NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (held in public)
Friday 6 December 2019, 9.00am – 12.15pm
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2019-20 (75)	Welcome, introductions and apologies: Laura Smith	Neil Franklin	N
9.05	2019-20 (76)	Declarations of interest	Neil Franklin	N
9.10	2019-20 (77)	Questions from members of the public – non notified	Neil Franklin	N
9.15	2019-20 (78)	Patient's story: Neighbourhood Team	Steph Lawrence	N
9.30	2019-20 (79)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 4 October 2019 and 1 November 2019 b. Actions' log c. Minutes from the Annual General Meeting held on 18 September 2019	Neil Franklin Neil Franklin Neil Franklin	 Y Y Y Y
		Quality and delivery		
9.40	2019-20 (80)	Chief Executive's report: • Including Health and Safety Executive contraventions letter	Thea Stein	Y
9.50	2019-20 (81)	Committees' assurance reports: a. Audit Committee: 18 October 2019 b. Quality Committee: 21 October 2019 and 25 November 2019 c. Business Committee: 23 October 2019 and 27 November 2019	 Jane Madeley Ian Lewis Brodie Clark	 Y Y Y
10.05	2019-20 (82)	Performance brief and domain reports: October 2019	Bryan Machin	Y
10.25	2019-20 (83)	Significant Risks and Board Assurance Framework (BAF) Summary report	Thea Stein	Y
10.35	2019-20 (84)	CAMHS • CAMHS New Care Models	 Bryan Machin	 Y
10.45	2019-20 (85)	Serious incidents summary report	Steph Lawrence	Y
10.55	2019-20 (86)	Patient safety and experience: six monthly report	Steph Lawrence	Y
11.00	2019-20 (87)	Freedom to Speak Up Guardian Report	Thea Stein	Y
11.10	2019-20 (88)	Guardian for Safe Working Hours Report	Turlough Mills	Y
11.20	2019-20 (89)	Standards for partnership governance	Bryan Machin	Y
11.30	2918-20 (90)	Healthcare worker flu vaccination best practice management checklist	Steph Lawrence	Y
		Strategy and planning		
11.40	2019-20 (91)	Workforce Strategy 2019-21: Diversity and Inclusion	Jenny Allen/Laura Smith	Y
11.50	2019-20 (92)	Digital Strategy 2020-2023	Bryan Machin	Y
		Reports		
12.00	2018-19 (93)	Board workplan	Thea Stein	Y
		Any other business		
12.05	2018-19 (94)	Major Incident Plan: to note approval in the Private session of the Board on 4 October 2019	Sam Prince	N
		Minutes		
12.10	2018-19 (95)	Approved minutes (for noting): a. Audit Committee: 1 August 2019 b. Quality Committee: 23 September 2019 and 21 October 2019 c. Business Committee: 25 September 2019 and 23 October 2019 d. West Yorkshire Mental Health Services Collaborative-Committees in Common: Chair's report 3 October 2019 e. West Yorkshire Mental Health Services Collaborative-Committees in Common: Minutes 3 October 2019	Neil Franklin	 Y Y Y Y Y
12.15	2018-19 (96)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public) Friday 7 February 2020, 9.00am - 12noon

Leeds Community Healthcare NHS Trust

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

Agenda item 2019-20 (79ai)

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

Friday 4 October 2019, 9.00am – 12.00 noon

Present:	Neil Franklin	Trust Chair,
	Thea Stein	Chief Executive
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
Apologies:	Brodie Clark	Non-Executive Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
In attendance:	Diane Allison	Company Secretary
	Margaret Duke	Aspirant Non-Executive Director Programme Participant
	Andrea North	General Manager Specialist Business Unit (for item 57)
	Jayne Burnett	Clinical Lead TB Service (for item 57)
Minutes:	Liz Thornton	Board Administrator
Observers:	Suzanne Slater	Clinical Governance Manager, Shadow Board Participant
	Sophia Nicholls	Organisational Development Lead, Shadow Board Participant
	Stuart Murdoch	Deputy Medical Director
Members of the public:	One member of the public was in attendance.	

Item	Discussion points	Action
2019-20 (53)	**Welcome and introductions** The Trust Chair welcomed Board members, a member of the public and members of staff attending the meeting. The Chair advised that as part of leadership development in the Trust a 'Shadow Board' had been established. He said that they had held their first meeting on the	

	3 October 2019 and their discussions and conclusions about some of the Board papers would be relayed to the Trust Board by the Executive Director of Finance and Resources who also chaired the Shadow Board during this meeting. **Apologies** Apologies were noted from Brodie Clark, Non-Executive Director and Jenny Allen, Director of Workforce, Organisational Development and System Development.	
2019-20 (54)	**Declarations of interest** Prior to the Trust Board meeting, the Trust 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 Board members. There were no declarations of interest made in relation to any items on the agenda.	
2019-20 (55)	**Questions from members of the public** There were no questions from the member of public in attendance.	
2019-20 (56a) **2019-20 (56b)**	**Minutes of the previous meeting held on 2 August 2019 and matters arising** The minutes were reviewed for accuracy and agreed to be a correct record. **Items from the actions' log** The Trust Chair noted that there were no outstanding actions to address	
2019-20 (57)	**A patient's story** The Executive Director of Nursing and Allied Health Professionals introduced the patient's story item and welcomed Jayne Burnett, Clinical Lead, Community TB Service and Andrea North, General Manager, Specialists Services. The Clinical Lead explained that although tuberculosis numbers nationally were reducing, cases were becoming more complex and many patients were vulnerable people, for example the homeless and people suffering from alcohol and drug abuse. This story was about a vulnerable man from Eastern Europe who was approached by members of a traveller community and on the promise of a better life he was trafficked to the UK where he became a victim of modern day slavery. When he arrived in the UK his passport was taken from him and he was taken to a traveller camp where he was made to undertake manual work with long hours for no pay. He worked in these conditions around the country for 12 years. In June 2016 he became unwell and was admitted to a hospital where he was diagnosed with Pulmonary TB. He received initial treatment but was never followed up in the community as he had no permanent address. On discharge he returned to the traveller's site because he had nowhere else to go. Eventually he managed to escape and whilst living on the streets he found out that the Salvation Army provided specialist support for all adult victims of modern slavery. Their first responders helped him to access a victim care fund through the National Crime Agency. He arrived in Leeds he was provided accommodation by the Palm Cove Society, an organisation sponsored by the Salvation Army. They work as a halfway house to give individuals time to breathe and develop life skills again and they provide shared housing. Not long after arriving at Palm Cove he became unwell and was referred to the Community TB services. The TB had spread throughout his body and into his central nervous system, he was extremely unwell and was hospitalised for 4 months. As a result he lost his accommodation at Palm Cove.	

	The Community TB Service, by working in partnership with other stakeholders across the city developed a local pathway which was trialled with this patient. The Clinical Lead explained that the pathway instigated a process by which social care colleagues carried out an initial assessment and if there were no social care needs they made a referral to housing options for an assessment for accommodation and subsistence payments. Through this pathway the Team managed to secure the patient a property and a small weekly allowance. On discharge from hospital it became apparent that the patient had had lost all daily life skills for example preparing food and showering during his years in slavery. It was clear he was depressed and a psychology assessment was arranged. The Team carried out daily observed therapy, and worked with the neighbourhood teams to ensure he received support at weekends and Bank holidays. Occupational Therapist worked with him to support him to cook and keep clean. They also took him shopping and in time he became more independent and happier. The Clinical Lead explained that as a caseload manager she had twelve months to help him back into society, the Team supported him in accessing English classes, visited the council one stop shop for assistance with applying for jobs to prepare him for work once he was fit enough, registered him with a GP practice and accompanied him to various employment agencies. The Clinical Lead explained that she had worked closely with Citizens UK, taking the patient to meetings which had enabled him to apply for universal credit, Citizens UK also arranged for him to meet with specialist lawyers to help him prove that he had the right to reside in the UK. The patient was now in safe accommodation and in paid employment. The Chair said that he was impressed to hear such a powerful story and invited questions from members of the Board. In response to a question from Non-Executive Director (RG), the Clinical Lead said that close links have also been maintained with Leeds City Council's Public Health Department and social services and a whole new way of working in Leeds has been developed, not only are the Community TB Service signposting services they are also working as one integrated service to meet patients complex needs and provide true patient centred care within the community which will result in patients receiving the resources they need in a more timely manner. The Executive Director of Nursing and Allied Health Professionals congratulated the Team on developing the pathway which she said had taken a significant amount of work and a great deal of tenacity. The Chair thanked the Clinical Lead for taking time to present the story to the Board, which he said illustrated the positive impact the work of the Community TB Service had had on this individual's life and the potential for the pathway to impact on the lives of other patients in the future.	
2019-20 (58)	**Chief Executive's report** The Chief Executive presented her report which provided the Board with an overview of the Trust's activities in support of its strategic objectives, the items highlighted included: • Annual General Meeting • Working with Primary Care Networks (PCNs) • Leeds Virtual Frailty Ward	

	• New assistant directors • Flu vaccine campaign • Staff survey 2019 • NHSE/I oversight framework 2019/20 • Communications report for August The Chair the Quality Committee and Non-Executive Director (IL), referred to the Infant Mental Health Service annual report for 2018-2019 which he said should be an exemplar for reports produced by other services in the Trust. He noted the reference to the service accepting 95% of referrals but given the significant impact the service had on the lives of young people he wondered if resources could be invested in increasing this to 100 per cent. It was noted that the Clinical Commissioning Group have made new money available to increase the scope to an older age range. The Executive Director of Operations said that when referrals were made to the Team they were considered on a balance between patient care and training as a key factor. She said that it was important to look at the Team's work alongside that of the 0-19 service, the investment in both services would be kept under review and the allocation of any new funding would be considered very carefully. In relation to the production of annual reports, the Executive Director of Operations observed that not all services were resourced to be able to produce similar reports. The Trust Chair reported that he had been able to observe the Youth Board in action, where five engaged young people had been in attendance. He said that the Youth Board would be working closely with the Quality Committee and he looked forward to seeing how it developed over the next year. The Chief Executive reported that a new Children's Mayor had been elected in Leeds on a winning manifesto about supporting the mental health of children in schools. She said that she intended to invite the new Mayor to visit the Trust in the near future. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	
2019-20 (59)	**Assurance reports from sub-committees** **Item 59(a) Charitable Funds Committee 20 September 2019** The report was presented by the Committee Deputy Chair and Trust Chair (NF) who highlighted the key issues discussed, namely: • **Finance report** - The Committee felt that there was more work to do on better defining the appropriate criteria for using charitable funds within the Trust. The Executive Director of Finance would be taking this piece of work forward. • **Annual report and accounts 2018/19** – these were signed off by the Committee. There were no questions raised about the report. **Item 59(b) Nominations and Remuneration Committee 20 September 2019** The report was presented by the Committee Chair and Trust Chair (NF) who highlighted the key issues discussed, namely: • **Clinical Excellence Awards (CEA) –** the CEA award panel for the 2018/19 had met on 27 August 2019 and five employer based CEA awards	

had been awarded to the suggested consultants.

There were no questions raised about the report.

Item 59(c) Quality Committee 25 September 2019
The report was provided by the Committee Chair and Non-Executive Director (IL) who highlighted the key issues discussed, namely:

- **Quality Spotlight -** focussed on palliative and end of life care. Two stories were presented; one by the Children's Business Unit and one by the Adult Business Unit.
  Future spotlight presentations would include a greater focus on learning.
- **Duty of Candour –** an audit into compliance with the statutory Duty of Candour process had concluded that there were inconsistencies in the way the information was captured and the timescales for responses. The Committee had received reasonable assurance that the action plan produced in response to the audit recommendations would address the issues. Future assurance would be provided through the performance brief.
- **Mortality report –** the Committee was advised that people with learning disabilities and those with serious mental illness appeared to be underrepresented in the Trust's mortality data. This was due in part to the fact that GP data codes couldn't be transferred onto the Trust's system; steps were being taken to resolve this.
- **Research and Development Strategy –** the Committee received an update on the progress being made with the draft strategy. The strategy's scope had been expanded in the light of previous comments by the Committee about including targets which were too ambitious for the timescales involved.

There were no questions raised about the report.

Item 59 (d) - Business Committee 25 September 2019
The report was presented by the Committee's Deputy Chair and Non-Executive Director (RG) who highlighted the key issues discussed, namely:

- **Standards of Partnership Governance –** the Committee reviewed the draft standards and welcomed the proposed approach for the management of partnership arrangements and received assurance that it had been tested out by business managers and the internal auditor, all of whom had provided positive feedback.
- **Performance Brief –** the committee reviewed the performance data for August 2019 and were apprised of a risk concerning the new care model, CAMHS Tier 4 and the Trust's budgets. More detail would be provided under item 60 on the agenda.
- **Triangulation –** the Committee received the quarterly update on quality, staffing and finance in the neighbourhood teams, triangulated into one report. Overall the position was stable and the Committee was advised that the Trust was in a similar position to that nationally.

  In response to a question from Non-Executive Director (IL), the Executive Director of Operations confirmed that in future the Quality Committee would also receive the report as a standalone paper.

  Referring to the update provided on the Administration Review Project in relation to the resolution of a significant legacy issue, Non-Executive Director (JM) observed that it was important to ensure that enough time and resources were focussed on this project.

	Outcome: The Board noted the update reports from the committee chairs and the matters highlighted.	
2019-20 (60)	**Performance brief and domain reports August 2019** The Executive Director of Finance and Resources presented the report, which highlighted any current concerns relating to contracts that the Trust holds with its commissioners and provided a focus on key performance areas that were of concern within the Trust during August 2019. The Executive Director of Finance and Resources said that the overall performance remained good in August 2019. The report was structured in line with the Care Quality Commission (CQC) domains with the addition of finance. ***Safe and caring*** 30% of all the patient safety incidents in August 2019 originated from external providers The Executive Director of Nursing and Allied Health Professionals reported that this was currently being discussed with the other providers and an update would be provided in future reports. ***Effective*** The Board noted that data for this domain was reported on a quarterly basis. The data for Quarter 1 was included in this report as it had been omitted from the report in June 2019. The Executive Director of Finance and Resources reported that the Shadow Board had expressed concern that priority 1 and priority 2 audits were currently behind schedule and felt that the assurance on further progress was not adequate. The Chief Executive said that the Quality Committee and the Senior Management Team had received good feedback on the outcomes and learning from completed audits but acknowledged that this could be reflected more strongly in the reports presented to the Board. ***Responsive*** The Board noted that the IAPT targets remained a challenge and the Trust continued to work with commissioners on waiting list initiatives. ***Well-led*** The Board noted that in August turnover remained low at 13.1%. Sickness absence remained lower than in previous years at 4.8% this was continuing a downward trend in recent months where overall sickness absence had been below 5%. Appraisal compliance rates continued to improve steadily and currently stood at 87.2%. The Chief Executive said that the improvement was due to a range of measures which had been put in place to improve the quality of appraisals and rates were showing a considerable improvement over the same time last year. The Board heard that the Statutory and Mandatory Training Compliance had fallen to 87.4%; this was linked to organisation–wide amendments to Infection Prevention and Control Training as part of the Statutory and Mandatory Compliance Training Project. The Board noted that these changes were initiated in August 2019 and some difficulties had been encountered in the migration of data. Rates were expected to	

	improve as the problems were resolved. ***Financial position*** The Executive Director of Finance and Resources said that the year to date financial position remained consistent with previous months and overall the surplus was 0.1m more than planned. The Trust continued to forecast delivery of the control total at the end of March 2020. The Trust had a forecast shortfall on 2019/20 CIP efficiency savings for the year; this would be mitigated by un-planned savings elsewhere. All other finance targets were forecast to be achieved for the year. The Executive Director of Finance and Resources provided a verbal update on an emerging financial risk. The Board was reminded that the financial planning assumption for the 2019/20 development costs of the new CAMHS Tier 4 unit was that they would be funded from an underspend on the CAMHS New Care Model; the anticipated development costs being less than the level of underspend in 2018/19. However, the Executive Director of Finance and Resources reported that patient activity data on the national database indicated a significant overspend on the New Care Model budget this year. He explained that this seemed to be due an increase in the average length of stay of patient admitted. He said that the New Care Models Team had already begun to refocus their efforts on this. He said that if the reported position did not improve the Trust potentially had no funding for the Tier 4 Unit development costs or its share of the New Care Models overspend. The Executive Director of Finance and Resources said that both of these financial risks were very significant. He said that he was working to clarify the uncertainties on the patient activity database and on mitigations to any financial risk that remained. A Non-Executive Director (JM) asked for clarification of the revenue development costs for the last year and this year. The Executive Director of Finance and Resources confirmed that they were £600K £800k respectively. A Non-Executive Director (IL) asked if the current overspend position was due to out of area referrals, and if the Trust had any influence over them. The Executive Director of Finance and Resources confirmed that this was a factor and there was a renewed focus on this. **Outcome:** The Board noted the Trust's performance for August 2019.	
2019-20 (61a)	**Significant risks and Board Assurance Framework Summary Report** The summary report provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures. It also provided an analysis of risk movement, presented the risk profiles, identified themes, and linked these material risks to the strategic risks on the Board Assurance Framework (BAF). The Board noted: • No risks scoring 15 or above • The three strongest themes were ➢ staff sickness absence, vacancies, retention of staff ➢ an increased demand for services ➢ work processes A Non-Executive Director (JM) observed that the paper reflected the process underpinning risk management but she felt that future reports should reflect more information about individual risks.	

