next Committee meeting, to be recorded in the meeting minutes and in the Chair's assurance report to the Board. The Committee's delegated decision making will be in accordance with the Trust's scheme of delegation as approved by the Board and as reflected in the Committee's terms of reference.

6.2 A Committee's urgent matters form (see Appendix B) should be completed by the requester, including obtaining the signature of the responsible Director.

6.3 The completed form, together with a copy of the appropriate document/s should be submitted to the Company Secretary.

6.4 The Company Secretary will confirm that the request for Committee's urgent matters is appropriate.

6.5 If is not considered appropriate for Committee's urgent matters, all documentation will be returned to the originator with an explanation of why it is considered inappropriate.

6.6 The Company Secretary will contact the relevant people as described in the terms of reference for the Committee to obtain their support for the Committee's urgent matters. This will be the Committee Chair and at least one other member of the Committee. Details of all members contacted, will be recorded on the 'Request for Committee's urgent matters form.

6.7 The completed form, together with a copy of the appropriate document/s must be submitted to the Company Secretary, who will ensure the item is presented at the next Committee meeting for information.

6.8 The Company Secretary will retain a record of all Committee's urgent matters forms.

7 Monitoring Compliance with and the Effectiveness of Procedural Documents

7.1 The Company Secretary will monitor performance against this procedure.

8. Dissemination

8.1 Once approved by the Board, this procedure will be disseminated to all Board members, senior managers, and Board and Committee administrative support.

9. Associated Documentation

9.1 In all cases reference should be made to section 5.2 of the organisation's Standing Orders and the relevant section of the terms of reference for Committees of the Board.

Appendix A

LEEDS COMMUNITY HEALTHCARE NHS TRUST

REQUEST FOR CHIEF EXECUTIVE AND CHAIR'S ACTION

The top part of this form should be completed and submitted, together with supporting documents, to the Company Secretary.

SUBJECT *(please give a brief outline of the item that requires Chief Executive and Chair's action, describe why this is deemed to be an emergency or requiring an urgent decision, and provide a copy of any relevant papers):*

RESPONSIBLE DIRECTOR:

RESPONSIBLE MANAGER (if different):

DATE:

- -

(This part of the form will be completed by Company Secretary and a copy will be returned to the originator)

APPROVAL BY CHIEF EXECUTIVE AND CHAIR:

Describe the decision made:

Chief Executive Signature _____ Date

Chair Signature _____ Date

CONSULTATION WITH OTHER MEMBERS:*

1.Name _____ Date _____

2.Name _____ Date _____

To be ratified at [insert name of meeting) on _____ (insert date)

Copy returned to originator _____ (insert date)

***** For urgent Board matters two Non-Executive Directors should be consulted

Appendix B

LEEDS COMMUNITY HEALTHCARE NHS TRUST

COMMITTEE'S URGENT MATTERS

The top part of this form should be completed and submitted, together with supporting documents, to the Company Secretary.

SUBJECT (please give a brief outline of the item that requires a Committee's urgent action, describe why this is deemed an urgent matter, and provide a copy of any relevant papers):

RESPONSIBLE DIRECTOR:

RESPONSIBLE MANAGER (if different):

DATE:

- -

(This part of the form will be completed by Company Secretary and a copy will be returned to the originator)

APPROVAL BY COMMITTEE CHAIR:

Describe the decision made:

Committee Chair Signature _____
Date

CONSULTATION WITH OTHER MEMBER(s):

1.Name _____ Date _____

2.Name _____ Date _____

To be noted at [insert name of meeting) on _____ (insert date)

Copy returned to originator _____ (insert date)

* For Committee’s urgent matters at least one other Committee member should be consulted.

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (50)

Version 4:23 July 2019

Topic	Frequency	Lead officer	24 May 2019	2 August 2019	4 October 2019	6 December 2019	7 February 2020	27 March 2020	27 May 2020
Preliminary business									
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X	X
Patient story	every meeting	EDN	X	X	X	X	X	X	X
Quality and delivery									
Chief Executive's report	every meeting	CE	X	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X	X
Perfomance Brief: annual report	Annual	EDFR	X						X
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X		X
Care Quality Commission inspection reports	as required	EMD							
Quality account	annual	EDN	X						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		X
Patient experience: complaints and incidents report	2 x year (six monthly Dec annual August)	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 Annual report	X		X	X		X Annual report
Strategy and planning									
Operational plan including financial plan	3 x year	EDFR	x 2018-19 End of year report		X			X 2020-21	x 2019-20 End of year report
Service strategy	as required	EDFR			X Patient engagement strategy				
Quality strategy	annual	EDN					X		
Workforce Strategy	every meeting from May 2019	DW	X Leadership and skills	X Resourcing	X Wellbeing	X Diversity and inclusion	X Integration and Partnership	X Proactive Analytics	X
Research and development strategy	annual	EMD		X Verbal update	X Full report				
Governance									
Medical Director's report: doctors' revalidation	annual	EMD		X					
Nurse and AHP revalidation	annual	EDN		X					
Well-led framework	as required	CS	X Self assess update	X CEs report		X Action plan			X Self assess update
Annual report	annual	EDFR	X						X
Annual accounts	annual	EDFR	X						X
Letter of representation (ISA 260)	annual	EDFR	X						X
Audit opinion	annual	EDFR	X						X
Audit Committee annual report (part of corporate governance report)	annual	CS	X						X
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS	X						X
Annual governance statement (part of corporate governance report)	annual	CS	X						X
Going concern statement (part of corporate governance report)	annual	EDFR						X	
NHS provider licence compliance	annual	CS	X						X
Committee terms of reference review	annual	CS	X						X
Board and sub-committee effectiveness	annual	CS	X						X
Register of sealings	annual	CS	X						X
Declarations of interest/fit and proper persons test (part of corporate governance report)	annual	CS						X	
Corporate governance update	as required	CS							
Reports									
Equality and diversity report	annual	DW				X			
Safeguarding annual report	annual	EDN			X				
Health and safety report - analysis of staff incidents and resultant actions	2 x year	EDFR				X			X
Infection prevention control annual report	annual	EDN			X				
Emergency preparedness annual report	annual	EDO			X				
Additional items									
West Yorkshire Mental Health Services Collaborative	as required	CE		X					
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							
Proposed new lease for 4th floor Stockdale House	as required								
LIFT Under Lease Plus Agreements (ULPAs) from Community Health Partnerships (CHP)	as required	EDFR							
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

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2019-20 (51ai)

Quality Committee
Monday 20 May 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Helen Thomson	Non-Executive Director
	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Ruth Burnett	Executive Medical Director
	Stephanie Lawrence	Executive Director of Nursing and Allied Health Professionals (AHP)
In Attendance	Diane Allison	Company Secretary
	Caroline McNamara	Clinical Lead, Adult Business Unit
	Suzanne Slater	Clinical Governance Manager
	Elaine Goodwin	Clinical Lead for Specialist Services
	Carolyn Nelson	Head of Medicines Management
	Cat Duff	Quality Lead for Children's services
Observing	Christine Pearson	Health Visitor
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Sam Prince	Executive Director of Operations
	Helen Rowland	Clinical Lead for Children's Services

Item no	Discussion item	Actions
Welcome and introductions		
2019-20 (11a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed everyone. The group introduced themselves. The Chair welcomed Helen Thomson, Non-Executive Director to the meeting as a member. Apologies were received from Sam Prince and Helen Rowland.	
2019-20 (11b)	**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.	
2019-20 (11c)	**Minutes of meeting held on 29 April 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2019-20 (11d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>2018-19 (88e) Operational plan</u> The item was on the agenda and the action was agreed as completed.	

	2018-19 (89b) Outcome measures update The Executive Medical Director advised the Committee that recruitment for the LCH Outcomes Programme Manager had been successful. Confirmation is still to be received from the Trust's Business Intelligence team regarding whether the city wide outcomes team can provide this function, or whether we will need to recruit on the funding available from the CCG. The Committee Chair referred to the Quality Account intentions regarding outcome measures and queried the timescale for confirmation of next steps. The Executive Medical Director confirmed that she would expect to have an answer by the next Committee meeting. **Action**: Executive Medical Director to update the Committee with regards to progress from the Business Intelligence team. The Trust Chair expressed disappointment on behalf of the Board. The Chief Executive stated that the Trust has some of the best work on outcome measures in the country, using data to drive improvement in quality and change. She stated that the issue is however, around having analytical capacity to be able to give to teams to use on the front line. The Committee Chair recognised the good work in developing outcome measures, however expressed the need for some urgency in having widely visible outcome measures. 2019-20 (4c) (i) Ligature risk documentation at Little Woodhouse Hall The Company Secretary updated the Committee, stating that the annual ligature test had been completed; however the breaking weight had not been documented. The Committee was advised that the paperwork would be provided. The action was agreed as closed subject to receiving the documentation. 2019-20 (4c) (ii) Waiting time impact on Adult SLT patients The Executive Director of Nursing and AHP confirmed that the update was included in the Specialist Clinical Lead report. The action was agreed as closed. 2019-20 (6a) Performance brief and domain reports The item was on the agenda and the action was agreed as completed. 2019-20 (6b) Quality account The item was on the agenda and the action was agreed as completed. 2019-20 (6c) Schedule of Key Performance Indicators The Executive Medical Director gave an update on the work to determine additional performance indicators for the Effective domain. The action was agreed as closed.	Executive Medical Director
(11e)	**Subgroup items to escalate** It was agreed that any items would be addressed at the point of reviewing the minutes.	
2019-20 (12)(i)	**Freedom to Speak Up Guardian report : Peer Review report** The Chief Executive introduced John Walsh, Freedom to Speak Up Guardian.	

	The Committee heard 42 staff members have met directly with the Freedom to Speak Up Guardian from across all the business units and had raised their concerns. The Freedom to Speak Up Guardian stated that he felt extremely supported in his role, however it is not without its challenges. *Peer review report* The Freedom to Speak Up Guardian presented the peer review report which had been completed with the Freedom to Speak Up Guardian at Locala. It was noted that the report reflects positively, with some questions and recommendations. The Trust Chair asked about the link between the Freedom to Speak Up and race equality work as he had detected some reticence of people to come forward from Black and Minority Ethnic (BAME) groups. It was noted that the Freedom to Speak Up Guardian has attended BAME groups to address the issue and to encourage more staff to speak up. The Chief Executive referred to the reverse mentoring scheme and commented that her mentor had been approached by people regarding issues around race since the race for equality event. It was noted that a second mentor had reported an increase in contacts following the BAME mentor event. The Committee agreed that an analysis of the number of contacts would be helpful. The Executive Director of Nursing and AHP referred to a BAME network meeting where Freedom to Speak Up was discussed and stated that it felt very open and honest. Going forwards, Directors will be invited to network meetings on a regular basis. The Committee agreed that Freedom to Speak Up is only one of the routes available to raise concerns and that it was important to understand the balance. It was also agreed that the work of the Freedom to Speak Up Guardian cannot be measured by the amount of people he sees and that it is more about embedding the culture. The Committee Chair thanked the Freedom to Speak Up Guardian for the report and his attendance at the meeting. **Assurance level:** reasonable.	
2019-20 (13) (i)	**Service spotlight review and committee effectiveness** The Committee discussed the value and format of the service spotlight item. It was felt that there was an issue around what is presented and that the Committee does not always receive the information required. There was some concern about the nature of the item and how it affects the business of the meeting. It was agreed that there is an issue with communicating to the services the reason for the spotlight and clarity with what is expected. The Executive Director of Nursing and AHP stated that the item currently felt rushed and that the Committee needed to ensure enough time is given for the item to ensure that the level of detail was received and balanced with the business part of the meeting. The Committee discussed how services were selected to present at the meeting. It is currently a random selection, however there was concern that if	

	a thematic approach was adopted, looking at outliers only, then some services could be missed. It was suggested that the Board members' service visits item could be higher up on the agenda, with more time being allocated for this. The Committee Chair acknowledged the dissatisfaction around the current process and surmised that discussions needed to continue. The Committee Chair was reluctant to remove the spotlights from the meetings until there is a proposal on how to make it work better. It was agreed that the service spotlight for July would be stood down and the time for the item would be used to discuss the issue further. **Action:** Executive Director of Nursing and AHP to discuss the service spotlight item at the Clinical Leads meeting and present a proposal as to how the item would work better at the meeting in July 2019.	Executive Director of Nursing and AHP
Key issues		
2019-20 (14a)	**Complaints review** The Executive Director of Nursing and AHP presented the report which shared the findings of the review into complaint responses undertaken by Healthwatch and of the quarterly review meeting held between the Executive Director of Nursing and AHPs and the Trust Chair. Healthwatch Leeds, along with a pool of volunteers from different backgrounds/ages/communities, looked at six Trust complaints letter responses and were asked for feedback on how they felt about the response, was it personal, was the response clear, and what were their suggestions for improving the responses. The information provided from the review was not consistent in nature as there was a difference in opinion around each response, depending on the reviewer. There was however consistency in suggestions for how responses can be improved, which are being used to make improvements to complaint responses. The Committee suggested that in addition to this work, the Complaints Team should follow-up a number of complaint responses to ensure that the recipients were satisfied with the outcome. **Assurance level:** reasonable	
2019-20 (14b)	**CQC inspection update** The Executive Director of Nursing and AHP advised the Committee that four core services had been inspected: • Sexual health • 0-19 PHINs / ICAN • CAMHS • Dental Positive feedback was received from CQC following the visits and nothing of urgency was required. The Committee was pleased to hear that CQC had described the Sexual Health service as being good to outstanding and the oral health service for children was described as exemplary.	
2019-20 (14c)	**Category 4 pressure ulcer incidents update** The Executive Director of Nursing and AHP updated the Committee on actions following the Category 4 pressure ulcer incidence: 1. A clear care plan is in place and will be shared with the care agency	

	involved. A further incidence is not anticipated. 2. The Clinical Lead for Adult Services had undertaken a deep dive investigation into concerns within the team and fed back that she was satisfied with the detail of review. It was agreed that the next synopsis would be brought to the next meeting. The Committee Chair asked about how the learning was being disseminated. It was confirmed that the learning would be discussed at the next Adult Business Unit quality and development meeting and at the Patient Safety and Experience Group. Learning would also be included in the Clinical Lead report.	
2019-20 (14d)	**Quality Account** The Executive Director of Nursing and AHP updated the Committee on progress with the production of the Quality Account and confirmed that it would be presented at the next Board meeting. The Committee Chair acknowledged the amount of care that goes into producing the accounts and stated that the Quality Account should reflect that commitment.	
Quality governance and safety		
2019-20 (15a)	**Performance brief and domain reports** The Executive Director of Nursing and AHP presented the end of year performance report 2018/19 and the April 2019 performance brief. *Safe* The Committee noted that two category 4 pressure ulcers had been reported in 2018/19, which was avoidable to LCH, and in April 2019/20 there had been an increase in category 3 pressure ulcers. The Committee was advised that the Patient Safety and Experience Group was examining learning from pressure ulcer incidents in greater detail. The Committee noted that there had been deterioration in inpatients recommending care and this is being explored further. The Committee Chair asked if the seven falls reported were attributable to LCH. The Executive Director of Nursing and Allied Health Professionals (AHP) agreed to provide confirmation of this at the next meeting. The Committee noted the increase in reporting incidents overall. It was agreed that the statement pertaining to patient safety incidents per 1000 contacts was incorrect and that the figure was currently out of the control level. *Responsive* The Committee Chair asked about the improvement plan relating to Children's waiting lists. It was confirmed that the issue would be discussed at the Business Committee. **Action**: The Executive Director of Nursing and Allied Health Professionals (AHP) to provide details of falls incidents attributable to LCH at June 2019 meeting.	