2019-20 (61b)	The Company Secretary agreed to consider the format of future reports. **Action:** The Company Secretary to consider how future reports could better reflect more detail on individual risks and themes. **Outcome:** The Board; • noted revisions to the risk register • noted the current assurance levels provided in the revised BAF summary **Mid-year proposed revisions to the Board Assurance Framework (BAF) 2019- 20** The Chief Executive introduced the report which presented the changes made to the BAF following the reviews undertaken by the Chairs of the Audit, Business and Quality Committees. She added that all three committees were supportive of the proposed changes in the report. **Outcome:** The Board: • approved the mid-year amendments to the BAF risks for 2019/20 • considered and confirmed reassignment of risk 4.1 to the Trust Board	**Company Secretary**
2019-20 (62)	**Organisational priorities position report** The Executive Director of Finance and Resources presented the report which provided an update on progress on the 15 priorities set out in the Trust's 2019/20 Operational Plan. He said that good progress had been made against the majority of priorities with only two priorities which were not on track; the digital strategy and the CAMHS Tier 4 new inpatient building and service model. A Non-Executive Director (IL) referred to Priority 12: develop an innovative and viable model for the CAMHS Tier 4 service to the agreed time-frame and asked what measures had been put in place to reduce unwarranted variation. The Executive Director of Operations explained that a project had been developed to look at variation and benchmark results across each business unit. The project would focus on process including a review of the number of patients seen, length of contact and length of caseload. A report would be made to the Business and Quality committees when the project was complete. The Executive Director of Finance and Resources reported that the Shadow Board had agreed that the report reflected the positive progress made against the 15 priorities but noted the tension between ambition and the capacity to deliver. **Outcome:** The Board: • noted the report • noted areas of achievement and those still to progress	
2019-20 (63)	**Engagement strategy** The Executive Director of Nursing and Allied Health Professionals presented the Strategy which provided the Trust with a framework for patient experience and engagement work for the next three years. She explained that an operational plan was being developed to ensure the strategy is implemented effectively. The Executive Director of Nursing and Allied Health Professionals advised that the strategy had been reviewed in depth by the Quality Committee and an implementation plan would be monitored through the relevant forums; this would include agreeing the resources required to support the strategy. The Board noted that a progress report would be presented to Quality Committee on a regular basis	

	and to the Trust Board as part of the report on Patient Experience twice each year. The Board reviewed the strategy in detail and members made a number of observations: Non- Executive Director (JM) said that she was pleased to see that the vision within the strategy was to build on the good work already in place, involve and listen to patients and put them at the heart of care, however she felt that it should include more detail about how it would make a difference to patients and the wider community. The Executive Director of Finance and Resources reported that the Shadow Board felt that they could approve the strategy subject to the inclusion of more information about the connection between the strategy, the city wide partnership work and the various city wide strategies in order to better reflect the shift of services into the community. The Executive Director of Nursing and Allied Health Professionals acknowledged that more work was needed to make the strategy a more outward facing document before it was finally published. **Outcome:** The Board approved the strategy subject to: • the strategy including more reference to the partnership work and links to city wide strategies • more information about how the strategy would improve the health of patients and more reference to the patient voice • strengthening references to the engagement work already in place It was agreed that the Trust Board would have oversight of this important agenda.	
2019-20 (64)	**Workforce strategy 2019-2021 :Progress and Delivery - Health and wellbeing** The Director of Workforce, Organisational Development and System Development (LS) presented the report which provided an update on progress and delivery of the Health and Wellbeing workstream within the Workforce Strategy. She highlighted the significant progress which had been achieved over the last six months on reducing sickness absence rates, developing the Workforce Disability Equality Standard action plan and training around the Equality Act 2010 and Reasonable Adjustments to equip managers with skills and knowledge. In response to a question from Non-Executive Director (RG), the Director of Workforce, Organisational Development and System Development (LS) explained that comparative data with other Trusts was sought every six months. A Non-Executive Director (HT) noted that the Trust had trained 16 staff as Mental Health First Aiders and asked whether there were any plans to train more. The Director of Workforce, Organisational Development and System Development (LS) said that the Trust would evaluate how this was working in practise. The Executive Director of Finance and Resources reported that the Shadow Board reviewed the report and thought that it was an accurate reflection about how staff felt about the progress made to improve staff health and wellbeing over the last six months. **Outcome:** The Board: • noted the progress made on Health and Wellbeing since April 2019 • endorsed the approach identified for this workstream during 2019/20	

2019-20 (65)	**Implications of the Amin Abdullah review** The Director of Workforce, Organisational Development and System Development (LS) presented the report and provided the background and context to the case. The report updated the Board on the findings from an Independent Inquiry and the NHS England and NHS Improvement Task and Finish Advisory Group, into a tragic event which had occurred at a London NHS Trust. NHS England and NHS Improvement had formally written to all NHS Trusts asking that HR Teams and the Board review the guidance and recommendations, assess their current procedures and processes and make adjustments where required to bring their organisation in line with best practice. The Director of Workforce, Organisational Development and System Development (LS) said that currently the Trust was fully compliant with three recommendations, partially compliant with four and there was a further three the Trust was not compliant with. The Board reviewed and considered the RAG rated self-assessment against the recommendations and commented on the actions against the recommendations rated as no compliant. In response to a question from Non-Executive Director (JM), the Director of Workforce, Organisational Development and System Development (LS) advised that all important communication with individuals who were subject to an investigation and disciplinary procedure did take place face-to-face. She agreed to ensure that this was made clear in the Communications Plan. The Board discussed the recommendation about individuals who suffer physical and mental harm, and this being treated as a 'Never Event' and be subject to investigation. The Director of Workforce, Organisational Development and System Development (LS) agreed to ask NHS Employers how this recommendation was being approached by employers across the NHS. **Action:** The Director of Workforce, Organisational Development and System Development (LS) to contact NHS Employers. The Board agreed that it would be challenging for the Task and Finish Group to balance the need to protect the interests of the individual and the interest of the organisation and a pragmatic approach would be required. In response to a question from a Non-Executive Director (HT), the Director of Workforce, Organisational Development and System Development (LS) reported that to ensure the organisation was in line with best practice the Trust was working with the Yorkshire and Humber HRD Network. The Trust was also working to ensure that individuals who worked across two organisations were not subject to two different investigation and disciplinary procedures. **Outcome:** The Board: • noted the key points from the Independent inquiry and NHS England and NHS Improvement • reviewed and commented on the RAG rating self-assessment • commented on the suggested next steps and associated timescales	**Director of Workforce, OD and System Development**
	The Executive Director of Nursing and Allied Health Professionals left the meeting.	

2019-20 (66)	**Draft estate strategy** The Executive Director of Finance and Resources presented the draft strategy. He explained that the draft had been considered in depth by the Business Committee who had agreed it should be put forward to the Board for approval. The Executive Director of Finance and Resources described the strategy as an enabling strategy which would ensure better utilisation of the Trust's estate and open up possibilities for the estate to support different and improved ways of working. A Non-Executive Director (IL) observed that the different ways of working described in the strategy would impact on clinicians and teams across the Trust and he asked whether staff had been consulted during its development. The Executive Director of Operations said that although it had not been possible to consult with individual members of staff there had been significant input from teams who were changing the way they delivered services. The aim was to fully engage with staff and patients in developing the plans that would complement the strategy. She added that the strategy would also be reviewed by the Scrutiny Board. A Non-Executive Director (JM) asked whether there were implications for the strategy in light of the recent Health and Safety Executive (HSE) Inspection and that the themes from their report should be referenced within the strategy. The Executive Director of Finance and Resources conformed that the key theme from the HSE Inspection was on risk assessments and this was included in the strategy. **Outcome:** The Board: • approved the estate strategy	
2019-20 (67)	**Safeguarding annual report 2018/19** The Executive Director of Operations presented the report on behalf of the Executive Director of Nursing and Allied Health Professionals which provided information and assurance to the Board that the Safeguarding Team and all staff within the Trust were committed to the safeguarding agenda and were compliant with current legislation, best practice and evidenced based care. The Executive Medical Director noted the level of information contained within the report on Sudden Unexpected Death in Infancy and Childhood (SUDIC) and would ensure that this was included in the Mortality Report. The Chair of the Quality Committee and Non-Executive Director (IL), advised that the Quality Committee had reviewed the report and commended it to the Board for approval and publication. **Outcome:** The Board: • Noted the content of the Safeguarding Annual Report 2018/19 and approved its publication.	
2019-20 (68)	**Infection Prevention and Control annual report 2018/19** The Executive Director of Operations presented the report on behalf of the Executive Director of Nursing and Allied Health Professionals, which provided information to the Board in relation to infection prevention and control activities within the Trust and assurance that the organisation was compliant with current legislation, best practice and evidence based care.	

	The Trust Chair commended the work of the team and placed on record the Board's congratulations to the IPC Team who had recently won the Infection Prevention Society award for team of the year and to Joanne Reynard, Senior Infection Prevention Nurse who was deservedly awarded practitioner of the year. The Chair of the Quality Committee and Non-Executive Director (IL) reported that the Quality Committee had reviewed the report and key plans for 2019/20 in detail and commended it to the Board for approval. Non-Executive Director (RG) noted that a central fund had been agreed to support clinical teams who could not replace condemned furniture on existing ward environment budgets and asked what plans had been put in place to utilise this funding. The Executive Director of Operations advised that an action plan would be developed to identify how the available funding would be spent. **Outcome:** The Board: • approved the infection and prevention control annual report 2018/19 for publication and the key plans for 2019/20.	
2019-20 (69)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information. She said that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	
2018-19 (70)	**Approved minutes for noting:** The Board noted the following final approved committee meeting minutes: a. Quality Committee: 22 July 2019 b. Business Committee: 24 July 2019 c. Audit Committee: 22 May 2019	
2019-20 (71)	**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 6 December 2019, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

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Signed by the Trust Chair:
Date: 6 December 2019

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (79aii)

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

Friday 1 November 2019 12.15pm – 1230pm

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Executive Medical Director
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Jenny Allen	Director of Workforce, Organisational Development (OD)and System Development (JA)
	Laura Smith	Director of Workforce, Organisational Development (OD)and System Development (LS)
Apologies:	Brodie Clark	Non-Executive Director
In attendance:	Diane Allison	Company Secretary (minute taker)

Item	Discussion points	Action
2019-20 (72**)**	**Declarations of interest** There were no declarations of interest made for the item on the agenda.	
2019-20 (73)	**Community Dental Services Reconfiguration** The Executive Director of Operations presented a paper that outlined the case for reducing the Community Dental Services delivery sites and provided details of the public consultation which had taken place. The Board was advised that the new Community Dental Services contract awarded to LCH In October 2018 had posed some challenges and the proposed solution was to reduce the number of sites from five to three, in order to provide the enhanced service required within the cost envelope. The Business Committee had considered the options appraisal at its meeting in October 2019 and recommended that the Board should approve the reduction to three sites from January 2020. The Scrutiny Board had also agreed to the proposal.	

	A Non-Executive Director (JM) asked whether there had been sufficient engagement with the public and scrutiny. The Executive Director of Operations confirmed that there had been sufficient ground work completed in terms of engagement exercises and appropriate scrutiny, including engagement with Healthwatch. The Chief Executive asked whether a quality impact assessment had been completed and this was confirmed. The Board discussed the need to be mindful of the forthcoming general election. **Outcome** The Board approved the proposed reconfiguration of the Community Dental Services	
2019-20 (74)	**Close of the extraordinary (public) Board** The Chair concluded the Board meeting.	
Date and time of next meeting **Friday 6 December 2019, 12.00– 1.00pm** **Boardroom, Leeds Community Healthcare NHS Trust,** **Stockdale House, Victoria Road, Leeds LS6 1P**		

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Signed by the Trust Chair: Neil Franklin
Date: 2019

AGENDA ITEM 2019-20 (79b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 6 December 2019

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting 4 October 2019				
2019-20 (61a)	Significant risks and BAF: consider format of future reports to better reflect more detail on individual risk themes	Company Secretary	December 2019	Completed
2019-20 (65)	Implications of the Amin Abdullah review: to contact NHS Employers to find out how the recommendation relating to individuals who suffer physical and mental harm as part of the disciplinary procedure to be recorded as a 'never event' is being approached by employers in the NHS.	Director of Workforce, System Development and OD	December 2019	Verbal Update 2 December 2019

Actions on log completed since last Board meeting	
Actions not due for completion before 6 December 2019; progressing to timescale	
Actions not due for completion before 6 December 2019; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 6 December 2019; not having met agreed timescales and/or requirements	

V1 24 10 2019

NHS
Leeds Community Healthcare
NHS Trust

Leeds Community Healthcare NHS Trust
Annual General Meeting – 2018-19

Agenda item 2019-20 (79c)

Thackray Medical Museum, Beckett Street, Leeds LS9 7LN

Tuesday 18 September 2019, 11.00am – 12.30pm

Present:	Neil Franklin	Trust Board Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Dr Ruth Burnett	Executive Medical Director
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
Apologies:	Jenny Allen	Director of Workforce, Organisational Development (OD) and System Development
	Laura Smith	Director of Workforce, Organisational Development (OD) and System Development
In attendance:	Diane Allison	Company Secretary
Minutes:	Liz Thornton	Board Administrator
Observers and members of the public:	68 members of staff and members of public attended	

Item	Discussion item
1.	**Welcome and introductions** The Trust Chair welcomed everyone to the Trust's 2018/19 Annual General Meeting (AGM) on behalf of the Board of directors. The Trust Chair said that 2018/19 had been a great year for the Trust in terms of the significant improvements made in the standards of care and managing within its allocated finances whilst continuing to keep the patient at the heart of its business. He spoke about the priorities of maintaining the highest quality services for the people of Leeds; the importance of effective partnerships with other health and social care providers and the importance of exploring new and effective ways of delivering services to ensure the Trust continued to work within the allocated funding. The Trust had a wonderful and dedicated workforce, both clinical and corporate and the Trust Chair said that he had visited many of these teams and seen them in action during the course of the year. He said that an engaged and happy workforce improved patient

	outcomes and the Trust was committed to supporting the health and wellbeing of all staff. The Trust Chair said that he was pleased to see that this year's annual report contained many examples of the Trust's services growing and developing. He highlighted in particular the progress being made towards building a new Child and Adolescent Mental Health Service in-patient unit. He said that the facility would serve the needs of children and young people from across West Yorkshire and the views of young people, staff and local people had been sought and would be at the heart of the delivery of this important project. The Trust Chair briefly outlined the format for the formal part of the meeting. The Chief Executive would present a review of the 2018/19 year and the Executive Director of Finance and Resources would present the Trust's 2018/19 annual accounts. A number of the Trust's Executive and Non-Executive Directors were present and there would be an opportunity for questions at the end of these presentations. The Trust Chair advised that, as the Annual General Meeting was a formal meeting of the Leeds Community Healthcare NHS Trust Board, it would minuted in the same way as all Board meetings, the minutes would be published on the Trust's website in the papers for the Board meeting on 6 December 2019.
	Chief Executive's presentation – reviewing the year 2018/19 The Chief Executive presented a review of the previous 12 months. She said that she particularly welcomed this opportunity to reflect on the past year and to recall her aspirations when she had joined the Trust five years ago as Chief Executive; when she had welcomed the opportunity to be part of an organisation which had a clear vision which was used every day to guide the Trust. The Chief Executive said there were many highlights she wanted to speak about with a particular focus on some of the work the Trust had done in partnership with others across Leeds, West Yorkshire and nationally to work as an organisation without walls and boundaries. She spoke about the work undertaken as part of the Partnership Executive Group, the System Resilience Team, the West Yorkshire Health Partnership. Leeds Academic Health Partnership, the personal medicine board, the stroke pathway steering group, the Committee in Common with the GP Confederation and the Primary Care and Community Services West Yorkshire Group. She highlighted a number of the biggest successes. The creation of a new alliance and team that would be working together to run Leeds Mental Health and Wellbeing Service formally known as the IAPT service. Eleven partners were working together and this had been a massive achievement. The Stroke Service had risen to the challenge to work in different ways and develop and change at an extraordinary pace. Big partnerships with the GP Confederation, the Council and other NHS Trusts to change services at a local level. The Chief Executive referred to the launch of the Youth Forum, which would impact on the way services were run and information provided. The launch of the the 0-19 services for the city of Leeds which was the new integrated health visiting and school nursing service which would work in different ways to provide the best possible support to families and children. The development of 'Chathealth' a confidential text based service for young people to ask questions about their health. She expressed her thanks to all community staff and their managers for the resilient manner in which they had faced the challenges 365 days a year. She said that team working and partnership was based on a good and supportive and engaged culture in an

	organisation. This year the indicators were that the culture and engagement within the Trust was going from strength to strength with good retention, lower staff sickness and good work across mental health and wellbeing and the development of reverse mentoring for BME communities, more training for staff in supporting the workforce with a disability and the launch of the rainbow badge in the Trust. In conclusion, the Chief Executive said that 2018/19 had been an exciting year, the Trust had achieved a great deal to be proud of and she looked forward to even greater progress in 2019/20. The Trust Chair thanked the Chief Executive for her report.
3.	**Executive Director of Finance and Resources** **Presentation of annual report and accounts 2019/20** The Executive Director of Finance and Resources provided a presentation and overview of the Trust's annual report and accounts for 2019/20. The Executive Director of Finance and Resources was pleased to report that although the national financial position in the NHS had been placed under considerable pressure, the Trust had maintained financial stability and had met all its key financial duties. The Trust had achieved a surplus of income over expenditure of just over £5.6 million in 2018/19, exceeding the income and expenditure surplus target set by NHS Improvement. During the year the Trust had taken advantage of an opportunity offered by NHS Improvement to improve the planned surplus by £0.5 million in return for £1 million additional Provider Sustainability Funding (PSF). He said that the PSF funding would be used to support the costs of the CAMHS in-patient facility being provided at St Mary's Hospital site. The Trust had also received further PSF £1.6 million at the end of the financial year as part of the national share of the PSF not earned by trusts nationally during the year. He added that this additional PSF was provided as cash only and could not be spent on day to day running costs. The Executive Director of Finance and Resources said that the Trust's financial results were only achieved through the hard work of all the staff; balancing their desire to continue to provide high quality care within a finite budget that required further efficiency savings every year. The Executive Director of Finance and Resources observed that 2019/20 would be another challenging year financially for the NHS but the Trust was determined to maintain good financial health in order to focus on the delivery of quality care. The Trust Vice Chair thanked the Executive Director of Finance and Resources for his presentation.
4.	**Question and answer session** The Trust Chair opened this section of the meeting by inviting questions and comments. He said that Trust Board members were in attendance and would assist in answering questions. **Question:** A member of the public asked what progress has been made with the development of the CAMHS residential unit at St. Mary's Hospital, with special reference to procurement of the building and services to be provided, with the financial difficulty experienced by Interserve. The Executive Director of Finance and Resources explained that the award of the

contract had been made following open competition with Interserve being awarded the contract to build the unit. Maintenance and domestic services to support the unit would be subject to a separate contract process which had not yet been completed.

The company had been re-structured and some additional protections had been put in place regarding payments.

Question:
A member of the public asked whether The Trust had treated any patients from abroad without receiving payment.

The Chief Executive said that this was not an issue for the Trust. Leeds Teaching Hospitals NHS Trust would be obliged to provide information about the number of patients they treated from abroad if a freedom of information request was made.

Question:
A member of the public was concerned about further privatising of the NHS and asked the Trust to consider this when awarding contracts.

The Chief Executive reported as a provider organisation the Trust primary focus was bidding for contracts rather than awarding them.

Question:
A member of the public was concerned about the services provided to patients who were unable to administer their own medication. Her experience as carer suggested that nurses were only able to undertake initial assessments and did not have time to assist with administering long term medications. She recommended that the Trust should support patients with dementia by working with mental health trusts and the Local Authority to ensure that medication was administered.

The Executive Director of Operations said that the Trust supported many patients with medicine prompts and the administration of medication where there was a clinical need or the patient was receiving services from the neighbourhood team. She said that staff also worked with patients, their families and adult social care providers to support them with the administration of medication in the short and long term. She said that patients could contact their local Community Hub, neighbourhood network or ask their GP for referral to the pharmacy technician for further help.

Question:
A member of the public was concerned about reports that NHS Trust were being asked to pay 6% interest on any money they borrowed.

The Executive Director of Finance and Resources reported that the Trust did not borrow money therefore the repayment of interest was not an issue.

Question:
A member of the public asked what the Trust was doing to encourage more patient and public involvement and using support from volunteers.

The Chief Executive said that using volunteers was not simple for a community trust, as many services were provided in the patient's home, but she said that the Trust would continue to look for opportunities for volunteers to be involved.

In relation to patient engagement she said that the Trust had recently appointed a new Patient Experience Lead and she would ask her to make contact to discuss the Trust's future plans after the meeting.

	The Trust Chair concluded the session by commenting positively on the quality and importance of the questions and thanked those who had raised such relevant and pertinent issues.
5.	**Close of the 2019/20 Annual General Meeting** The Trust Chair thanked everyone for attending and closed the formal part of the meeting. He the invited the audience to stay and listen to a presentation from Chris Pointon about the 'Hello my name is ……' campaign.
	Date, time and venue of the Leeds Community Healthcare NHS Trust 2020/21 Annual General Meeting: **To be confirmed**

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Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (80)

Meeting: Trust Board 6 December 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:

- Care Quality Commission (CQC) rating 'Good'
- Health and Safety Executive inspection report
- Staff survey 2019 response rates
- Inclusive Top 50 UK Employers
- 'Winter' pressures
- Leeds Mental Wellbeing Service
- Urgent Community Response (Accelerator Site application)

Media report (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 our staff engagement work

Chief Executive's report

1. CQC inspection report

The CQC inspected the Trust in June 2019 and has recently published its findings. We are pleased to say that we have been rated 'Good'.

I am so pleased and proud that our Trust's overall rating remains at 'Good'. We have more outstanding ratings than in our last report which is great news. Our community health services are rated 'Good' across the board, with outstanding features, and we are particularly delighted that the Leeds Integrated Sexual Health Service has been recognised as an 'Outstanding' service overall. This service was 'Requires Improvement' in the last inspection and has gone from there to 'Outstanding'. This is an incredible success. 100% of our services are rated 'Good' or 'Outstanding' for Caring.

The report also highlights areas of improvements and we are committed in every area of our quality improvement work. In particular, the CQC report highlights areas for improvement in children's community mental health services and in our child and adolescent mental health in-patient facility. We already have plans to build a new in-patient unit to replace Little Woodhouse Hall. Our continued focus now is to provide ongoing support to our teams and to continue the work, much of which is already underway, on our improvement action plans and, of course, the new building. We have completed the action plan for CQC in response to the "must dos" and this was submitted to them on the 15 November 2019. The plan was overseen by the Executive Director of Nursing and AHPs, with support from the Medical and Operational directors and all teams. The final plan was signed off by the executive team and by a subgroup of Quality Committee.

The full CQC action and improvement plan will be overseen by Quality Committee.

2. Health and Safety Executive report

The Health and Safety Executive (HSE) visited the Trust in August and September 2019 to assess how the Trust is managing the risks to our staff from violence and aggression, and musculoskeletal disorders (MSK) relating to moving and handling. They visited several areas of the Trust, interviewed directors, managers and staff, met with unions and our specialist staff who work in these areas. The HSE recognised the great culture in the organisation and the positive commitment and attitude they encountered from everyone they met. They concluded in their report, however, that whilst our culture was good, the Trust could do more to systematically manage these types of risks and to ensure that we have all the right procedures in place.

This report (appended for your reference) has strengthened our resolve and commitment to ensuring that we get this right in every way that we can and a full action plan is being developed. This will be presented to our Business Committee and shared with staff-side representatives then submitted to the HSE at the end of January next year. It has already been discussed with JNCF and JNC and four areas

of the action plan are being developed (lone working, violence and aggression, moving and handling, and the overarching health and safety management plan). Work has started, at pace on the lone worker policy and procedure and a new safety alert device is already being trialled with the stroke team.

3. Inclusive Top 50 UK Employers

LCH is very proud to again be included in the 2019 list of Inclusive Top 50 UK Employers. At the Inclusive Companies Awards on 28 November 2019 it was revealed that we are now ranked as **14th**. So many colleagues are proactively involved in the inclusion agenda, and this award gives real recognition of their commitment and the change in culture they are leading.

4. Workforce Race Equality Standard (WRES): National culture change pilot

We were delighted to be invited to be one of six organisations trialling a year-long WRES culture change pilot which will be launched on Wednesday 22 January 2020 and involves six NHS organisations, including NHS England. The pilot uses an evidence based systematic approach to improve the WRES data as well as to improve the culture in the organisation and includes conducting diagnostics, arranging a number of workshops, devising a detailed implementation plan, building capacity and capability, and reporting to the Board and to Senior Management Team.

5. Freedom to Speak Up index report 2019 – we are sixth in the country

The Freedom to Speak Up (FTSU) index report 2019 has been published. It is the first of its kind and it focuses on FTSU and openness which is seen as core to good culture. The Trust is listed as sixth in the country based upon the answers given to questions taken from the staff survey. This great result is down to fostering an open culture where all our staff are heard and understood and in particular the work of our Freedom to Speak Up Guardian, John Walsh.

6. Staff survey 2019 response rate

The NHS Staff Survey went live on 7 October 2019, closing on 29 November 2019. During this campaign, we have encouraged people to join the conversation across our organisation by demonstrating the impact of feedback from previous surveys. Progression of the BAME and disability agendas, leadership development and a focus on talent management & development have all been strongly influenced and improved by staff views through the survey.

As at 27 November 2019, our response rate was 53% which means we have exceeded the 2018 rate (52%). Numerically, 132 more people have engaged with the Survey this year (1567) than at the same point last year (1435). We have achieved 53% response rates across both Adults and Specialists business units,

45% for Children's Business Unit and 77% of Corporate Services staff have completed the Survey.

The results will be received in January 2020 and these will subsequently be shared with the Board and with staff. We will be discussing the results and what they tell us, extensively throughout spring 2020, as a key part of our work around staff engagement.

7. Leeds Mental Wellbeing Service

The Leeds Mental Wellbeing Service (LMWS) went live on 1 November 2019. LCH is the lead provider (contract holder) and the LMWS partnership also includes Leeds and York Partnership Foundation Trust, the Leeds GP Confederation, Touchstone, Northpoint Wellbeing, Community Links, Home Start Leeds and Women's Counselling and Therapy Service. Clinical leadership is provided by Leeds GP Confederation.

The new service will provide:

- Delivery of the nationally mandated Improving Access to Psychological Therapies (IAPT) model - including support for people with long term conditions and medically unexplained symptoms
- Delivery of primary care liaison, to enable improved access to mental health support in primary care for people with complex Common Mental Health Disorders (CMHD), people with stable Serious Mental Illness (SMI), and those who require emotional health and well-being support. This will build upon the identified benefits of the Primary Care Liaison Pilots, by up-scaling delivery of primary care liaison city wide
- Delivery of psychological and peer support for women with CMHD in the perinatal period and their partners - this support will be at a level below that provided for by LYPFT specialist community perinatal services, and also for those people who struggle to engage with statutory services

8. 'Winter' pressures

The system in Leeds has experienced considerable pressure over the last two weeks with increased attendances at A&E and a high level of admissions. The mutual aid arrangements have been put in place to maintain flow throughout the system.

Chief Executives have recently received a winter letter communication from NHS England/NHS Improvement setting set out what the expected national "defaults" now are on several important elements of a local winter plan. In it systems were encouraged to agree a Winter Delivery Agreement. The letter was considered by the System Resilience Assurance Board and a stocktake taken against the national "defaults".

In the “defaults” list community health services are expected “*to be able to operate to the same ‘clock speed’ of responsiveness as acute emergency services, e.g. 2 hour home response where that would avoid hospital admissions or speed discharges*”. This is a challenge for our service as the Trust is currently commissioned to provide a four-hour response in these circumstances.

9. Flu vaccine campaign

The Infection Prevention and Control (IPC) team launched the 2019/20 seasonal staff influenza campaign on 1 October 2019 and this year the target that has been outlined by NHS England and NHS Improvement in the CQUIN, is that 80% of frontline staff with patient contact require to be vaccinated. Changing staff attitudes and behaviours towards the vaccine creates ongoing issues to successfully promote the vaccine and achieve high vaccine uptake. This year we have continued to be innovative with new ideas and developments to achieve this, with new ways of working such as the ‘Have a jab, give a Jab’ promotion, and working in collaboration with Leeds City Council to develop a new suite of promotional material that aims to myth bust some of the inaccuracies around flu and the vaccine.