	Assurance level: reasonable	
2019-20 (15b)	**Clinical governance report** The Executive Director of Nursing and AHP presented the clinical governance report and highlighted the recent learning from coroner's inquests. The Committee heard that the Regulation 28 response had been sent to the Coroner and shared with the CCG and CQC. It was noted that the first Patient Safety, Experience and Governance Group (PSEGG) workshop had been held in April 2019. The Committee heard that Healthwatch had completed a review of patient engagement and initiatives from across the organisation. The feedback would be used to help formulate further initiatives. <u>Clinical Lead Quality reports</u> *Specialist Business Unit (SBU)* • The SBU annual celebration event took place on 1 May 2019, showcasing new and innovative ways of working. • HMP and YOI Wetherby, including the healthcare provision, was inspected by HMIP and CQC in March 2019. There was positive feedback in terms of healthcare. Recommendations from a recent Health Needs Assessment (HNA) will support ongoing work to provide service provision. • *Update on Risk 957: Increase in demand for the Adult Speech and Language Therapy Service* - The Committee received a further update on the actions being put in place to manage the waiting list risk. Measures include additional resource and work being done jointly with the commissioners around capacity and demand. The Committee was advised that the service anticipates these actions will start to have an effect on the wait lists by the end of July 2019. The Committee agreed that it would be useful to include the learning in the Quality Account next year. *Adult Business Unit (ABU)* • Establishing the New Ways of Working (NWoW) is a key priority in the 19/20 ABU business plan and progress is monitored via monthly performance meetings. • A senior clinician has been successfully admitted to the Frail Older Peoples Fellowships with Kings College London programme. • Population Health Management programme update: First cohort due to be completed, with cohort 2 commencing in May/June 2019 and cohort 3 scheduled for December 2019. • Statutory and Mandatory training is below target, however there are actions in place to address this. The Trust Chair expressed concern about Band 5 staff being tasked to complete appraisals and asked for assurance that the staff have adequate line management, focusing on quality. The Trust Chair asked about team performance information on the Quality Boards. The Clinical Lead for Adult Services commented that the Quality Boards were developed for ward environments and would only ever provide a snapshot in time, but they do allow improvements and problems to be tracked.	

	Children's' Business Unit (CBU) • Work continues on describing pathways. • PHINS reports good morale and engagement in the mobilisation process. • CAMHS - The Infant mental health: babies, brains and bonding training won the award for contribution to health visiting education at the national Journal of Health Visiting awards. • Positive quality and CQC visits. • Appraisal rates are below target, however actions are in place to address this.	
2019-20 (15c)	**Quality improvement priorities – Quarter 4 position report** The Quality Account quality improvement priorities report provided the Committee with the Quarter 4 position and final outcome against the 2018/19 priorities. The Committee noted that 19 measures had been completed, 3 measures were on target for achievement within 2019/20 and 5 had not been progressed or achieved the target. The Committee was advised that for the priorities not yet achieved, plans are largely in place to achieve these in the coming year.	
2019-20 (15d)	**Guardian for safe working hours** The Committee heard that there are still challenges engaging Junior Doctors, who are not in the CAMHS service. There has been combined work between the Joint Negotiating Committee (JNC), Guardian for safe working hours (GSWH) and the Executive Medical Director with the commencement of a rolling rota for Medical & Dental engagement meetings for all staff starting next month, which should provide an opportunity for them to engage with more staff regularly and increase the profile of both roles within LCH. It was noted that the report was difficult to understand and agreed that the Executive Medical Director would provide guidance on the writing of the report to the author. In order to provide assurance, the Committee agreed that a statement from the author confirming that there were no concerns would be required. **Action:** Executive Medical Director to provide guidance on the writing of the report to the author.	Executive Medical Director
2019-20 (15e)	**Risk register** <u>Risk 966: Non-registered staff capacity in Night Nursing Services and Risk 967: Neighbourhood Nigh Nursing Service - documentation</u> Two of the new risks added to the risk register concern the night nursing service. Risk 966 was the reduced capacity of non-registered staff (sub-contractor staff), and Risk 967 was the sub-contractor staff's lack of access to the Night Service electronic patient records. The Committee considered the connections between the two risks and was advised that there was a plan to mitigate both risks. <u>Risk 968: Unavailability of CPR training for clinical staff across LCH</u> The Committee heard that the first new trainer was now in post and sessions are booked until the end of August 2019. The Committee was advised that the risk would be reduced. <u>Risk 969: Staff shortages at Hannah House</u>	

	The Committee was advisedthat children would not be admitted if staffing was not at the correct level. It was agreed that this needed to be articulated in the narrative. The Executive Director of Nursing and AHP was confident that the risk would reduce to 6, with a targeted campaign to recruit.	
2019-20 (15f)	**Board assurance framework** The Committee was advised that patient engagement had been brought in line with the risk cluster under patient safety. The Communications Department have been tasked to review the sources of assurance under the 4 risks that the Committee has been assigned, providing assurance as to whether the risk is being managed.	
2019-20 (15g)	**Mortality report** The Quarter 4 Mortality figures and an update on the Trust's process for capturing and interrogating mortality data was presented to the Committee. The Committee was advised that the data continued to show no significant variation from previous data and trends. The Committee was advised that an agreed minimum dataset and format has been standardised for Business Unit reports into the Mortality Surveillance Group and Business Unit Mortality Governance meetings have taken place regularly in all Business Units. There was improved data quality and the Committee was advised that the Trust was now in a position to report these reliably. The Committee queried the resource required to manage the process of recording and analysing mortality figures. The Committee was advised that the new process was now embedded, that the clinical leads were able to pick up abnormalities and that deaths of people with learning disabilities and mental health conditions were being flagged from April 2019. The Adult and Specialist Business Units are conducting a piece of work with the Business Intelligence team to validate the data and move to a position where the correct data can be pulled directly from the central systems rather than being reliant on Business Unit spreadsheets.	
2019-20 (15h)	**Board members' service visits** The paper was received for information and highlighted the visit by the Committee Chair to the Community Neurology Rehabilitation Unit (CNRU).	
Clinical effectiveness		
2019-20 (16a)	**Patient group directions (PGDs)** The Committee was asked to ratify two PGDs. 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.	
2019-20 (16b)	**NICE guidance compliance update** The Committee was advised that significant progress has been made in the ability to implement the guidance. The Committee Chair asked about services that are unable to be compliant with the guidance. It was agreed if a service could not comply because some requirements were outside of their remit, there should be a process which evaluates whether the service is as compliant as possible and a reporting of	

	that position.	
2019-20 (16c)	**Internal audit report: Paediatric Neuro Disability waiting times** The Committee noted the appraisal review of Paediatric Neuro Developmental Service waiting lists, which had been given reasonable assurance. It was agreed that a timescale was required for the actions identified. **Action:** Executive Director of Operations to identify and confirm the timescale for completion of the actions.	Executive Director of Operations
Patient experience		
2019-20 (17a)	**Patient experience and engagement: incidents, complaints, concerns and feedback** The report provided the Committee with an annual update of patient experience and the management of patient safety Incidents. It summarised the outcomes, themes, actions and learning from Patient Safety and analysed identified themes, triangulating information where possible to identify commonalities across all sources of intelligence. Areas for concern were noted as: limited information was provided from the Friends and Family Test, due to its anonymous nature, complaint themes are consistent with last year, learning is being used for system change and improvement, but it is not consistent, there has been a reduction in low/no harm incident reports, there is incorrect pressure ulcer categorisation. The Committee was advised that its subgroup, the Patient Safety and Experience Group would examine the themes in greater detail. **Assurance level:** reasonable	
Sub Group minutes		
2019-20 (18a)	**Clinical Effectiveness Group (CEG) meeting 24 April 2019** The minutes were received, and the following items were highlighted: • Significant work has been undertaken to improve the Trust's position with overdue policies and assurance is provided in regards to sustained progress. • There have been substantial improvements in the Quality Challenge+ and the number of visits undertaken in Quarter 4, with the new process agreed for 2019-20. • There has been a good level of attendance at both CEG workshops held in 2019. • The Trust is not compliant with the Falsified Medicines Directive, but this has been added to the Trust risk register and will be monitored in-line with EU Exit developments.	
2019-20 (18b)	**Patient Safety, Experience and Governance Group meeting 28 March 2019** The minutes were received. There were no items to highlight to the Committee.	
2019-20 (18c)	**Mortality Surveillance Group meeting 9 April 2019** The minutes were received. There were no items to highlight. It was agreed that the flash report would be circulated following the meeting.	Executive

	Action: Executive Medical Director to circulate flash report to Committee members and attendees.	Medical Director
2019-20 (18d)	**Safeguarding Committee** The Executive Director of Nursing and AHP highlighted the agreed targets for recording of consent. The Committee Chair commented on the record of attendance and apologies, in particular the number of designated and named staff. It was agreed that this would be reviewed within the Group.	
Quality Committee work plan		
2019-20 (19a)	**Work plan and format of meetings** The Committee Chair asked for feedback on the meeting. The Executive Director of Nursing and AHP commented that there could have been more focus on the Performance Brief, particularly the Safe and Caring domains. The Committee agreed that there was a voluminous set of papers to read through before the meeting. The Committee also agreed that the Clinical Lead reports were very important. It was noted that there was some challenge in the meeting.	
2019-20 (20)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair would provide an update to the Board at the next meeting on the following issues: • Verbal updates on CQC inspection, Grade 4 pressure ulcer incidents and the Quality Account • Service spotlight and working of committee • FSUG report • Review of pressure ulcers to be included in the Performance brief • Performance report: reasonable assurance across board. • Complaints review • Risk 957 • Quality Account • GSWH • Risk Register: Risks 966 & 967 • Mortality report • Patient safety report	
2019-20 (21)	**Any other business** There was no further business.	
	Dates and times of future meetings (09:30 – 12:30) 24 June 2019 22 July 2019 23 September 2019 21 October 2019 25 November 2019	