There have been challenges to delivering a successful campaign. Initially at the start of the campaign there was a delayed amount of vaccines available from the manufacturers however this has been resolved to date. Similar to the 2018/19 we are experiencing difficulties with the accuracy of staff data on ESR.

As at 29 November 2019, the Trust has provided 133 clinics and vaccinated 56.2% of frontline staff, which demonstrates that we are slightly ahead of last year’s campaign.

10. Primary Care Networks

We continue to work with the leadership of the new Primary Care Networks (PCNs) and to take forward our employment offer, our offer to be a partner of the PCNs to ensure data sharing and to support the new leadership.

11. Urgent Community Response (Accelerator Site application)

NHS England and Improvement have established a national programme for community health services to support the delivery of the commitments from the NHS Long Term Plan. One of the expectations of the long term plan is for community health providers to meet the Urgent Community Response (UCR) national standards of 2 hours response for urgent care and a 2 day response for access to intermediate care/reablement. These national standards need to be implemented across the country by 2023/24.

The Trust (in partnership with organisations across the system) has submitted a bid to become an accelerator site for implementation of the Urgent Community Response.

As well as rapidly working to achieve the national standards, the accelerators will be supported to:

- use 111 as the single point of access (SPA)
- develop solutions to plan capacity and respond to demand based on e-rostering/e-scheduling software
- fully utilise the updated community health data set to capture standardised information to evidence meeting the national standards
- create a live capacity tracker of the community urgent care services, that will be available to all relevant local health and social care providers
- develop a sustainable workforce model to staff the new care model
- work with Local Authority and partner health organisations to co-produce a solution for all intermediate care/rehabilitation (bed based and home packages of support) to deliver the 2-day standard

Successful bidders will be notified week commencing 2 December 2019.

12. Continuing Professional Development Funding for all Registered Nurses and AHP's

The Chief Nursing Officer, Ruth May announced at her annual conference this year that the above had been secure for the groups mentioned as £1,000 per registrant for 3 years and trusts would receive this money from April 2020. It has been made very clear this must be utilised for nurse and AHP continuing professional development.

A steering group led by the Executive Director of Nursing is being convened to oversee this funding and how it is spent, in conjunction with engagement work with staff to ensure they are aware of the funding and to obtain their views on how they would see this being used to best effect. There are some suggestions for investment in robust centralised training and education around long term condition management and leadership but an element of this also has to be about staffs' personal development needs and be linked to the appraisal process.

13. Yorkshire Evening Post (YEP) Health Awards

The YEP has announced their shortlist for this year's Health Awards and our staff have been nominated six times in four different categories. The awards event is being held on Friday 6 December 2019 at Elland Road, Leeds. The six nominees are:

- Community healthcare award: Integrated Children's Additional Needs Team, and Meanwood Integrated Neighbourhood Team
- Nurse of the year: Emma Williams, Leeds School Immunisation Team
- Doctor of the year: Dr Joanne Thomas, Community Specialist Paediatrician
- Mental health and wellbeing award: Dr Jason Miller, Clinical Psychologist (Dr Miller left the Trust on 11 October 2019), and 0-19 Public Health Integrated Nursing Service

14. Risk of Reinforced Autoclaved Aerated Concrete Planks (RAAC)

On Monday 11 November, 2019, NHS England and NHS Improvement issued a letter to all NHS Trusts and Foundation Trusts highlighting issues in relation to the presence of RAAC planks within roof structures of buildings. This was in response to a safety alert issued by the Standing Committee on Structural Safety warning of the risks associated with RAAC planks used in flat roof construction in the 1960s-1980s as there had been instances of failure of RAAC roof planks for a number of reasons.

A survey was required for completion by close of business on Tuesday 12 November 2019 to answer the questions raised in the letter. The Estates team have been in close contact with the NHS England and NHS Improvement Estates and Facilities Team in relation to this issue, and they have suggested that the Trust exercise extra caution given that a health building in the ICS area has RAAC planks and their research around the issue has highlighted that these were approved for use by the Leeds Regional Hospital Board in the 1960s.

LCH has eleven properties which were of flat roofed construction, built between 1960 and 1984, and all were inspected visually by the estates team in order to establish what further work was required. Of the properties inspected, the following were found to have concrete planks:

- Burmantofts Health Centre
- Chapeltown Health Centre
- Hunslet Health Centre
- Morley Health Centre

Inspection at Holt Park was restricted and this will require re-inspection. However survey information held by the team suggests that there are no concrete planks in place.

In line with the guidance, professional survey work is now required to identify whether the planks are indeed RAAC. The team consider this to be unlikely based on the visual survey, but recommend that this survey work is carried out, with an intrusive core needed to be taken should the surveyor consider it prudent. The estates team have contacted a number of qualified professionals to understand whether they are able to undertake this work and will select a company based on highest expertise and lowest cost.

15. CCG strategic commissioning

As the CCG become a more strategic commissioner of population outcomes it means the CCG, with commissioning partners, will change the way it commissions and it may mean that some tasks currently undertaken by commissioners will be undertaken by providers in the future. It also means providers taking more responsibility for using their collective resources to improve health outcomes and reduce inequalities.

The CCG have appointed Deloitte LLP (working in partnership with an NHS Commissioning Support Unit, AGEM) to work with them over the next 9-12 months to

develop their approach towards becoming a strategic commissioner. Katherine Sheerin will be the lead director and Gina Davy the project lead.

The external facilitators will bring together in an inclusive way people at the CCG, practice members, providers (from all sectors), people and other partners to design how this will work in the future. The CCG will keep providers up to date with regular updates and opportunities to raise questions as well as providing briefings at future PEG sessions.

16. Recommendation

The Board is recommended to:

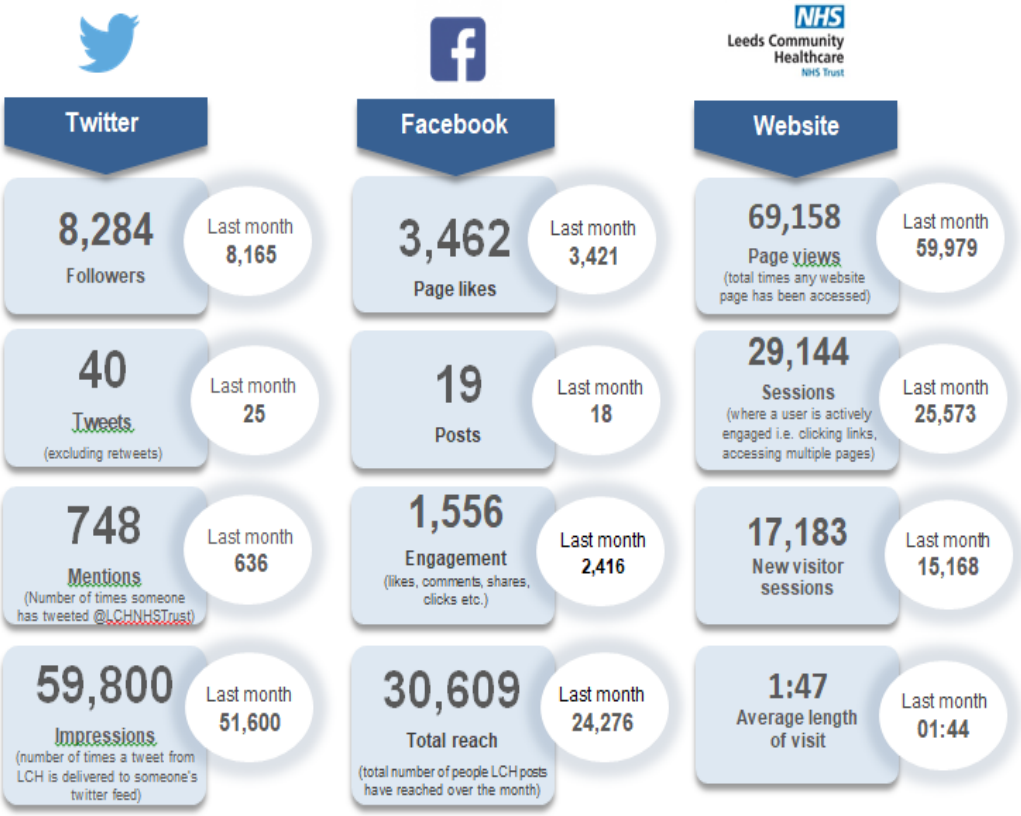
- Note the contents of this report and the work undertaken to drive forward our strategic goals and particularly our staff engagement work

Appendix One

LCH Trust Communications report – October 2019

This report has been put together by the Trust's Communications Team. All figures provided are true figures (not percentages) taken at the date of collection. Further information is available on request.

Social and Online Media



Twitter

1. As part of our 0-19 Public Health Integrated Nursing Service, 11-19 year olds can text a Specialist Public Health Nurse on 07520619750 for confidential health support and advice on a range of health issues. Read more (link and pic) – 2,531 reached, 19 retweets, 21 likes
2. The freedom to speak up index report has been published and it focuses on openness which is seen as core to good culture. We are delighted to say that we are listed as sixth in the country based upon answers given in the staff survey. Read more here: link and pic) – 2,117 reached, 3 retweets, 13 likes
3. Brilliant stuff! ☺ (Retweet of: @MrsWatchorn- Enormous appreciation to @Gelong_Thubten sharing Wisdom in Woodsley today. "Use mindfulness to develop positive thinking and clarity of mind.") – 2,016 reached, 3 retweets, 5 likes

Facebook

1. Young people aged 11-19 can text ChatHealth for confidential support and advice on topics such as bullying and emotional health as well as physical health. Find out more here ☞ https://bit.ly/2MRB5xd (link) – 4,003 reach, 53 reactions, 26 likes, 0 comments, 22 shares
2. Come along to our Leeds Adults Services engagement event for patients and their family and carers. Staff are also welcome. No need to book, the event runs from 10am-2pm on 17 October at the Bridge Community Church, LS9 7BQ - free admission and parking!– 2,467 reach, 46 reactions, 24 likes, 0 comments, 21 shares.
3. Happy Diwali to everyone celebrating this week! (pic)– 2,294 reach, 72 reactions, 49 likes, 2 comments, 15 shares

Website

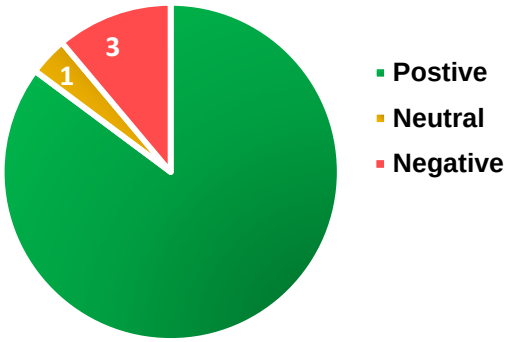
1. IAPT Home – 10,448 page views
2. Homepage – 5,483 page views
3. Speech and Language Therapy Toolkit – 3,845 page views
4. Our services A – Z – 3,035 page views
5. Our service, A – Z, Neighbourhood Teams - 1,753 page views

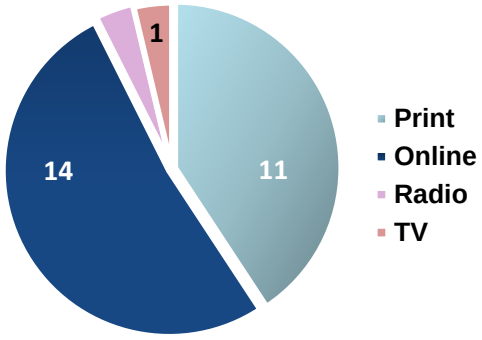
Most mentioned on Twitter

*Based on Trust tweets between 1 October 2019 and 31 October 2019

Print and Broadcast Media

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





Summary of coverage

1. **Parents share top tips for family service-** Yorkshire Evening Post, 4 October 2019 *This feature highlights the five short videos we made to publicise our 0-19 Public Health Integrated Nursing Service.* (Copy available from the Communications Team)
2. **Sepsis discussion as part of IPC Week on Chapel FM-** Louise Popple and Liz Grogan from our Infection, Prevention and Control Team talk about Sepsis as part of their business networks show for IPC week. Listen here: https://www.chapelfm.co.uk/elfm-player/archive/?_sfm_prog_show=1603
3. **Mental health therapy by text-** Yorkshire Evening Post, 24 October 2019. This feature outlines the offer of a digital mental health service which was raised at Leeds City Council's health scrutiny board. (Copy available from the Communications Team)
4. **Mental health sufferers in Leeds could soon get treatment via text message-** Leeds Live, 23 October 2019. *This feature outlines the offer of a digital mental health service which was raised at Leeds City Council's health scrutiny board.* https://www.leeds-live.co.uk/news/leeds-news/mental-health-sufferers-leeds-could-17128909

HSE

Health and Safety Executive

Notification of Contravention

FOD SANE Ops 3 Group 11

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Leeds Community Healthcare NHS Trust
First Floor
Stockdale House
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Leeds
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Reference: 4606323

Date: 21 October 2019

For the attention of Thea Stein – Chief Executive

Dear Madam,

HEALTH AND SAFETY AT WORK ETC ACT 1974

An audit was undertaken of the Trust between 19 August 2019 – 19 September 2019 to determine how well you were managing specific risks employees are exposed to during the course of their work, namely violence and aggression (V&A), and musculoskeletal disorders (MSK's). The audit was carried out by Kate Dixon, Louise Redgrove, Jackie Ferguson (HM Inspectors of Health & Safety) and Christina Evriviades (HM Specialist Inspector of Health & Safety – Occupational Health). We visited Trust Headquarters and a number of other locations. During the course of our visits we identified contraventions of health and safety law.

ACTION REQUIRED

In **Appendix 1** I have explained those contraventions. I require you to take action to ensure that you are managing health and safety more effectively and complying with the law. If you do not understand the action required or why it is necessary for you to comply with the law, please contact me or my Principal Inspector as soon as possible.

Please write to me confirming the action you will be taking on these matters by the **end of March 2020**.

Important information

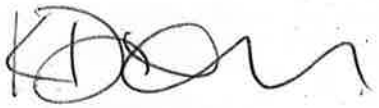
Please read the important information enclosed which informs you that a fee will now be payable by you. This fee covers our costs in these circumstances and is applicable because we have observed significant contraventions of the law.

I have included a copy of this letter for the attention of your employees because Section 28(8) of the Health and Safety at Work etc. Act 1974 requires me to inform your employees about matters affecting their health and safety. I would be grateful if you could bring it to their attention. I have also enclosed a copy of this letter to Ann Cherry (Staff Side Chair UNISON) and Debbie Hammill (Staff Side Representative RCN).

We would like to thank all staff involved in the audit for their time and amenable participation. It was much appreciated.

If you require further information or advice, please visit HSE's website or contact me direct on 07786 190930.

Yours faithfully,



Mrs. Katie Dixon
HM Inspector of Health and Safety

Appendix 1 - Material Breaches

Contraventions requiring action

HEALTH & SAFETY AT WORK ETC ACT 1974

During the course of the audit, we conducted a number of interviews with employees and were provided with relevant documentation and Trust statistics.

The information gathered has been assessed against duties placed on the Trust by the above Act and Management of Health & Safety at Work Regulations 1999 using the framework detailed in HSE publication "Managing for Health & Safety" (HSG65). The model for managing health and safety outlined in this document is the 'Plan, Do, Check, Act' approach, and it is in this format that we are providing feedback.

We have concluded there is evidence to indicate the Trust is not doing all that is reasonably practicable to manage V&A, and MSK's and have breached the following legislation:

Health & Safety at Work etc Act 1974, Section 2(1): It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all his employees

Health & Safety at Work etc Act 1974, Section 3(1): It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety

Management of Health & Safety at Work Regulations 1999, Regulation 3: Every employer shall make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed whilst they are at work

Management of Health & Safety at Work Regulations 1999, Regulation 5: Every employer shall make and give effect to such arrangements as are appropriate, having regard to the nature of his activities and the size of his undertaking, for the effective planning, organisation, control, monitoring and review of the preventive and protective measures.

Management of Health & Safety at Work Regulations 1999, Regulation 11(b): Where two or more employers share a workplace (whether on a temporary or a permanent basis) each such employer shall(taking into account the nature of his activities) take all reasonable steps to co-ordinate the measures he takes to comply with the requirements and prohibitions imposed upon him by or under the relevant statutory provisions and by Part II of the Fire Precautions (Workplace) Regulations 1997 with the measures the other employers concerned are taking to comply with the requirements and prohibitions imposed upon them by that legislation.

PLAN

To implement your overall health and safety policy, you need to establish and maintain and effective health and safety management system that is proportionate to the risks. This should include determining your policies in relation to V&A and MSK's, as well as planning for implementation. In relation to this, we concluded the following:

Resources & Competence

1. In order to properly plan for the management of V&A, and MSK's, those involved at the planning stage, i.e. Directors, should have training provided to them commensurate to their role. There was no evidence to demonstrate this had been done.

2. There is one Security lead within the organisation, who is responsible for several issues including management of V&A. He is clearly competent and a valuable asset to the Trust. There is evidence to indicate a significant proportion of this time is spent advising staff at a local service level. Whilst this is necessary, it does not allow him time to carry out other functions required by your policy, such as

monitoring compliance with the relevant policies. You should review the resources provided to this area of work.

3. There is no MSK lead within the Trust. This is a fundamental role to help devise and oversee the implementation of the policy, as well as the contract with the training provider.

Policies

You have three relevant policies: Violence and Aggression Policy (PL334); Lone Worker Policy (PL335) and Safe Moving and Handling Policy (PL247).

4. The following gaps are evident in all three policies:

    a. There is no reference to the relevant data collated by the Trust, e.g. incident data, staff survey results, near miss data etc. It is therefore not clear what the contents are informed by;

    b. They do not identify high risk locations, tasks or roles.

5. Occupational Health (OH) is not integrated in to the health and safety management system. The function is not mentioned in any of the relevant policies. As a result, there is no evidence to confirm they are involved in planning the management of either V&A or MSK's.

6. In the V&A and Lone Working Policy the responsibilities of different roles are outlined. They refer to 'line managers' and 'managers.' Your organogram details several different management levels which this could refer to. Clarity of roles and responsibilities is important for the policy to be effectively implemented and monitored. As such, this area of the policies should be reviewed.

7. The V&A and Lone Working Policy refers to monitoring compliance and effectiveness. These only refer to reactive indicators, i.e. Datix reports and training statistics. There is no reference to the Trust checking risk assessments are done; whether the quality and content of these are suitable and sufficient; and whether the identified controls have been implemented.

8. In relation to the V&A policy:

    a. It states Staff must 'ensure risk assessments are completed and documented.' There is no indication of what type of risk assessment must be produced and when. i.e. all on referral to the service/only those with known history/post-incident. There is no reference to legal requirement that only significant findings should be recorded;

    b. The section relating to Shared Services lacks clarity. It does not define how the risk of V&A for employees working in such areas will be managed;

    c. The process for reporting incidents to the Police is ambiguous and should be clarified;

    d. The training needs do not refer to other training requirements, i.e. PMVA which is mandatory for staff working in certain locations.

9. In relation to the Lone Working Policy:

    a. The Managers responsibilities require subjective decision making without the necessary support or training to do so. This is resulting in an inconsistent application of the policy throughout the Trust;

    b. It requires managers to 'decide the extent of supervision required for lone workers' (page 6). It is not clear what this means, or how this should be carried out.

    c. On page 7 is states '*Ensure in the event of a 9 day injury RIDDOR forms are completed and if necessary the Health and Safety Executive are notified.*' This is incorrect. An accident resulting in an absence (or return to work on reduced duties) for more than 7 days must be

reported. Reporting an incident under RIDDOR is, by default, notifying the Health and Safety Executive.

d. There is reference to '*appropriate procedures and suitable precautions*' (page 6). We assume this may be a reference to lone working devices or emergency code words, however it is not clear, nor does it tell the reader what the standards for such procedures and precautions should be.

10. In relation to the MSK policy;

a. The Managers responsibilities are onerous and there is no evidence that such employees have the necessary time, skills and/or training to carry such tasks;

b. There are two sections relating to 'Risk Assessment' (Sections 5 & 9). The need for two separate sections, and their respective contents is not clear. This should be clarified.

c. The section relating to 'Specialist Advice' (Section 7) indicates that '*following any specialist visit and risk assessment, a copy of the risk assessment will be forwarded to Workforce Development to inform commissioning of future training and to the General Manager who will inform commissioners of future needs.*' There is no evidence to confirm this is being done.

d. There is a section relating to 'Monitoring Compliance & Effectiveness' (Section 11). There is no evidence that the first three requirements in the table are being carried out.

DO

Organisations should aim to protect people by introducing management systems and practices that ensure risks are dealt with sensibly, responsibly and proportionately. This requires three elements: profiling your V&A and MSK risks by carrying out risk assessments; organising how these will be addressed and implementing your policies and procedures. In relation to this, we concluded the following:

Risk Assessment

11. In relation to V&A and Lone Working:

a. The generic V&A risk assessment for all LCH is not adequately detailed to be considered suitable and sufficient. Although some locations are identified by name, there is no indication as to why this is the case. There is no clear identification of high-risk areas or locations. Policies are not considered to be control measures.

b. There is evidence to indicate that security/environmental risk assessments are not consistently carried out. They should be carried for all buildings LCH staff are working in. This must be done by someone with the necessary competence and resources, with clear benchmarks to inform decision making.

c. We didn't see many examples of lone working risk assessments. We have been provided with two:
   i. Generic lone working risk assessment indicates safety alert devices should be provided to staff (page 8). This has not happened.
   ii. Generic lone working risk assessment for domestic services was completed after our visit. It is not adequately detailed to be considered suitable and sufficient. For example, it does not consider the risk posed by staff having key access to buildings containing pharmacies.

d. The generic V&A risk assessment identifies the control measure: 'security presence as required.' There is no evidence that a decision on whether security is required at a particular location is made on risk.

12. In relation to MSK's:

    a. We have been provided with a number of templates for MSK risk assessments. In order to be considered suitable and sufficient, such assessments must consider the factors detailed in Schedule 1 of the Manual Handling Operations Regulations 1992. Not all of the templates refer to these considerations, therefore not all of your risk assessments can be considered to be suitable and sufficient. They are also not complying with the requirements outlined in your MSK policy (Appendix 1).

    b. In some circumstances, there seems to be a reliance on the use of 'dynamic risk assessments' as a control measure. This is only acceptable in rapidly changing situations where circumstances are outside the control of the dutyholder. The vast majority of your manual handling tasks will be planned with known loads, therefore dynamic risk assessments should not be required. In the event that dynamic risk assessments are deemed necessary, you must ensure the relevant employees have sufficient competency to carry out such work.

Procedures

13. Procedures for lone working in the community adopted in different locations are inconsistent both in relation to:

    a. Procedures for staff confirming they are safe throughout a shift;

    b. Procedures for summoning help in an emergency (using emergency code words).

    This matter has been raised as a risk and has been on the corporate risk register since October 2016 but no action has been taken.

14. Procedures for response to a panic alarm in a building are inconsistent. Some locations have permanent security whereas others don't. Therefore, some locations have a suitably trained person responding to an incident, whereas others don't. In one location, it is not indicated who would respond to a panic alarm. The differences do not appear to be applied on the basis of risk.

15. There is no evidence to confirm any procedures are routinely tested to ensure they work.

Equipment

16. We were informed that not all relevant staff are provided with a Trust smartphone.

17. In WYOI, mobile phones are not allowed. This has not identified as increasing the risk on any document we have been provided with. WYOI radios are provided as an alternative means of communication; however, there is evidence to indicate that not all relevant staff are provided with these. This increases the likelihood for staff to inadvertently walk into an incident. This issue has been on the corporate risk register since April 2016, but no action has yet been taken.

18. At WYOI there is no green panic alarm in the reception room to summon help. We have seen no evidence to confirm this has been identified as an issue in any risk assessment. We have also been informed that information on offender risk might not always be known on 'late reception' therefore increasing the risk of V&A.

19. Mobile panic alarms are provided however (a) no one checking they are being carried (b) staff are unclear about battery requirements to charge or change (c) there is no requirement to check they are working.

20. In relation moving and handling, aids are mainly identified by patient needs rather than being required to reduce the risk of injury to employee. For example, carrying out leg dressings is a well-known risk to employees working in healthcare. The simple solution is the provision of leg rests and these should be provided at all patients' homes where this task is required.

Training

21. There has been good feedback from staff about the quality and relevance of the training provided, both in relation to V&A and moving and handling. However, the following issues were identified in relation to training:
    a. We have been informed that accessing training courses is sometimes a problem;

    b. None of the training courses require an assessment of competence. Staff are only required to attend training;

    c. LCH policies are not referred to during the course of the training;

    d. It is unclear whether staff working at Leeds Equipment Service are required to have CRT training;

    e. There is no evidence that anyone is formally evaluating the courses to ensure they meet the needs of staff.

CHECK

Monitoring and reporting are important parts of health and safety arrangements. Effective management systems allow organisations to receive both specific and routine reports of the health and safety policy. Proactively measuring performance ensures that your plans have been implemented. In relation to this, we concluded the following:

22. Whilst there is comprehensive evidence to confirm statutory/mandatory training attendance is being monitored, there is no evidence to indicate that compliance with any other aspects of the policies are being monitored.

ACT

It is essential you review your health and safety performance. This will facilitate an understanding as to whether effective leadership, management, staff competence and employee consultation have been embedded within the Trusts' health and safety management system. A systematic review will allow you to determine whether your system is effective in managing risk and protecting people. In relation to this, we concluded the following:

23. There is no evidence you are using any indicators (e,g. staff survey results, incident data, RIDDOR's) to inform policy;

24. There is no evidence that any of the policies in relation to the management of MSK's or V&A are being audited, and the results of this being used to inform reviews.

OTHER MATTERS

1. There is a lack of clarity around the reporting of incidents within the Trust as required by the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). We have established that 8 incidents have been reported under RIDDOR since the start of 2016. However, your own figures would suggest that 44 incidents should have been reported. This suggests there has been a significant failure to comply with the requirements of the Regulations. You must review your procedures to ensure all RIDDOR's are reported.

2. We have a number of concerns around your incident data provided to us. It does not appear to be wholly accurate and does not tell the whole picture. For example, we were informed Datix is also used to record offender on offender violence/aggression at WYOI. You must ensure it can be used to identify employee related incidents as this data is required to inform formation of policy. We were also

concerned about the reporting culture within the Trust. In certain locations, there seems to be high tolerance levels to verbal aggression.

ACTION REQUIRED

You must review your existing policies and procedures to address the issues outlined in the paragraphs above. Further guidance on the matters can be found in the HSE publication 'Managing for Health & Safety' (HSG65) and Research Reports RR440 & RR495 (both publications relating to management of V&A in healthcare settings). As discussed, please produce a written action plan to address these points and send a copy to HSE by the end of March 2020.

IMPORTANT INFORMATION

The Health and Safety and Nuclear (Fees) Regulations 2016

RECOVERY OF COSTS

Under regulations 22 and 23 of the Health and Safety and Nuclear (Fees) Regulations 2016, HSE will recover the costs that it incurs for the work it does in relation to certain contraventions of health and safety law. These contraventions are known as 'material breaches'. The costs for the whole visit where a material breach is first identified are recoverable, along with other associated work.

This cost recovery is also known as 'Fee for Intervention'. Further information is available on HSE's website at http://www.hse.gov.uk/fee-for-intervention/ .

I am notifying you that the contravention(s) listed in **Appendix 1** are, in my opinion, material breaches for which a fee is payable by you to HSE under Fee for Intervention. The reasons for my opinion are also given in Appendix 1.

HSE will send you one or more invoices for the costs incurred.

Under regulation 24(5) of the Fees Regulations 2016 you have the right to dispute the invoice. You can find further information about Fee for Intervention and details of the terms on which you can dispute an invoice in the leaflet HSE 48 - *Fee for Intervention: What you need to know* at http://www.hse.gov.uk/pubns/hse48.pdf.

There are exemptions and disapplications, where HSE cannot recover its costs for carrying out its functions, which can be found in HSE 47 - *Guidance on the Application of Fee for Intervention* at http://www.hse.gov.uk/pubns/hse47.pdf.

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (81a)

Report to: Trust Board 6 December 2019
Report title: Audit Committee 18 October 2019: Committee's Chair assurance report
Responsible Director: Chair of Audit Committee **Report author:** Company Secretary
Previously considered by: Not applicable

Summary

This paper identifies the key issues for the Board arising from the Audit Committee 18 October 2019.

Internal Audit

The Committee noted good progress was being made against the 2019/20 internal audit programme, with a third of the programme having been completed. Four of the completed internal audits were presented to the Committee. Three of which received reasonable assurance. These were Budgetary Control and Cost Improvement Plan, Conflicts of Interest, and Professional Medical Assurance. The GDPR audit had been determined as substantial assurance. The Committee noted that the review had evidenced that the Trust had a robust framework in place to ensure ongoing compliance of the Data Protection legislation including appropriate policies, procedures and guidance.

Information Governance

It was reported that the assurance requirements for the 2019-20 Data security and protection toolkit consists of a 2 stage external reporting to NHS Digital: a baseline report on the 31 October 2019 and a final submission report on the 31 March 2020. The Committee was advised the Trust had assessed its position against the 10 Data Standards and that 11 assertions out of 40 were currently compliant. An improvement plan had been developed to ensure compliance with the remaining 29 assertions by 31 March 2020. Two concerns with achieving compliance highlighted to the Committee were that the Trust must have a cyber security trained specialist and provide an increased level of evidence to support compliance with the emerging cyber agenda, The proposal is for a permanent skilled resource to mitigate the cyber security specialist and cyber security assurance risks The Committee approved the submission of the baseline assessment of the Data Security & Protection Toolkit.

Standards of Partnership Governance

The revised draft Standards of Partnership Governance and the accompanying process for applying these were reviewed by the Committee. The Committee requested additions to the draft document including the provision of clarity of clinical responsibility for patient pathways, for the wording of the level of governance arrangements required to be amended as full governance arrangements may not be necessary for uncomplicated partnerships, and having an escalation process up to director level for when there were concerns about the management of contracts. The Committee agreed that subject to these amendments, it was satisfied that the document could be presented to the Board for approval in December 2019.