Leeds Community Healthcare NHS Trust

PUBLIC MINUTES

AGENDA ITEM 2019-20 (51aii)

Quality Committee
Monday 24 June 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Helen Thomson	Non-Executive Director
	Neil Franklin	Trust Chair (Items 22 – 25c)
	Thea Stein	Chief Executive
	Ruth Burnett	Executive Medical Director
	Stephanie Lawrence	Executive Director of Nursing and Allied Health Professionals (AHP)
In Attendance	Diane Allison	Company Secretary
	Caroline McNamara	Clinical Lead, Adult Business Unit
	Helen Rowland	Clinical Lead for Children's Services
	Suzanne Slater	Clinical Governance Manager
	Elaine Goodwin	Clinical Lead for Specialist Services
	Carolyn Nelson	Head of Medicines Management
	Em Campbell	Service Manager, Neighbourhood Teams (West 2) (Item 23)
	Sarah Brownlow	Clinical Pathway Lead (Item 23)
	Kirsty Jones	Clinical Pathway Lead (Item 23)
	Bernie Bell	Business Development Lead (Item 23)
	Alison Langton	Clinical Pathway Lead (Item 23)
	Gill Lockwood	Service Manager, Pudsey ((Item 23)
	Heather Thrippleton	Patient Engagement and Experience Lead (Item 24)
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Sam Prince	Executive Director of Operations

Item no	Discussion item	Actions
Welcome and introductions		
2019-20 (22)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed everyone. The group introduced themselves. Apologies were received from the Executive Director of Operations.	
Business unit focus		
2019/20 (23)	**ABU Workshop: Population Health Management** Representatives from the Adult Business Unit Population Health Management (PHM) team were invited to present details of the work undertaken in the PHM development programme from January 2019 and to look ahead to the work planned for the next cohort. Representatives from the four Neighbourhood Teams (NT) aligned to the four local care partnerships (LCP); West 1 Pudsey; West 2 Woodsley; North 2 Seacroft and South 2 Garforth, Kippax and Rothwell attended. The Committee Chair welcomed all to the meeting and the group introduced themselves. The Committee learnt that the programme was delivered by NHS England and their partner Optum Alliance who provide dedicated expertise. The programme	

	focussed on progressing a PHM approach to improve outcomes for people living with frailty. The team presented their journey so far, and then the Committee divided into four into groups to hold round table conversations with members of the team about the experience and impact of the programme. The Committee agreed that the approach is about people, relationships, co-ordination and keeping patients at the centre of care with robust data and the patient voice. The Committee Chair thanked the team for their presentation and workshop, stating that it would be beneficial to revisit the programme at a meeting later in the year.	
2019/20 (24)	**Patient engagement workshop** The Patient Engagement and Experience Lead joined the meeting to present the progress in terms of developing a Patient Engagement strategy for the Trust. The Committee learnt that the strategy would be developed in partnership with volunteers, staff, partners (Healthwatch, CCG, NIHR Biomedical research centre), patients and carers. The strategy aims to provide a framework for Patient Experience and Engagement work with the Trust for the next 3 years (2019-2022), including a shared vision for Patient Engagement and Experience, key priorities clear aims and objectives within the priorities. The Committee then broke into three groups to deliver a round table SWOT analysis. The following themes were identified: *Strengths* • Culture • Leadership • Not starting from scratch • Frontline passion *Weaknesses* • Consistency • Embedding • Lack of resource but not making it an excuse • Reliance on FFT • Alternatives strategies e.g. digital and webchat *Opportunities* • Partnership working • Leadership • Potential to increase resources • Extensive use of patient groups *Threats* • Less discussion, more action • Making it more meaningful for teams • Focusing on the process versus outcomes • External factors • Lack of resources The Clinical Lead for Children's Services commented that if the Trust is going to provide the best care, it would need to look at staff behaviours and patient	

	views. The focus needs to be on this rather than targets and numbers. The Chief Executive stated that it is important to have a simple strategy, ensuring that patients are heard and are the experts. The Committee Chair thanked the Patient Engagement and Experience Lead for the presentation and workshop.	
Formal meeting		
2019-20 (25a)	**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.	
2019-20 (25b)	**Minutes of meeting held on 20 May 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following amendments: <u>Item 2019-20 (14c) Category 4 pressure ulcer incidents update</u> *Amend wording:* The Committee Chair asked about how the learning was being disseminated. It was confirmed that the learning would be discussed at the next ~~organisational~~ *Adult Business Unit Quality Development meeting* and at the Patient Safety and Experience Group. <u>Item 2019-20 (15g) Mortality report</u> *Add wording:* The Adult *and Specialist* Business Units are conducting a piece of work with the Business Intelligence team to validate the data and move to a position where the correct data can be pulled directly from the central systems rather than being reliant on Business Unit spreadsheets.	
2019-20 (25c)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>Item 2019-20 (11d) Outcome measures update</u> The Executive Medical Director updated the Committee with progress and confirmed that the citywide team were unable to provide business intelligence resources. Transformation funding would be made available from the CCG to recruit within the Trust. It was agreed that a verbal update would be given at the Committee in September 2019, with a report to be provided in November 2019. **Action:** Executive Medical Director to provide a verbal update to the Committee in September 2019 in relation to outcome measures. **Action:** Executive Medical Director to provide an update **report** on outcome measures in November 2019. <u>Item 2019-20 (15a) Performance Brief</u> The Executive Director of Nursing and AHP provided details of falls incidents attributable to the Trust. It was confirmed that there have been seven major harm falls. One has now been reclassified as moderate harm. The remaining six have undergone a 72 hour review which identified that five were attributable to the Trust. The Committee Chair asked about the care of the patients where	**Executive Medical Director** **Executive Medical Director**

	the incidents were not attributable to the Trust. The Executive Director of Nursing and AHP confirmed that everything is done to support patients to manage their risk. <u>Item 2019-20 (15d) Guardian for safe working hours</u> The Executive Medical Director confirmed that the action was completed. <u>Item 2019-20 (16c) Internal audit report: Paediatric Neuro Disability waiting times</u> The Executive Director of Operations provided an update to the Committee and included the revised timescales to the action plan which would be considered by the Audit Committee. It was agreed that the action was closed. <u>Item 2019-20 (18c) Mortality Surveillance Group meeting 9 April 2019</u> It was agreed that the action was completed.	
(25d)	**Key issues: Serious Incident** Please refer to the private minutes.	
Quality governance and safety		
2019-20 (26a)	**Performance brief and domain reports** *Safe* The Executive Director of Nursing and AHP informed the Committee of a fourth avoidable Category 3 pressure ulcer identified in June 2019. This would be investigated at the Patient Safety Experience Governance Group (PSEGG) in July 2019 to ensure that it receives a deeper review and investigation to identify learning. It was noted that an update on the incident and subsequent investigation would be included in the ABU clinical lead report in July 2019. **Action:** Update on the Category 3 pressure ulcer incident identified in June 2019 and subsequent investigation to be included in the ABU clinical lead report in July 2019. The Committee heard that a deep dive review was taking place on the Duty of Candour cases over the last two years to review timeframes, letters and if the process has been followed appropriately. The outcome of the review will be presented to the PSEGG meeting in July 2019, with an update to be given to the Committee in September 2019. **Action:** Executive Director of Nursing and AHP to provide an update on the outcome of the Duty of Candour review to the Committee in September 2019. Safe staffing was recorded as amber because there was an issue with registered nurse numbers in Hannah House. One child's stay was cancelled as a result to ensure patient safety. The Committee noted that the service was working very hard to ensure appropriate staffing levels. All other in-patient units were reported as adequately staffed. The Committee discussed the increased number of incidents being reported; the most noticeable increase was of incidents that were categorised as near miss or no harm. This was seen as a positive sign of a strong reporting culture whereby incidents are recognised and managed before serious harm occurs. The increase in incidents overdue for closure was recognised as being due to capacity issues. It was noted that the Quality Manager within the ABU was	**Clinical Lead, ABU** **Executive Director of Nursing and AHP**

	reviewing all overdue incidents on a weekly basis to action or close as appropriate. *Caring* In relation to the Friends and Family Test (FFT), the Committee heard that the noted spike in patient experience returns in the Community Neurology Team, and the two 'would not recommend' returns from last month, have been reviewed and explored further. One is thought to be the patient ticking the wrong box on the form as the comments provided were all positive. The second negative response, related to staff absence and review timeframes. The feedback has been shared with the service to identify any actions as required. Forms are anonymous so unfortunately the teams cannot follow this up directly with patients. The Committee Chair reiterated his concern that the graphs presented as part of the performance brief were difficult to understand as a scale was not provided. **Action:** Company Secretary to discuss a solution to the issue with graphs within the Performance Brief with the Head of Business Intelligence. *Responsive* The Committee heard that there were several national targets applied to the IAPT service and access within six weeks continued to improve. The Clinical Lead for Specialist Services reported that the service had an improvement plan in place, which has been agreed with commissioners as the delay is a direct result of increasing the numbers accessing the service. There was an overarching expectation that 95% of patients begin treatment within 18 weeks and the service routinely met this standard. The service expects the standard to be met going forward. It was also noted that ongoing work to upgrade triage to an electronic system was underway.	**Company Secretary**
2019-20 (26b)	**Update from CQC inspection visit** The Executive Director of Nursing and AHP confirmed that further information requested from the CQC had been sent. It was noted that the Trust expected to receive the initial report in late July/early August 2019 and rating in late August/early September 2019.	
Quality Committee work plan		
2019-20 (27)	**Work plan and format of meetings** It was confirmed that the next workshop would take place in October 2019. The service spotlight has been added to the work plan and will be discussed at the meeting in July 2019.	
2019-20 (28a)	**Matters for the Board and other committees including assurance levels** It was agreed that the Committee Chair's report to Board would include information on the following issue: • Pressure ulcers • Population Health Management workshop • Patient Engagement workshop	
2019-20 (28b)	**Reflections on meeting** The Committee Chair asked for feedback on the meeting. It was generally agreed that the workshops were useful; however there was a view expressed that there was not enough time in the meeting to complete a deep dive into two	

	areas. The Committee Chair asked the Committee to consider what would constitute a deep dive and what does the Committee need to enable it to be part of the conversation without doing all the work. **Action:** Executive Director of Nursing and AHP to discuss the format of the October SBU workshop at the Clinical Leads meeting and will give an update at the meeting in July 2019.	**Executive Director of Nursing and AHP**
2019-20 (29)	**Any other business** There was no further business.	
	Dates and times of future meetings (09:30 – 12:30) 22 July 2019 23 September 2019 21 October 2019 25 November 2019	

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (51bi)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 22 May 2019 (10.00am – 1.00pm)

Present:	Brodie Clark (Chair)	Non-Executive Director
	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
	Richard Slough	Assistant Director of Business Intelligence, Systems & IT
	Victoria Douglas-McTurk	Head of Business Intelligence
	Melanie Clewer	Data Quality Manager
	Jennifer Harrison	Data Quality Officer
Apologies:	Helen Thomson	Non-Executive Director (HT)
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2019/20 **(10)**	The Committee Chair welcomed everyone to the meeting. **(a) - Apologies:** Noted as above. **(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. No additional potential conflict of interest regarding the meeting's agenda were raised. **(c) - Minutes of last meeting** The public and private minutes of the meeting dated 24 April 2019 were noted for accuracy and approved by the Committee. **(d) – Matters arising from the minutes and review of actions** *d(i) - Ligature load testing at Little Woodhouse Hall (LWH)* The Executive Director of Finance & Resources reported that the final verification on the annual load testing of ligature risks at LWH had not been fully resolved. He remained assured that the load testing had been completed, however the specialist firm who had undertaken the work in November 2018 had been asked to return as the quality of documentation was not satisfactory. On that basis the Committee Chair agreed to close the outstanding action.	

	d(ii) – Improving access to psychological therapies (IAPT) Please see private minutes. *d(iii) – Wetherby Young Offenders Institute (WYOI)* Please see private minutes.	
2019/20 **(10)** Additional item	**Leeds Community Pain Service** Please see private minutes.	
2019/20 **(11)**	**Data quality presentation** The Committee Chair welcomed representatives from the Business Intelligence team to the meeting. The presentation covered the importance of data quality approach and the vision. The Data Quality Manager said that the aim was to change the mind set of data owners; having the right information in the right place and in a timely manner. The team had created a number of quality assurance tools and infographics to change attitudes without having clinical and financial implications. The Committee was advised that quality data across all services assisted with forecasting and planning and creating a cycle of events that ensures safety and quality was consistent and in a central place for all data quality reports. A learning culture and encouragement was being shared across the organisation to improve the patient's journey and to encourage collaborative working. The Data Quality Manager said that the data was now more visible and credible; encouraging people to have accurate, up to date information which made neighbourhood teams' workload easier to monitor, record and produce accurate information. The Head of Business Intelligence added that data quality helps to monitor the accuracy of reports and identifies errors, risks and training needs for all services. She said that work was underway to steadily engage with all services prior to their reports being published. The Committee Chair thanked the representatives from the Business Intelligence team and said that he would be glad to help in any way to raise awareness with services. The Executive Director of Finance & Resources said that he was assured that the basic data quality approach had been well established. This could also benefit finance managers and budget holders through developing tools that shows people the importance of understanding their information.	
2019/20 **(12)**	**Project management** **(a) Patient administration update** The Executive Director of Operations tabled a paper providing an update on the administration review and the next steps. The team was currently working on the 'to be' processes with services. She said the 'as is' processes during last year clarified the variation in administration across the organisation. The Executive Director of Operations said the aim was to develop a patient administration function for the Trust which would provide an efficient way of managing the patient journey from referral to discharge across the services and	

	to create a business support network to provide essential administration and management support to clinical teams and managers. The Executive Director of Operations said that work was continuing to get to a place where there was a single way of dealing with referrals, standards around responses, people doing similar work on similar banding and having a consistency approach, and bringing administration services under one single professional management structure. It was noted that the first services to use single point of access were health visiting and school nursing teams. This meant that patients had one telephone number to ring to get to the right place; bringing all those pockets of referral management into one so that standards could be applied. The Executive Director of Operations said the waiting times would be monitored better in a consistent way in order for patients to receive the best service. The 'to be' workshops were held in April/May 2019 for the three business units. The workshops concentrated on analysis of referral and appointment data and standardisation of functions to establish a single gateway for the business units. Work was also underway with the corporate teams to explore the benefits. The Executive Director of Operations said that the final model was expected to be in development from July to September 2019, and shared with the Committee in October 2019. There were some challenges noted; delivery of 'to be' stage to timescale and staff signing up to the administration project, and also the limitation of SystmOne architecture. The Executive Director of Operations said that there were still some services not completely supportive of the project. The Executive Director of Operations said that in the meantime the project team had been struggling to recruit into a senior post. The senior management team had agreed to the recruitment of a most senior post in the new administration structure including three team leaders covering each of the business units. The Associate Non-Executive Director (RG) said he was interested in the design vision, mainly because of staff engagement and future work. He asked whether SystmOne would be used for everything or complimented by other solutions and work flows. The Executive Director of Operations said that when she talked to staff about the single point of access to provide quick access to services and patients, some staff interprets that as having a call centre. She said that she would need a skilled team to be able to understand the needs of the population and direct patients to the right place. There were units set up for every service on SystmOne and to understand units was quite a complicated expectation. The Executive Director of Operations said she was also exploring the use of e-referrals. **Action:** • An update at the next Committee meeting in June 2019 was to include the analysing from 'to be' workshops. • The Committee Chair welcomed details of the final model in October 2019. **(b) Projects update: Change Board (including flash report)** The Executive Director of Operations introduced the projects report and said that there were no escalations to report to the Committee. The Committee was advised of a new proposal, bringing the management of	SP