Leeds Community Healthcare NHS Trust

Agenda Item 2019-20 (81bi)

Report to: Trust Board (circulated by email)
Report title: Quality Committee (workshop) 21 October 2019: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Associate Director of Nursing & Clinical Governance
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 21 October 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

The October 2019 Quality Committee meeting was a focussed workshop with separate presentations from Leeds Sexual Health and the Stroke Pathway teams who shared their different experiences, impacts and subsequent learning whilst undertaking their contrasting integration and transformation journeys. The Committee also engaged in an interactive session on the implementation of the National Patient Safety Strategy (July 2019) in LCH.

Workshop session one: Working in partnership to deliver integrated care and care closer to home.

The Committee heard from Leeds Sexual Health Service (LSH) about their journey from 2015 as Contraception and Sexual Health (CASH) and Genitourinary Medicine (GUM) services to the recommissioned Leeds Sexual Health service. This integrated service is now delivered through a partnership between LCH, LTHT and Leeds Mesmac. In 2017 LSH were rated as 'requires improvement' by CQC and since this time the service has worked hard to significantly improve care within what has often been a complex and challenging integrated context. This has resulted in positive feedback from service users; a reduction in complaints; a reduction in patient walk-outs before being seen; an increase in service user contacts; staff more able to effectively manage the patient flow through the service and very positive verbal feedback from CQC who revisited in Jan 2019.

The Committee then heard from the Leeds Stroke Services. In the summer of 2018 Newton Europe's diagnostic analysis highlighted that Leeds was an outlier for the acute length of staff for patients who had experienced a stroke (32 days compared to the national average of 21 days). Since September 2018 LCH, LTHT and commissioners have been working in partnership to revise the Leeds Stroke pathway. Whilst encountering challenges along the way they adopted the Leeds Plan 'We are Team Leeds' approach, building on existing relationships, improving communication across services, shared learning and a joint approach to identifying ideas and actions to make changes to continue service improvement. By August 2019 the average acute stay for patients who have experienced stroke had reduced to 15 days (from 32) resulting in patients being cared for much sooner, safely and effectively in their own homes.

The Committee workshop involved a general discussion in relation to the challenges that both services experienced during their transformation journeys and the common learning which is being shared across SBU. The key findings that contributed to effective integrated services included having a shared vision across organisations; creative commissioning relationships; robust leadership and effective communication at all levels.

Workshop session two: Patient Safety Strategy

Colleagues from the Clinical Governance Team and Human Resources provided the Committee with an integrated presentation on the key principles of the Patient Safety Strategy and the data from incident, complaint and workforce data showing our current position in relation to a 'Just Culture'.

The Committee was invited to contribute to the early discussions on how this is to be implemented across LCH by undertaking table top activities considering how LCH should involve staff and patients in their processes, the challenges and opportunities of this and potential outcome measures. The voices of LCH staff are also being heard through other forums including a PSEGG workshop at the end of the month. A further update on progress and actions will be presented to the Quality Committee in February 2020.

Performance brief and domain reports

The Committee reviewed the Performance Brief. It was noted that it was difficult to confer any significant issues from the small numbers reported monthly within the Safe domain and that trends would continue to be monitored. The increase in patient safety incidents with harm was discussed. The Clinical Governance Manager confirmed this was as a result of newly introduced national reporting requirements around pressure ulcers and had been raised at the September 2019 Committee.

The Committee were pleased to see the development of LCH's first Always Event in the Continence, Urology and Colorectal service (CUCS) and are keen to monitor the progress of this and learning for future Always Events.

Achievement of the expected 60 Quality Challenge+ walks in 2018/19 was discussed. It was confirmed that the number of walks was slightly below trajectory at current in-year position however more training has taken place and this should increase over Q3.

A further discussion took place of enhancing the feedback around Research & Development and that the learning from Research would be valuable in addition to the reporting of numbers of patients recruited. This will be addressed through the implementation of the new research and development strategy.

IAPT response times were discussed and the Director of Operations explained how the current achievement reflects the change in commissioner focus on access targets. This is being considered within the implementation of the Leeds Mental Wellbeing Service and it is expected this will lead to an initial backlog for the new service to address.

NHS
Leeds Community Healthcare
NHS Trust

Agenda item 2019-20 (81bii)

Report to: Trust Board 6 December 2019
Report title: Quality Committee 25 November 2019: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author**: Assistant Director of Nursing and Clinical Governance
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Quality Committee meeting held on 25 November 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable. The November 2019 Quality Committee meeting was a business meeting.

Quality Spotlight – PHINS 0-19 Service
The presentation focussed on this newly established service from the tender in October 2018 to the present. The team described the staff engagement which commenced pre-bid and continues by means of market place events, vlogs and weekly newsletters. Growth of the workforce has been one of the biggest challenges and has been supported with a leadership development training plan for the service leaders to ensure all leaders have the right skills for their roles. The Committee was interested to hear about the development of dual clinical training in order to meet the demands of the new service.
The Committee heard about a range of service reviews and initiatives aimed at improving efficiencies and quality. This included a Single Point of Access (SPA); aspects of oral health promotion and two quality improvement initiatives: Adverse Childhood Experience (ACES) which has changed documentation to ensure the voice of the child is captured; and the development of Chathealth, an anonymised text service for 11-19 year olds that is already gaining traction via schools and community groups (300 texts received by end of Q2). Continued work is ongoing in relation to providing an 8am-8pm offer and co-location of services.
The Committee heard that this service has a large number of commissioner set KPIs and discussion centred about how service evaluation could focus in future on some key clinical and population based/public health outcomes in order to evidence improvement.

Key Issues: CQC and CAMHS: Limited assurance
The CQC 'must-do' action plan was submitted on 15 November 2019 behind which is a wider CAMHS transformation plan. The Committee heard that implementation of the plan is progressing across the CAMHS service and will be reported on again at Quality Committee in January to provide further assurance. LYPFT expertise has been sought to support Mental Health Act Governance. An unannounced CQC Mental Health Act inspection took place at Little Woodhouse Hall last week and received positive verbal feedback, a formal feedback report is still awaited.

Outcome measures project - Reasonable assurance
The Committee was provided with a helpful update on progress confirming this has now started to gain traction in many of our services. It was acknowledged that not all outcome measures from all services were reflected within the report and therefore the actual position was improved on the position presented. The committee will review progress in 6 months.

Performance Brief and Domain Reports - Reasonable Assurance
The Committee agreed that reasonable assurance was provided for the Safe, Caring, Responsive and Well-Led domains. It noted specific waiting list times and the quality impact of these will be brought to a future Quality Committee. The Committee was unanimous in recommending that future performance brief for domains should be received quarterly with more frequent exception reporting of issues and actions.

Neighbourhood team triangulation report – Reasonable Assurance
This paper was presented for the first time at Quality Committee. It noted that capacity and demand has largely remained stable alongside improvements in recruitment and retention. However it was identified that variation does exist between teams at any given point in time. The Committee agreed that it should focus on quality impact of variations in staffing and as a first step a pro-active audit of deferred visits would be appropriate with other quality issues being presented in future quarterly reports.

Clinical Governance report – Reasonable Assurance
Escalations from the report were received by the Committee. It was reported that the virtual frailty ward has gone live today. It was noted that SBU are reviewing the risk assessment around the dental waiting list times. CBU provided an update on the progress of the Youth Board who are now looking at increasing their profile, recruiting more members and to progress a "take-over" challenge in 2020.

Risk register report – Reasonable Assurance
The paper highlighted a number of new risks which have been added to the risk register. It was noted that all eight new risks have potential implications on quality. All new risks were discussed and agreed that appropriate mitigation was in place and recorded.

Standards of partnership governance – Committee approved addition
This paper was presented with a proposed addition of a section on clinical accountability to the draft Standards of Partnership Governance. The Committee approved the added paragraph.

Mortality report – Reasonable Assurance
The paper presented recent mortality information and identified the challenges of obtaining timely and accurate data required for the mortality reviews. The Committee heard how discussions have been held to resolve this between clinical and business intelligence colleagues and about work with other partners to continue to refine our processes and learning.

Patient Group Directions – Reasonable Assurance
This report was received and noted by the Committee inclusive of two PGDs for ratification. Both PGDs were ratified by the Committee.

Clinical audit update – Reasonable Assurance
The paper was presented summarising Q1 and Q2 2019/20 data as an improved position on this time last year. It was also noted that it is National Clinical Audit week this week and the first LCH Clinical Audit Plaudit was taking place on November 26th. Acknowledgement of the support from the audit & effectiveness team was also noted. The Committee concluded that future reports would benefit from having more examples of learning and improvements to provide further assurance.

I**nternal Audit of Compliance Review of Professional Assurance (Medical Staff) – Reasonable Assurance**
The Committee noted the paper and requested the potential for a wider assurance audit across all professional disciplines be brought to the attention of Audit Committee.

Patient Safety, Experience and Engagement (six monthly report) – Reasonable Assurance
The Committee agreed that in many ways this was a more useful synthesis of performance in providing assurances around specific areas of quality than the standard performance report. It was noted that a number of 'avoidable' unstageable pressure ulcers are included within the report yet not reflected in monthly reports and this is to be resolved.

The Committee reviewed and recommended that the Board approves the following documents:
Quarterly report of the Guardian of safe working hours (Reasonable Assurance)
Freedom to Speak Up Guardian report (Reasonable Assurance)
Patient Group Directions
MHA Governance Group report (accepted with noting of inclusion of discussions around restraint)

Report to: Trust Board (circulated by email)
Report title: Business Committee 23 October 2019: Committee Chair's 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 23 October 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Electronic Patient record (EPR) update – Reasonable assurance
The EPR project team presented an overview of the benefits realisation approach for the EPR project including: quality, patient safety and clinical excellence; ability to run the business; patient experience; and staff efficiency. The Committee was advised that whilst data collection was still in its infancy, it was already proving useful to services and was being welcomed by clinicians and managers. Examples were provided of how data was being used to good effect including identifying where patients risk assessments had not been completed, managing unoutcomed visits, understanding capacity and demand for better use of resources, provision of targeted training and support. The benefits of accessing patient records centrally, as opposed to keeping paper records in patients' houses were also described, including being able to refer to contemporaneous records, the ability to randomly sample records for documentation audits, and the reduced risk of data security breaches. The Committee was reasonably assured of the benefits being realised by this project. It recommended that the focus should now be on exploring the data to establish where the largest improvement gains could be made. The Committee also recommended that the presentation should be shared with the Quality Committee.

CAMHS T4 Business Case
The Executive Director of Finance and Resources provided the Committee members with copies of the draft full business case for their consideration out with of the meeting. The Committee discussed the high level financial risks and the Executive Director of Finance and Resources explained the current and planned mitigation. The Committee was keen to understand the risk share arrangements. Next steps were for Committee members to provide comment and for a further iteration of the draft business case to be presented in November 2019 to both the Business and Quality Committees, prior to being received at December Board for approval. The Committee was advised that a similar governance process and timescale was being adopted by LYPFT to ensure that its Board governance structure had an opportunity to scrutinise the same document.

Digital Strategy – Reasonable Assurance
The Committee reviewed the draft Digital Strategy, having seen earlier versions at previous meetings. The Committee was advised that the draft strategy had been further developed taking into consideration the context in which the Trust now works, and will work in the future. The Digital Strategy is aligned with the workforce and estate strategies. The Committee suggested that it should also link with the 'Making Stuff Better' strategy for quality improvement. The Committee discussed whether the strategy would better enable the use of technology to support services where there were resource issues that were leading to workforce pressures and whether the Trust had the ambition and appetite for this, how workforce digital literacy could be improved, the resourcing implications of the strategy and the existing 'tech debt' for replacement of systems and equipment. The Committee suggested that the Trust should establish new arrangements to capture service improvement ideas utilising new Digital Models and ensure the workplan for 2020/21 onwards had the full support of the Executive Directors and CCIO. The Committee agreed that with minor changes the Board should receive the draft strategy at its December 2019 meeting for approval.

Community Dental Service Reconfiguration
The Executive Director of Operations presented a paper that outlined the case for reducing the Community Dental Service's delivery sites and provided details of the public consultation which had taken place. The Committee was advised that the new community dental service contract awarded to LCH In October 2018 had posed some challenges and the proposed solution was to reduce the number of sites from five to three, in order to provide the enhanced service required within the cost envelope. The Committee considered the options appraisal and the level of public engagement. It also enquired about engagement with staff who may be affected by the proposed changes and the plan for the redundant estate. The Committee agreed to recommend to Trust Board that it should approve the proposal to reduce to three delivery sites.

NHSE/I: New Financial Architecture
The Executive Director of Finance and Resources described the new arrangements that would replace control totals and that the Trust's suggested surplus target for the coming year was £780K. As the Trust's surplus is linked in with the aggregate target for the ICS, if the Trust did not agree to the suggested target, it could adversely affect the financial position of other Trusts in the ICS. The Executive Director of Finance and Resources advised that he had accepted the target and explained that the latest planning document was due to be submitted by noon that day describing how the Trust would meet the suggested surplus target. The Business Committee noted the agreed surplus target and the Executive Director of Finance and Resources confirmed that he would apprise the Board at the November 2019 workshop.

Performance Brief
The Committee reviewed the September 2019 performance data, in particular the Responsive, Well Led and Finance sections. The Committee agreed there was more work to be done to drive up the appraisal rate by improving data quality and continuing a targeted campaign. The Committee discussed sickness absence rates, in particular long term sickness and how these cases were being managed. The Committee asked for further information to be provided on the number of cases of sickness absence connected with staff who were involved in disciplinary procedures. The Executive Director of Finance and Resources provided an overview of the current financial situation, and advised the Committee that he was confident that the control total would be achieved.

Productivity /Corporate Benchmarking

The Committee received a paper informing it of the Productivity Group's assessment of its purpose and how it intended to improve progress against its objectives. The paper described the group's agreed priority work areas which included taking the lead on the Getting it Right First Time programme of work, and focussing the programme around seven Trust services. This will involve leading on the assessment of information for the Model Community Services Programme, continuing its involvement with the ICS in understanding variation across the wider patch, and receiving and sharing learning from a number of existing workstreams within the Trust which are looking at productivity. The Productivity Group will also consider the information provided in the corporate benchmarking report and annual reference cost data with a view to identifying improvement opportunities. The Committee noted the renewed focus but requested further reports on tangible progress at the Committee in January 2020.

The Committee was provided with the Corporate Benchmarking Report produced by NHS Improvement, which includes the Trust's corporate data for comparison. From the report it was clear that the Governance and Risk category, and within that the subsections of Corporate Governance and Clinical Governance, had the greatest potential for cost reduction. The report presented to the Committee cautioned against a conclusion that this would be possible or desirable. The recommendation was that further exploration of cost reduction opportunities should be undertaken by the Productivity Group. Concern was raised about the quality and reliability of the benchmarking data. The Executive Director of Finance and Resources was asked to establish if the definitions of roles to be included in the benchmarking data were being accurately applied to the Trust's data submission. It was agreed that a further update would be provided to the Committee in January 2020.

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (81cii)

Report to: Trust Board 6 December 2019
Report title: Business Committee 27 November 2019: Committee Chair's 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 27 November 2019 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Integrated Children's Additional Needs Service (ICAN): Reasonable assurance
The Committee received a presentation on the ICAN transformation programme, including the vision and aims, the challenges, key workstreams, timescales and a progress update. The Committee was advised that staff and broader engagement was a priority for the success of the programme, and workshops had taken place for staff to work through the challenges together and find solutions. There is an EPR workstream to ensure that the patient record system could support the changes required by the service. The Committee was advised that the anticipated completion date for the programme was September 2020. The Committee recognised that the transformation programme was complex. It was reasonably assured with the update received.

Change Management: Reasonable assurance
The Committee received an overview of the Trust's major change projects, including Estates Utilisation, Administration Review, E-Rostering and ICAN Transformation. The Committee was advised that e-rostering had gone live across a number of neighbourhood teams with no problems being reported. The Estates project reported delays, though the current major schemes were now complete. The Committee agreed the Administration Review revised timescales as a result of the need to resolve current staff pay banding anomalies; the Committee was advised that there would be a further update in January 2020. The Committee remained very concerned with this latter project – and received assurance on the staffing capability and the realistic new delivery timeframe.

Digital Strategy
The Committee reviewed the draft Digital Strategy, having seen earlier versions at previous meetings. The Committee was advised that the draft strategy had been further amended taking into consideration the comments made at the October 2019 Committee meeting concerning the Trust's level of ambition, organisational culture and supporting staff in reaching and maintaining digital competency. The Committee was content that with minor enhancements, the Board should receive the draft strategy at its December 2019 meeting for approval.

Workforce Strategy (Diversity and Inclusion priority and Equality and Diversity annual report): Reasonable assurance
The Committee received the Workforce Strategy update, which served as an annual report by including details of the Trust's Equality and Diversity activities for 2019, and an update on the Diversity and Inclusion priority within the Workforce Strategy. The Committee enquired about some metrics which appeared to be getting worse. There was discussion about whether this was due to increased reporting because of better awareness and greater confidence to speak up, or whether the situation was actually worse. This will be further tested out and reported back to Committee. There was a strong recognition of the continued positive shaping of the WRES program.

Leeds school-age flu immunisation bid
The Committee was provided with a summary of the bid for this service, which is commissioned by NHS England. The immunisation target for 2019/20 is at least 65% to be attained across all primary school years. The bid was submitted on 25 October 2019 and the Trust will find out if it has been successful on 12 December 2019. The Committee was advised there were no quality or TUPE risks identified.

LILIE system replacement (Leeds Sexual Health Service)
The Committee was advised the current contract for this electronic patient record system (called LILIE) is due to expire in July 2020. The current system did not meet service requirements, particularly in regard to pathology, and an options appraisal had been carried out. The recommendation was to approve implementing SystmOne with supplier managed migration. The Committee discussed the implications for LTHT who jointly provide the Leeds Sexual Health Service and understood that there were other similar jointly run services where SystmOne was in use with no issues. The Committee agreed the recommendation for SystmOne.

Performance Brief
The Committee reviewed the October 2019 performance data, in particular the Responsive, Well Led and Finance sections. The Committee was advised that the Children's Business Unit has a much improved financial position. The Committee discussed the staff incidents reported in detail and in particular the physical abuse incidents, querying whether these were carried out with intent to harm staff, or whether they were the result of providing care to those patients with sometimes challenging behaviour. The Committee asked for this additional information to be available for future reports, and some indication of trend.

The Committee explored the reasons for the increased number of patients waiting over 18 weeks for a consultant-led service and whether there had been earlier warnings of this declining situation. The Committee was assured that action was being taken to manage the situation and it was anticipated that within 3 months, it would be back above target. The Committee discussed appraisal rates, which remain below target. The WRES indicators currently captured in the Performance Brief are annually reportable targets. The Committee recommended that these are removed and replaced by other WRES performance measures, which could be evaluated more frequently, as well as having some additional narrative about WRES and WDES staff engagement. The Committee agreed that the newly added appendix on service specific measures with contractual financial sanctions was a useful addition to the Performance Brief.

Neighbourhood Teams Triangulation Report
The Committee was updated on the Neighbourhood Team performance matrix. It continues as a very positive analysis – and even more so as the quality output delivery is being taken up through the Quality Committee. The Chair encouraged future discussion to focus on those few outlier teams which evidenced exceptionally strong or weak performances.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2018-19 (82i)

Meeting: Trust Board 6 December 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, 20 November 2019 Quality Committee, 25 November 2019 Business Committee, 27 November 2019	**For information**	

Purpose of the report

This report seeks to provide assurance to 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.

Main issues for Consideration

In the **Safe** domain, there has been a steady rise in patient safety incidents reported. This is a result of the 2 added categories of Moisture Associated Skin Damage (MASD) & Deep Tissue Injury (DTI) from April 2019.

Staff safety incident data and thematic information has been included in the Performance Brief this month. The incident categories included are physical and verbal abuse, moving and handling, sharps/needle-stick injuries and slips, trips and falls.

In the **Caring** domain, 91.74% of Community patients would recommend the service to family and friends overall. Of inpatient services, 100% would recommend. The Engagement Strategy was approved by the Trust Board in October; work is now ongoing to collaboratively produce an Operational plan to be shared with Quality Committee in January 2020.

In the **Responsive** domain the Trust has dipped below the nationally set waiting targets for percentage of patients waiting over 18 weeks for a consultant-led service. This dip was not anticipated and is being investigated.

There have been 4 further breaches of the 6 weeks wait for diagnostic test in the Audiology service.

The School Immunisations service achieved a strong performance on coverage levels for the academic year 2018/19.

In the **Well Led** domain, both statutory and mandatory training compliance (aligned with the Core Skills Training Framework) and appraisal compliance continue to steadily rise. Turnover remains low and the impact of the Trust's joined up approach to retention across a number of interventions including staff engagement, Leadership Development, Diversity and Inclusion and our approach to staff health and well-being has been recognised through nomination for team of the year in the annual NHS I/E retention awards.

Our Staff Survey response rate is showing a healthy trajectory against both the national average as well as our performance last year with 43% of staff having completed the survey with three weeks to go. Importantly, excellent work continues corporately and throughout the Business Units to engage staff with the Trust every day. Disappointingly, sickness absence and in particular long term sickness absence has increased this month and further work is ongoing both to understand this as well as to proactively manage absence and support staff on long term sickness.

In the **Finance** domain, the year to date financial position is consistent with previous months and overall the surplus continues to be £0.1m more than planned.

Pay costs are £0.3m underspent and there are 58 WTE vacancies slightly less than last month as a result of the newly qualified nursing cohort commencing. Non-pay costs continue to report a small overspending.

The Trust continues to forecast delivery of the control total at the end of March. The small forecast shortfall on 2019/20 CIP efficiency savings is being mitigated by un-planned savings elsewhere. All other finance targets are forecast to be achieved for the year.

The Executive Director of Finance remains 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.

Recommendations

The Board is recommended to:

- Note present levels of performance
- Determine levels of assurance on any specific points
- Comment on the intention to include reports in a "flash report" format next month

Performance Brief – October 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 – 20th November 2019
Quality Committee – 25th November 2019
Business Committee – 27th November 2019
Trust Board – 6th December 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 October 2019.

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

In the **Safe** domain, there has been a steady rise in patient safety incidents reported. This is a result of the 2 added categories of Moisture Associated Skin Damage (MASD) & Deep Tissue Injury (DTI) from April 2019.

Staff safety incident data and thematic information has been included in the Performance Brief this month. The incident categories included are physical and verbal abuse, moving and handling, sharps/needle-stick injuries and slips, trips and falls.

In the **Caring** domain, 91.74% of Community patients would recommend the service to family and friends overall. Of inpatient services, 100% would recommend. The Engagement Strategy was approved by the Trust Board in October; work is now ongoing to collaboratively produce an Operational plan to be shared with Quality Committee in January 2020.

In the **Responsive** domain the Trust has dipped below the nationally set waiting targets for percentage of patients waiting over 18 weeks for a consultant-led service. This dip was not anticipated and is being investigated.

There have been 4 further breaches of the 6 weeks wait for diagnostic test in the Audiology service.

The School Immunisations service achieved a strong performance on coverage levels for the academic year 2018/19.

In the **Well Led** domain, both statutory and mandatory training compliance (aligned with the Core Skills Training Framework) and appraisal compliance continue to steadily rise. Turnover remains low and the impact of the Trust's joined up approach to retention across a number of interventions including staff engagement, Leadership Development, Diversity and Inclusion and our approach to staff health and well-being has been recognised through nomination for team of the year in the annual NHS I/E retention awards.

Our Staff Survey response rate is showing a healthy trajectory against both the national average as well as our performance last year with 43% of staff having completed the survey with three weeks to go. Importantly, excellent work continues corporately and throughout the Business Units to engage staff with the Trust every day. Disappointingly, sickness absence and in particular long term sickness absence has increased this month and further work is ongoing both to understand this as well as to proactively manage absence and support staff on long term sickness.

In the **Finance** domain, the year to date financial position is consistent with previous months and overall the surplus continues to be £0.1m more than planned.

Pay costs are £0.3m underspent and there are 58 WTE vacancies slightly less than last month as a result of the newly qualified nursing cohort commencing. Non-pay costs continue to report a small overspending.

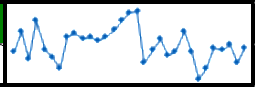
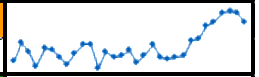
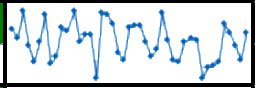
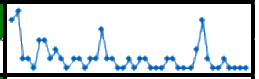
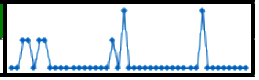
The Trust continues to forecast delivery of the control total at the end of March. The small forecast shortfall on 2019/20 CIP efficiency savings is being mitigated by un-planned savings elsewhere. All other finance targets are forecast to be achieved for the year.

The Director of Finance remains 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.

Safe – October 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	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Monthly Time Series
Overall Safe Staffing Fill Rate - Inpatients	SL	>=97%	-	●	2019/20	94.7%	97.1%	97.7%	
					2018/19	101.0%	101.1%	97.5%	
Patient Safety Incidents Reported in Month Reported as Harmful	SL	0.64 to 1.26	1.32	●	2019/20	1.21	1.43	1.30	
					2018/19	0.86	0.85	1.01	
Serious Incident Rate	SL	0 to 0.1	0.04	●	2019/20	0.04	0.04	0.06	
					2018/19	0.04	0.05	0.02	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	5	1	●	2019/20	1	0	0	
					2018/19	1	2	0	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	0	●	2019/20	0	0	0	
					2018/19	0	0	0	

Areas noted as a result of this report are as follows

There has been a steady rise in patient safety incidents reported, with 6 consecutive points above the upper control limit (see appendix 5). This is a result of the 2 added categories of Moisture Associated Skin Damage (MASD) & Deep Tissue Injury (DTI) from April 2019.

The Duty of Candour Policy has been updated and approved by the Clinical and Corporate Policy group (CCPG) and was ratified by SMT in October 2019. However there has been feedback that clinical staff are confused about professional and statutory duty and this is being considered in the review of the reporting process where simple guidance will be provided for staff. This is in addition to a Duty of Candour focus at the PSEEG workshop held at the end of October. The Pressure Ulcer Policy has been also been updated and approved by the Steering group in November 2019. This is due at CCPG in November for approval prior to being submitted to SMT for ratification.

The internal review of the 72 hour report process is now complete and improvements are being progressed. The team is currently trialling a more inclusive and robust process of reviewing the 72 hour reports – initially just for pressure ulcers – through a weekly serious incident (SI) decision meeting. Future plans are to evolve these in to Skype meetings so that 72 hour report authors can also attend 'virtually' from their bases. If this evaluates positively the plan will be for all 72 hour reports to follow this process.

October Data Review

- 626 incidents have been reported in Datix in October (a reduction from last month) with 332 (53%) reported as patient safety incidents, which is also a reduction on the previous month. 149 incidents (45%) are internal to LCH with the top 3 categories being skin damage (inclusive of pressure ulcers and the 2 new categories of MASD and DTI); accident that may result in personal injury and medication incidents. Compared to the previous month accident that may result in personal injury has replaced slip, trip and falls incidents. The reduction in slip, trip and fall incidents has occurred following a peak last month and number remain within normal variance. This will however be monitored for a sustained reduction and will be monitored and reflected in greater detail within 6 monthly reports.

- 23% of patient safety incidents this month originated from organisations external to LCH. These are predominantly incidents relating to LTHT. In order to ensure LTHT Quality team receive timely notification of these incidents we are pursuing a reciprocal Datix sharing agreement with LTHT.

- 48 staff incidents were reported in October, a slight reduction on the previous month. 6 incidents & 41 incidents were reported as minimal harm and no harm respectively. 1 incident was reported as moderate harm, appropriate actions were taken and this incident has been closed. The staff member continues in work.

- 11 major harm incidents were reported in October, which is a slight increase on last month. This was 1 Category 4 pressure ulcer & 10 unwitnessed falls resulting in fractured neck of femur. All 11 incidents were found to be unavoidable to LCH. A detailed review of incident themes and learning will be explored in the 6 monthly report.

Staff safety incidents

Safe- people are protected from abuse and avoidable harm	**Year to date**	**Q1**	**Q2**	**Oct 2019**
Number of staff physical abuse incidents	31	14	16	1
Number of staff verbal abuse incidents	92	42	41	9
Number of staff moving and handling incidents	4	1	2	1
Number of staff sharps/needlestick incidents	17	7	8	2
Number of staff slip, trip, fall incidents	19	7	10	2

As small numbers of staff safety incidents by category are reported each month, thematic review is difficult. Incidents over the last seven months (April to October 2019) were reviewed collectively to establish themes for this report. Areas to note from this report are as follows:

1. **Physical abuse, assault or violence**

A review of incidents of physical violence in neighbourhood teams reported mostly concerned patients who had a mental health condition and were agitated. Three incidents of physical violence reported by Seacroft neighbourhood team involved the same patient, the police were involved and an alternative care plan was arranged. Six incidents were in the Community Dental Service, and involved patients with challenging behaviour.

2. **Verbal aggression**

Three of the verbal abuse incidents reported also included racial abuse. Eight incidents occurred at reception areas with missed appointments and confusion over appointment dates being a catalyst in some of those incidents. Seven incidents were in IAPT. In neighbourhood teams the highest reporters over the seven month period reviewed were North 2, West 2 and South 1. Three incidents in the Chapeltown neighbourhood team concerned the same patient. Verbal abuse incidents were reported by the Seacroft neighbourhood team for the patient who also became physically abusive.

3. **Moving and Handling**

A small number of incidents were reported (4 incidents) therefore thematic information cannot be reliably noted. Inadequate assessment of manual handing risks (task, individual, load, or environment) was a cause across three incidents. Two incidents involved staff from Leeds Community Equipment Service being injured whilst moving equipment in patients' homes.

4. **Sharps/needle-sticks**

The majority of incidents were related to diabetic patient visits by neighbourhood teams. The reported cause was often that safety needles were not being used or there had been unsafe disposal of sharps. Two incidents involved 'butterfly' devices used for taking blood samples. No member of staff has been reported as contracting a blood-borne virus as a result of a sharps/needle-stick incident. Sharps and needle-stick incidents are monitored by the Infection Prevention and Control Group who meet on a bi-monthly basis.

5. **Slips, trips and falls**

A small amount of staff falls incidents occurred each month with no strong themes being identified. Half of the falls reported occurred outside and were mostly staff losing their footing or stumbling on uneven surfaces.

6. Next steps

As part of the Health and Safety Executive action plan, awareness will be raised about the importance of reporting staff incidents, including near miss and no harm incidents.

It is proposed that a further thematic review of staff incidents should take place in May 2020.