	major projects under the oversight of one change management team; creating a central team to align and maintain the projects more closely. The Executive Director of Operations said that the central function would help to understand how projects impacted on each other and move resource around during peaks and troughs of work load. **Outcome:** The Business Committee received the report. **(c) Productivity group update** The Executive Director of Finance & Resources said that the review of progress on productivity during last year in the assessment on priorities required further thinking of what was being achieved. He continued to say that one of the first actions was to be more engaged with staff, be more productive to allow staff to provide better care and be able to deliver cost improvement programmes. **Action:** The Executive Director of Finance & Resources to provide an update on progress at the next meeting in June 2019. **(d) Child and Adolescent Mental Health Service (CAMHS) Tier 4 update** The Executive Director of Finance & Resources said that there were no further changes to report since the Extraordinary Trust Board Meeting on 3 May 2019. He confirmed that the building design phase was complete and signed off for submission of planning permission.	SP BM
2019/20 **(13)**	**Strategies** **Digital strategy update** The Assistant Director of Business Intelligence, Systems & IT provided details of progress of implementation of the Trust's digital strategy in the six months since it was last considered by Business Committee. The report covered areas of progress on the existing strategy and also identified those which were either completed or moved to business as usual. Where work was delayed or off track, reasons were identified and actions taken to bring the activity back in line with the plan. The paper also outlined the proposed approach for developing the replacement digital strategy along with potential timescales. The Assistant Director of Business Intelligence, Systems & IT said that the most significant achievement since the last update was the completed installation of public Wi-Fi across the estate; where patients could access Wi-Fi within NHS health centres and clinics. He said that since writing the paper two other developments to note were; receiving approval for the main connections to health and social care network and having the configuration set up and approved, and now going through the system. The Assistant Director of Business Intelligence, Systems & IT said that he had secured additional capacity from NHS Digital to help create the development of the digital strategy as part of their senior management development and leadership programme placement scheme. Plans for the next eight to twelve weeks included developing the engagement mechanisms to reach out to staff, including road shows, a series of interviews with key players and the senior managers in the organisation, engaging with the Chief Clinical Information Officer and the wider Integrated Care System group.	

	The Committee Chair said that he was looking for some direction of IT's future role and function within the organisation and some principles around that, some around clarity on ambition and deliverables and how the organisation might benefit from it the quickest. **Action:** The replacement digital strategy to be received at Business Committee in September 2019, before being presented to the Trust Board in October 2019 for approval. **Outcome:** The Business Committee noted the continued progress being made against the current and emerging digital priorities and the progress made in developing the digital strategy priorities and the planned timescale for its refresh.	BM
2019/20 **(14)**	**Performance management** a(i) **Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief for the first month of the financial year 2019/20. He said overall performance remained good in April 2019. A summary narrative for each domain was provided in the report. The safe and caring domains were considered on Monday 20 May 2019 by the Quality Committee. *Effective* The effective measure is reported quarterly and will appear in the July 2019 report. *Responsive* The patient contacts were in line with profile. All measures were reported as green, achieving the target. The Chief Executive suggested adding further narrative in the responsive domain to explain about the waiting times reported deteriorating since August 2018 or 9 data points below the median. *Well Led* The well led measures were positive in a number of areas, whilst appraisals remained an area requiring ongoing focus and support. The Director of Workforce (LS) said that she remained confident that appraisals were happening but the problem was with services not having confidence in the electronic staff record system. The Executive Director of Finance & Resources said that it was important to note that work was on going to target the most underperforming areas with support from workforce directorate. He said that those low performing areas were reported to the operational performance panel meetings where the general managers were accountable and were asked about their processes in their local areas and their action plans. In response to the Associate Non-Executive Director (RG) asking about the pressure ulcer trend, the Chief Executive said that there was a detailed discussion at the Quality Committee meeting and assured the Committee that at the moment there was nothing suggesting a trend. She said comprehensive work was underway by teams involved. Clinical Leads were revisiting training and pressure ulcer review panels were taking place out in the community.	

	The Executive Director of Operations said that work was continuing in the IAPT service with the waiting list initiative funded by the Commissioners to address the back log. She said the new contract was based on better modelling but the challenge remained with recruiting the right staff. The issue about not seeing people within six weeks was a direct result of an increased number of referrals for first appointments. An update on IAPT service will be included in the future performance reports. Detailed discussions took place regarding agency staff and agency cap and affordability. The Director of Workforce (LS) said that the Trust was better on substantive capacity and using bank more effectively through e-rostering system. In summary the Committee Chair said that there were some satisfactory outcomes in the well-led domains in terms of a number of issues particularly with the position of sickness absence, retention and statutory and mandatory training but concerns remained in recruitment and appraisal rates. The Committee noted that actions to remedy this were underway to get those targets on track. **Outcome:** The Committee noted the present levels of performance and determine levels of assurance on any specific points. **FINANCE** The Executive Director of Finance & Resources said that the headline for this month was that the Trust was slightly overspending. The Trust would need to take action to reduce spending by £2m to meet the control total by the end of the financial year. The Trust's cash position remained positive. The Executive Director of Finance & Resources said that if the Trust was successful in winning the IAPT bid, the overhead contribution would be in addition to the reported position. The pay award funding for public health commissioned services had now been agreed nationally. The Trust would be informed in due course of its share of the available funds. The Executive Director of Finance & Resources said that any over spending and current forecast in the business units was also discussed at the operations performance panel meetings resulting in actions to bring back in balance. **a(ia) Neighbourhood teams KPI report** The neighbourhood team dashboard report provided a detailed analysis of the position within the adult business unit for quarter four (2018/19) period. This was the last of this type of report and in future a quarterly update on this would be provided as an appendix to the monthly performance brief. The Committee Chair said that it was a very helpful report in terms of providing detailed analysis of data. The Executive Director of Operations said that she was starting to see enough evidence to close some of those workforce gaps and to lessen the requirement to use agency staff over time. **Outcome:** The Business Committee received the report. It was noted that in future this report will be combined with the quarterly triangulating quality, staffing and finance report and appended to the performance brief.	

a(ii) Performance brief annual summary report
The annual summary report was received by the Committee. No further action was recommended.

(b) Procurement update
The Executive Director of Finance & Resources introduced the paper to give the Committee an oversight of the procurement activity and performance during 2018/19, ensuring the Trust demonstrated good practice and compliance.

The annual procurement report to the Business Committee provided assurance and information regarding the efficacy of the procurement processes and evidence the delivery of the procurement strategy in support of the Trust's corporate objectives.

The Executive Director of Finance & Resources said that a major piece of work was completed to improve the procurement performance, and potentially efficiency through the roll out of the national catalogue system. Due to issues with progressing of the NHS Shared Business Services catalogue management system it had not been possible to deliver this year's savings target. The new system is expected to be more efficient and effective for people to use and generate savings. A savings of £10k had been identified for 2019/20.

The procurement structure remains the same with the Trust's Procurement Manager providing support for the Trust's purchase processes and works with Leeds & York Partnership NHS Trust (LYPFT) supplies department who deliver the transactional processes through an inter-trust contract. The Trust also receives support through the North of England Commercial Procurement Collaborative for high level tendering processes.

Outcome:
The report provided the Committee with an update on the progress of implementing the Trust's procurement strategy and noted the progress made in 2018/19 and the work being undertaken in 2019/20.

(c) Workforce strategy priority update: leadership & skills
The Committee received an update on progress and delivery on the leadership and skills development work stream within the workforce strategy. This was an update on one of the strategy's six priorities during the period October 2018 to April 2019 before being presented to the Trust Board meeting on 24 May 2019.

The Director of Workforce (LS) said that leadership and skills development was an area where significant progress had been made in the past six months. She said training dates for the calendar year 2019 are now almost full for each component of the programme. The programme aims to deliver training to 180 managers and aspiring managers before the end of 2019/20. Take up had been encouraging, with only 13 places remaining in 2019/20 across the 3 modules of the programme and there was an external interest from the GP Confederation and Primary Care Networks.

Options for increasing the programme's capacity in-year are being scoped. They were also looking to scale up the programme to meet the level of demand and adapt the programme to encourage others to run it.

A shadow board development programme had been commissioned to go live in September 2019, targeting 'below board level' senior managers. The Director of Workforce (LS) said that the proposal had been through the senior

management team, and will be presented at the Trust Board meeting on 24 May 2019.

An update on learning and development was due at the next Business Committee meeting in June 2019. The Committee Chair said that he would welcome the Head of Organisational Development & Improvement to attend.

Outcome:
The Committee noted progress made on leadership and skills development in the last six months.

(d) Operational and non-clinical risks register
The Committee considered changes to non-clinical risks on the risk register scoring 8 or above, as follows:
Risk 969 - staff shortages at Hannah House
Risk 970 - insufficient governance processes between LCH and SWYPFT (subcontractor) for mental health services at Wetherby YOI/ Adel Beck
Five non-clinical risks had been deescalated.

The Company Secretary referred to appendix one showing risks that were pertinent to the Business Committee. She said this fuller report was produced three times a year to demonstrate to the Committee how risks were managed.

The Company Secretary said that the most important part of this report was the risk themes which indicated persistent threats. Themes within the current risk register were as follows:

- Six risks relate to an increase in demand for services (high numbers of referrals and subsequent follow-on appointments)
- Five risks are concerned with shortages of staff due to vacancies, recruitment issues and the high turnover of staff
- Four risks are related to processes and systems
- Three risks relate to sickness
- Three risks are concerned with contractors and subcontractors

Outcome:
The committee noted the contents of the risk register.

(e) Board assurance framework (BAF)
The Company Secretary introduced the paper to provide the Business Committee with details of the revised BAF for 2019/20 and the responsibilities of the committees and the Board. In particular, it listed the sources of assurance the Business Committee currently had sight of, which it evaluated in order to assure the Board that strategic risks were being managed. The Business Committee has been assigned twelve of the strategic risks.

The Committee Chair suggested reviewing the BAF in a small group outside the meeting as it had been previously done. It was agreed that the Committee Chair, Associate Non-Executive Director (RG), Executive Director of Finance & Resources and Company Secretary would meet in July 2019 to review the BAF and report back to the Committee in due course.

The Committee reviewed risk 2.2 and agreed to take out the word ‘activity’ to make into a contract requirement in general, rather than being limited to activity requirements.

Action:
A meeting was to be arranged for July 2019 to review the BAF 2019/20 to

	consider whether additional sources of assurance are required by the Business Committee. (Meeting agreed for 8 July 2019). **Outcome:** The Committee noted the revised BAF 2019/20 and the strategic risks assigned to the Business Committee. Further discussions are to be had outside the meeting. **(f) Internal audit reports:** Review of bank and agency non-medical Review of well-led framework The Committee noted audits completed as part of the approved 2018/19 plan, both of which had received reasonable assurance. No other comments were noted.	
2019/20 **(15)**	**Business Committee's work plan** The work plan was reviewed by the Committee members and the following changes were agreed. • The neighbourhood team report and quality, staffing and finance triangulation report is to become one report and updates to be provided quarterly to the Committee. Scheduled service support session were agreed as follows: • IAPT – June 2019 • CAMHS waiting list – July 2019 **Outcome:** The Committee agreed the work plan.	
2019/20 **(16)**	**Matters for the Board and other Committees** The Committee Chair will provide a verbal update to the Trust Board on 24 May 2019 on: • Leeds Community pain service contract • Digital strategy • Performance brief and domain reports • IAPT service update • Neighbourhood teams report • Procurement • Leadership and skills development	
2019/20 **(17)**	**Any other business** None discussed.	

Leeds Community Healthcare NHS Trust

MINUTES

Agenda Item 2019/20 (51bii)

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 26 June 2019 (9.00 am to 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director
	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
Attendance:	Jenny Allen	Director of Workforce
	Diane Allison	Company Secretary
	Anne McGee	Head of Organisational Development & Improvement (for 21b)
	Catherine Scott	Administration Services Manager (Subject Expert) (for 20a)
	Marie Hoddell	Admin Review Project Support Officer (for 20a)
	Samantha Donaldson	Admin Review Project Manager (for 20a)
	Steve Callaghan	IAPT Service Manager (for 19a)
Apologies:	Helen Thomson	Non-Executive Director (HT)
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2019/20 **(18)**	**Welcome and introductions** **a) Apologies**: Please see above. **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. No additional potential conflict of interest regarding the meeting's agenda were raised. **c) Minutes of last meeting** The public and private minutes of the meeting dated 22 May 2019 were noted for accuracy and approved by the Committee. **d) Matters arising from the minutes and review of action log** The Committee reviewed the action log and no comments were noted.	
2019/20 **(19)**	**Business development** a) **Leeds Improving Assess to Psychological Therapy (IAPT)** (Please see private minutes) b) **Employment offer to Primary Care Network (PCN)** The Executive Director of Finance & Resources said that this was an important employment offer for the Business Committee's information; an approach which the organisation was taking, offering to work with the GP Confederation on PCN recruitment and contracts. To recruit and employ new staff on their	

behalf and then potentially, to provide a service to the PCN to enable them to discharge the contract that they had been offered to PCN.

The Executive Director of Finance & Resources said that recently a number of conversations and workshops had taken place for interested PCN representatives, to look at the workforce offer, clinical governance, finance arrangements and co-production. The Executive Director of Finance & Resources said that an agreement had been reached to continue working up a service level agreement to employ and provide those people with a SLA to the PCN.

The Executive Director of Finance & Resources said that it was more of a three way partnership; Primary Care Development currently employed by Clinical Commissioning Group (CCG), the GP Confederation, a member organisation representing the Practices who are part of the PCNs and the Trust providing the under arching infrastructure.

Outcome:
The Business Committee noted a positive conversation with the CCG. A written decision was expected from the CCG before the next development session.

c) New Care Model (NCM)
The Executive Director of Finance & Resources provided the Committee with more background to the new care model. He said the Trust had commissioning responsibility for the Child and Adolescent Mental Health Services (CAMHS) NCM for providing tier 4 beds as a pilot scheme; budget for which was £7m.

The Commissioners had now decided to go through a procurement exercise, inviting bids from lead providers to move into business as usual. The Trust was leading on CAMHS in West Yorkshire, SWYPFT led on forensic and LYPFT was leading on eating disorders. The Executive Director of Finance & Resources said that there had been a debate about partnership working and the model, either to have one lead provider for all those specialist services or to stay as is; each organisation continuing to lead on each specialism service within the overarching governance structure that West Yorkshire had established.

The Trust had opted to bid to become the lead provider of CAMHS. A Board approval was required to submit that bid on the recommendation of the Business Committee. The Executive Director of Finance & Resources said that there were clearly two risks to consider, the cohort of patients include those with learning disability and autism, currently excluded and the Commissioners also want to rebase the financial cost from the 2016/17 baseline to the 2017/18 outturn. He said in terms of the financial risk it would be seen across all partners.

The Committee was asked for its approval to submit a bid to retain the interest in becoming lead provider for CAMHS. The Executive Director of Finance & Resources said the business case was due for submission by 5 July 2019 to express an interest to continue.

The Committee Chair said that in principle he was content with the proposal but would like to see the business case before submission. The Executive Director of Finance & Resources agreed to continue with further discussions outside the meeting.

	Outcome: The Committee Chair agreed in principle to sign off the documentation subject to seeing the draft business case.	
2019/20 **(20)**	**Project management** a) **Patient administration update** (presentation) The Committee Chair welcomed representatives from the patient administration project team. The Committee was provided with an update on key milestones achieved since the last update in November 2018; the overarching workforce principles had been agreed, and a single professional structure with three leadership roles had been approved by SMT. Issues that were currently being experienced were around differences of opinion around the administration model, inconsistencies in pay grade, and differentiating between business support functions and patient administration roles. The main challenge was to achieve a balance between quality, staff morale and financial savings. The Committee heard that staff were beginning to recognise what the project was aiming to achieve. The Committee was advised that in April/May 2019 three 'to be' workshops were held for each of the business units, and a joint business support workshop looked at the business support element to standardise the protocol for business support, and identified any local support requirements needed by services. The Administration Review Project Manager said that work was underway in June and July 2019 that will help to prepare a case for change paper for SMT in August 2019 and be in a position to address some of the challenges described in the presentation slides. She said that the intension was to have the model defined by August 2019 and then start to articulate the efficiencies on that, linked to benefits realisation. The aim was to improve patient experience by streamlining the patient journey and improving patient access/entering services. It was clear that administration staff were on board with what was being achieved. There were a few complex services that may not be able to work in the model described. The complex services would be reviewed after achieving the objective of establishing the administration model. The Committee Chair thanked the representatives from the Administration Project team. He noted the key messages in terms of engagement and the work that had gone well and evaluated positively. **b) Productivity group update** The Executive Director of Finance & Resources requested that this item on the agenda be deferred to next month's meeting in July 2019. He said work was progressing, including terms of reference for the group, but not complete. **Outcome:** The productivity group update had been deferred to next month's meeting. **c) CAMHS Tier 4 update** (Please see private minutes) **d) Estates strategy** (Please see private minutes)	

2019/20 **(21)**	**Performance management** **a) Performance brief and domain reports** The Committee reviewed the May 2019 performance brief and domain reports. The Executive Director of Finance & Resources said that the overall performance remained good. The Committee was advised that management of long term absence was currently being concentrated on. Retention figures remained good, compared with the national picture, however it was agreed that the Trust should maintain its focus on this. The Chief Executive said that the Quality Committee was concerned about the increased number of incidents, but it was considered as a good indicator to have as a high level of reporting correlating with a good safety culture. The Executive Director of Operations confirmed that this was about near misses and if reporting is increased there is better focus on training and monitoring. In respond to a question from the Committee Chair about the workforce disability action plan, the Director of Workforce (JA) said that at the next Board workshop on 5 July 2019 Workforce Disability Equality Standard (WDES) would be covering expectations and standards. She said in the meantime there was continued focus on disability plan and training addressing concerns raised. A Non-Executive Director (RG) noticed that the sickness absence remained below target and well within tolerance. The Director of Workforce (JA) said that the overall sickness absence was at 5.2%, (1.7% short term and 3.5% long term). She said that over the last two years long term absence had been on the downward steady trajectory and short term sickness remained level. **Finance** The Committee was advised that although there was more risk involved in meeting the financial control total this year and that anticipated additional income would not mitigate this entirely, the Director of Finance and Resources remained confident that the control total would be achieved. It was noted that the children's business unit was forecasting £358k over spend by year end. The Executive Director of Operations said that agency staff and locum doctors in the Integrated Children's Additional Needs service (ICAN) service was driving the over spend. There was a challenge of reducing the locums from two and a half to one by September 2019 and then reduced altogether by year end. The Executive Director of Finance & Resources added that the key point in terms of the overall financial position was the achievement of cost reduction of £1.7m by end of the financial year. If the children's business unit reduced by yearend and the Trust received £700k of public health pay award and the award of IAPT contract, would bring £400k of additional contribution. b) **Learning and development update** (presentation) The Committee Chair welcomed the Head of Organisational Development & Improvement to the meeting. The Committee received an update on the delivery of the leadership and learning development offer. This included the 'leading by example' programme, the leadership competency framework, the shadow board development programme and a board leadership programme.	

	The leadership development programme was one of the key learning and development offers been established since January 2019. The aim was to deliver to 180 managers and aspiring managers. The Head of Organisational Development & Improvement said that it was evaluating well and was on track for meeting the target for the end of the year. The Committee was advised that the development programme should move the Trust to be the organisation that it strives to be. The Committee agreed that this programme was progressing at a remarkable pace. The Committee asked about the potential for marketing the programme externally and was advised that the GP Confederation had taken up this opportunity. The Committee discussed how to quantify the impact the programme was having on staff and what the indicators would be. The Head of Organisational Development & Improvement said that the statutory and mandatory training was another part of the learning and development offer to ensure that the systems and processes were clear about which group of staff needed which level of training and appropriately configured on the electronic staff record so that people were getting the right competency profile and accurately recorded. The streamlined project ensured that partners across West Yorkshire and Harrogate all work together to meet the Core Skills Training Framework (regional competency framework); enabling staff to maintain compliance if moving between organisations in Leeds and beyond. The Head of Organisational Development & Improvement said that a significant amount of work was underway around appraisals training package and tools to support a staged approach. She said the key thing was recognition of the diverse nature of workforce and that not everybody was accessing opportunities for learning and development in the same way. The team was actively engaged with BAME network, raising awareness and working on talent management approach to enable inclusivity. This was part of the talent management strategy and offered opportunities for people to take on a 'stretch' role in project management to secure the right people quickly. The Committee Chair thanked the Head of Organisational Development & Improvement and said that it was good to hear in clarity what the different steps were in terms of training programmes. **c) Operational and non-clinical risks register** The Committee considered changes to non-clinical risks on the risk register as follows: • No extreme risks (scoring 15 or more). • Two new risks • One risk had an increased score • One risk had a decreased score • One risk had been closed since the previous report. **Risks reviewed by the Committee as follows:** **Risk 975:** *Capital affordability and Business case approval of CAMHS Tier 4 Development* The estimated cost of the core scheme was over the NHS Improvement threshold of £15m. The business case approval process for the scheme can be significantly longer with consequent delay to the scheme.	

	Risk 976: *Affordability of revenue costs of new CAMHS Tier 4 service in new building* The modelling of the revenue costs of the service model for CAMHS Tier 4 in the new building being developed has resulted in a total cost significantly in excess of expected current NHS England funding levels. This was about the ongoing operational costs of service model being mitigated. **Risk 957:** *Increase in demand for the adult speech and language therapy service.* • Potential negative impact on waiting time identified as there was a delay in the date when the locums leave the service and the new starters will have been inducted. • Clinical staff covering some of the administration tasks prior to new starters taking on their roles, this meant that their capacity for addressing waiting times is reduced The Executive Director of Operations said that this was a clinical risk rather than a financial risk.	
2019/20 **(22)**	**Minutes to note** **Draft health and safety group minutes (21.05.19).** The Committee received the draft health and safety group minutes of meeting dated 21 May 2019. The Committee asked the Executive Director of Finance & Resources to review the quality of health and safety group minutes.	
2019/20 **(23)**	**Business Committee work plan** The work plan was reviewed by the Committee members and no changes were requested. **Outcome:** The Committee agreed the work plan.	
2019/20 **(24)**	**Matters for the Board and other Committees** • IAPT contract update • New care model update • Patient administration update • Estate strategy • Performance brief and domain reports • Learning and development update.	
2019/20 **(25)**	**Any other business** The Executive Director of Finance & Resources tabled a paper for the Business Committee to approve the renewal of the mobile phone contract with O2. He said that the Trust was on a rolling contract at the moment that offered poor value for money. A new 28 month contract with O2 offered the opportunity to purchase a mobile device management system service, a joint data allowance and lower tariffs. The Committee was asked to approve the signing of the contract to continue with 02. The Executive Director of Finance & Resources said that this was required to be signed by end of June 2019 in order to take advantage of the offer. The SMT had considered the options and agreed that it was the best value for money for a 28 month contract.	

	Outcome: The Committee agreed to recommend the Trust Board approves the 02 contract for providing better support for the organisation.	

NHS
Leeds Community Healthcare
NHS Trust

Agenda item 2019-20 (51c)

Chair's Report

Name of the meeting being reported on:	West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)
Date your meeting took place:	28 June 2019
Name of meeting reporting to:	Trust Board (LCH) 2 August 2019

Key discussion points and matters to be escalated:

This paper provides an update from the WYMHSC C-In-C on 28 June 2019 of which members of the four trusts were present. The full action notes are attached with the key decisions and actions highlighted below:

- The WYMHSC Joint Governor and Non-Executive Director's event held 24 June 2019 was discussed with members noting:
  - The need for feedback to be incorporated into future events including format, agenda content and meeting logistics.
  - A Dementia paper to be prepared for consideration at the System Leadership Executive Group by Yorkshire & Humber Dementia & Older People's Mental Health Clinical Networks to establish the learning and future positioning of the Dementia pilot work after March 2020.
  - Communication to Governors and NEDs to highlight the release of the Long Term Plan Implementation Framework and further opportunity to engage in the draft 5-year strategy before September.
  - Questions raised on the new Tier 4 CAMHS build.
  - Branding of the Mental Health, Learning Disabilities & Autism (MH, LD & A) programme to be discussed with the core Integrated Care System (ICS) comms team.
  - The actions and presentation slides from the event itself.

- Members noted the Transforming Care Partnerships (TCPs) update from Brent Kilmurray and agreed to start looking at the longer term model from a provider point of view; coming forward with an offer to present to NHSE/I. ICS MH, LD & Autism 5-year strategy work will help realise realistic programme priorities.
- NHSE Specialised Commissioning New Care Model (NCM) developments were discussed with three separate bids for CAMHS, Adult Eating Disorder and Forensic Services pilots to be submitted with an overarching ICS narrative.
- Assessment and Treatment Units (ATU) update provided with expectations that the final business case will come back to the C-In-C meeting on 3 October.
- Members provided feedback to be incorporated into the Forensics New Care Model, Provider Collaborative Application and acknowledged that the Mental Health Secure Care Specialist Community Forensic Team (SCFT) Trial Site Application (Wave 2) bid had been submitted.
- Additional bids have also been prepared for submission:
  - Investment in Crisis and Home treatment services – shared model for WY&H for investment in community mental health services over existing investment.
  - Early intervention for psychosis – establishing a service targeted at the cohort of people transitioning from children to adult services.

• Members noted that capturing a shared view of the benefits of working collaboratively is essential and will be worked through as part of the programme review process.	
Report by:	Brodie Clark (Vice Chair) 18 July 2019