Inquests (for information only)

Incident ID 38529 relates to an unexpected death of person in A&E following detainment in police custody. This case has been adjourned until May or September 2020 however LCH has been named as an interested party. The police custody staff member, who is now a former employee, has been offered support from both the service and legal team in preparation.

Risks for Escalations and Assurance

No risks or escalations to note

Caring – October 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	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Monthly Time Series
Percentage of Respondents Recommending Care - Inpatient and Community (FFT)	SL	>=95%	95.7%	●	2019/20	96.7%	96.6%	91.8%	
					2018/19	-	-	-	
Percentage of Respondents Recommending Inpatient Care (FFT)	SL	>=95%	90.0%	●	2019/20	85.7%	90.7%	100.0%	
					2018/19	91.7%	100.0%	100.0%	
Percentage of Respondents Recommending Community Care (FFT)	SL	>=95%	95.7%	●	2019/20	96.7%	96.6%	91.7%	
					2018/19	95.9%	96.9%	96.0%	
Total Number of Formal Complaints Received	SL	No Target	141		2019/20	62	59	20	
					2018/19	43	40	22	
Number of Formal Complaints Upheld	SL	No Target	68		2019/20	19	37	12	
					2018/19	-	-	-	
Number of Formal Complaints Responded to within timeframe	SL	No Target	106		2019/20	33	50	23	
					2018/19	-	-	-	
Number of Compliments Received	SL	No Target	871		2019/20	374	342	155	
					2018/19	-	-	-	
Mixed Sex Accommodation Breaches	*SL*	*0*	*0*		*2019/20*				
					2018/19	*0*	*0*	*0*	

PATIENT EXPERIENCE

Friends and Family Test (FFT)

Overall, 91.74% of Community patients would recommend the service to family and friends. Of inpatient services, 100% would recommend.

A further breakdown of this is provided in the table below, by business unit.

September 19	Number of responses received	% of which recommend	% of which would not recommend	Number of comments received	Overall response rate
ABU Services	195	92.31%	2.56%	174	9.19%
CBU Services	712	86.24%	2.39%	994	27.13%
CBU Inpatients	0	N/A	N/A	N/A	N/A
SBU Services	691	97.25%	0.87%	868	6.90%
SBU Inpatients	8	100%	0%	12	47.06%

There have been no FFT responses for Children's inpatient services (Little Woodhouse Hall and Hannah House) in October. This is consistent with the services discharges.

There were 2048 FFT comments collated in October; mostly the comments received have been positive; with an exception of 31 negative or constructive comments mainly relating to waiting times, feeling safe, and parking. Comments around waiting relate to waiting times and waiting area; both CBU and ABU have received 3 comments around waiting, with SBU receiving 10. There are comments relating to waiting times being too long for Community Neurology services, Community Dental, MSK and the Diabetes service.

Of the 1047 positive comments received across all Business units the top 5 themes were; 322 related to friendliness, 228 related to emotional and physical support, 193 related to Compassion, 177 related to helpfulness, and 127 related to staff being professional and competent.

September CHI-ESQ data:
For CAMHS the Children's CHI-ESQ data for September is as follows:
- 84% would recommend; 26 out of 31 children said Yes (84%), 2 Maybe (6.5%), 1 would not recommend (3%) and 2 don't know (6.5%).

For CAMHS the Parent/Carer CHI-ESQ data for September is as follows:
- 95% Extremely likely to recommend (36/38 responses), 5% likely to recommend (2/38 responses).

The latest PSEGG workshop took place in October and focussed on:

- Reviewing proposed changes to the complaint process, introducing the new FFT questions and looking at how we share learning

- Exploring the new Patient Safety Strategy, what this means for staff, what it means for LCH
- Duty of Candour- reintroducing the process, outlining the timeframes and expectations – myth busting, what to do if?
- Learning from incidents including Fabuleeds

36 members of staff attended the workshop. Feedback forms have been circulated to attendees and qualitative feedback will be gathered.

In partnership with Leeds Teaching Hospitals Trust, The Patient Experience Team have been supporting the Community Neurological service with a city-wide piece of work looking at patient experience across Neurological services; asking what currently works well and what could be improved. The focus of this work is to improve the patient journey through Neurological services and promote better joined up working. This work is ongoing with a view to gathering feedback towards the end of the year and into the new year.

The Engagement Strategy was approved by the Trust Board in October; work is now ongoing to collaboratively produce an Operational plan to be shared with Quality Committee in January 2020.

The monthly highlight reports will include patient experience information available from the Quality Challenge visits that have taken place that month (where reports have been finalised). There has been one Quality Challenge visit in October however the report for this visit has not yet been finalised and so has not been included in this month's report. We will gather this information as standard going forward.

Complaints, Concerns and Claims

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

Feedback	October 2019 Received
Complaints	20
Concerns	35
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 meeting the above targets.

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

Key Performance Indicators and Developments	September 2019 Status
Acknowledged within 3 days	20 (100% Compliance)
Responded to within 180 days	23 (100%)
Active PET Caseload	29
PHSO requests	0

There are 29 complaints on the caseload for October. There have been 3 complaints that have been reopened within October and 1 complaints are ongoing with the PHSO.

All 20 complaints were acknowledged within 3 working days; One of the 20 complaints received, was found to be for LTHT following initial acknowledgment. At this time it has been closed as Withdrawn by LCH.

The importance of fully completing Action Plans on Datix® for every upheld or partially upheld complaint has been communicated to all staff involved in investigating complaints- this is now being monitored and will be included in the monthly patient experience highlight report and will be fed back at Patient Safety Experience and Governance Group meetings.

Due to concerns of an increased number of complaints related to staff attitude within the MSK service there has been an internal audit to identify any areas for concern; the audit work is ongoing however to date the findings do not suggest an increase in complaints relating to staff attitude over a 12 month period. There have been 4 comments related to attitude for the MSK service in October and all of these are positive; stating staff have a positive and professional attitude to care.

For October, there have been no noticeable trends or clusters for incoming complaints across Business Unit, and within services; there have been no complaints that have required escalation prior to investigation.

Effective – Quarter 2 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.

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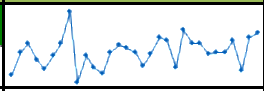
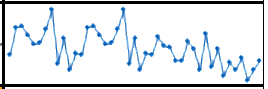
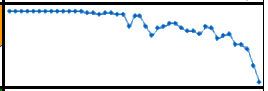
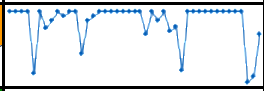
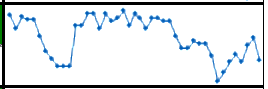
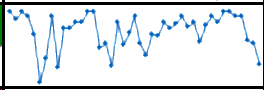
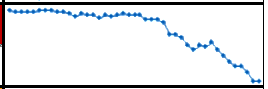
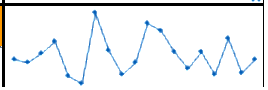
Information in the effective domain is reported quarterly therefore there is no update this month.

Responsive – October 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	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Monthly Time Series
Patient Contacts - Variance from Profile	SP	0 to ± 5%	-0.7%	●	2019/20	-1.4%	-1.1%	2.4%	
					2018/19	-3.0%	-6.4%	0.9%	
Patient Contacts	SP	No Target	821,984	●	2019/20	349,934	349,946	122,104	
					2018/19	392,694	373,902	133,983	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	94.0%	●	2019/20	94.7%	91.6%	89.0%	
					2018/19	97.0%	97.8%	96.8%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	0	●	2019/20	0	0	0	
					2018/19	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	97.9%	●	2019/20	100.0%	94.1%	97.9%	
					2018/19	99.7%	97.0%	100.0%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	97.9%	●	2019/20	97.9%	98.4%	97.8%	
					2018/19	98.9%	98.4%	98.1%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	99.4%	●	2019/20	99.9%	99.3%	98.2%	
					2018/19	98.9%	99.6%	99.5%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	51.0%	●	2019/20	57.4%	48.0%	41.3%	
					2018/19	98.9%	99.6%	99.5%	
IAPT - Percentage of people who complete treatment and recover	SP	>=50%	47.8%	●	2019/20	50.0%	49.1%	49.7%	
					2018/19	49.9%	48.4%	57.7%	

Statutory Breaches and Waiting Lists
The has Trust dipped below the nationally set waiting targets for percentage of patients waiting over 18 weeks for a consultant-led service. The hotspots are in Paediatrics due to absence vacancies in the medical workforce. These gaps have been filled to date by locums but the service is now implementing a plan in place to ensure all patients are seen within 18 weeks with a reduced reliance on locums.

There have been 4 further breaches of the 6 week wait for diagnostic tests in the Audiology service, with an improvement in performance from last month. If financial sanctions are imposed they would total £400. The breaches were caused by a period of staff sickness, and no breaches are anticipated in November.

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.

CAMHS
There has been a significant fall in the percentage of Next Steps patients seen within 12 weeks. This is due to an increase in referrals from the MindMate Single Point of Access who have recently undertaken some work to clear a backlog of referrals.

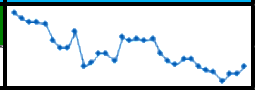
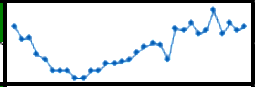
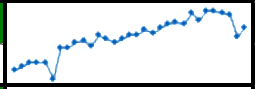
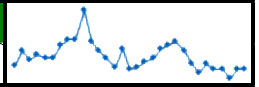
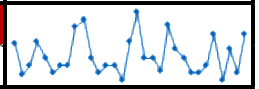
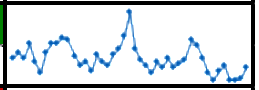
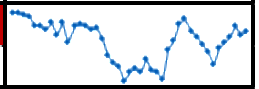
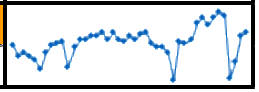
School Immunisations
The School Immunisations service achieved the following coverage levels for the academic year 2018/2019:

Immunisation	Target	Coverage
DIPHTHERIA; POLIO; TETANUS	85%	**88%**
GARDASIL; HUMAN PAPILLOMAVIRUS: 1	90%	**93%**
GARDASIL; HUMAN PAPILLOMAVIRUS: 2	90%	**89%**
MENINGOCOCCAL ACWY	85%	**88%**

Well-Led – October 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

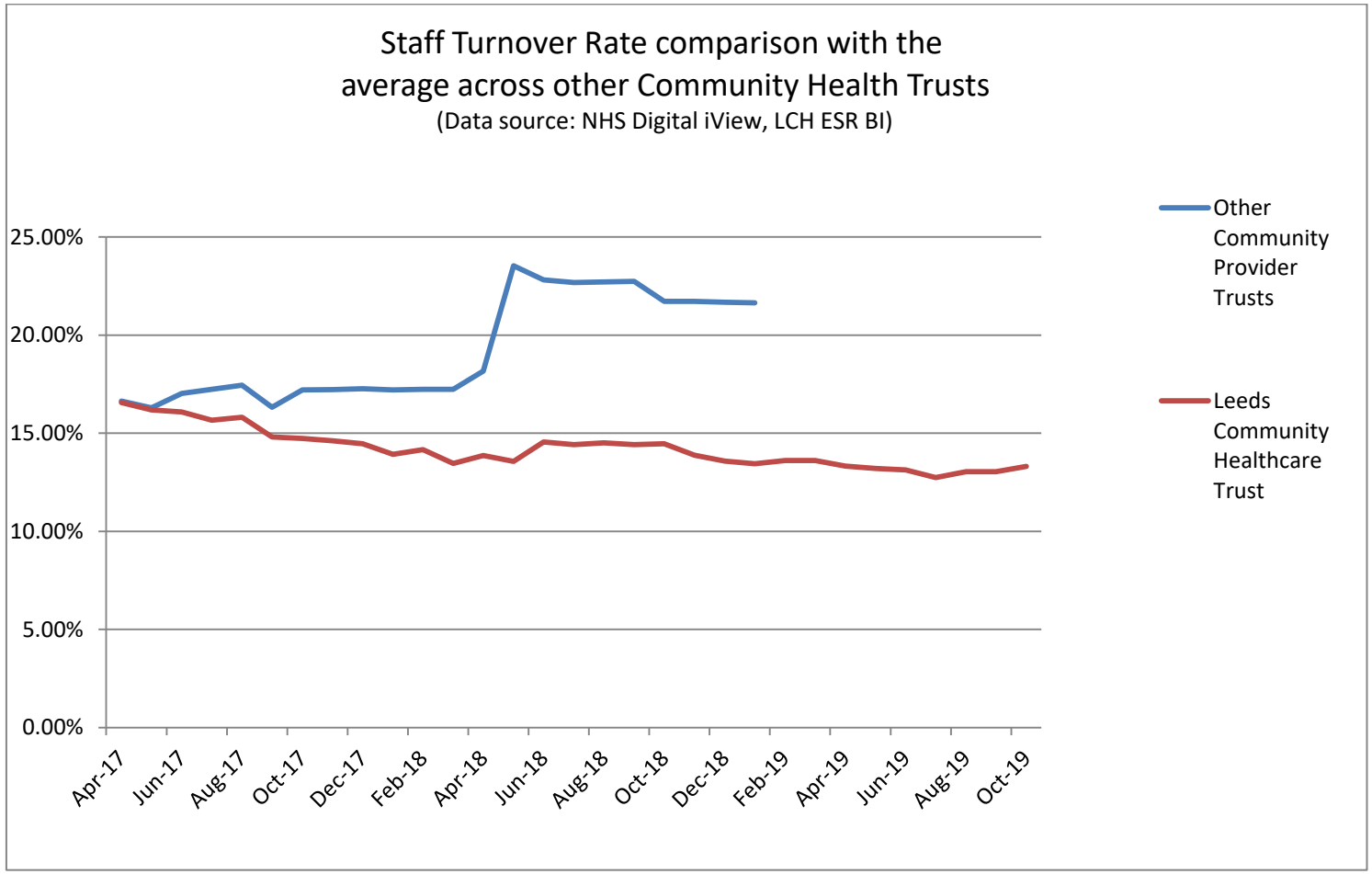
Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	2 Yr Monthly Time Series
Staff Turnover	LS/JA	<=14.5%	-	●	2019/20	13.1%	13.0%	13.3%	
					2018/19	14.6%	14.5%	14.5%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	-	●	2019/20	20.1%	17.3%	17.8%	
					2018/19	13.2%	14.4%	15.7%	
Stability Index	LS/JA	>=85%	-	●	2019/20	87.6%	85.7%	86.4%	
					2018/19	85.6%	86.0%	86.0%	
Short term sickness absence rate (%)	LS/JA	<=2.2%	-	●	2019/20	1.5%	1.5%	1.5%	
					2018/19	2.2%	1.6%	1.9%	
Long term sickness absence rate (%)	LS/JA	<=3.6%	-	●	2019/20	3.9%	3.4%	3.9%	
					2018/19	3.3%	3.8%	3.6%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	-	●	2019/20	5.4%	4.9%	5.3%	
					2018/19	5.5%	5.4%	5.5%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	LS/JA	>=95%	-	●	2019/20	84.6%	85.6%	86.2%	
					2018/19	79.9%	82.3%	87.5%	
6 universal Statutory and Mandatory training requirements	LS/JA	>=95%	-	●	2019/20	93.8%	90.9%	91.5%	
					2018/19	89.6%	88.9%	90.3%	

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	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	2 Yr Monthly Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	>=52.0%	-	●	2019/20	**71.1%**	**81.6%**	Staff Survey	
					2018/19	63.0%	60.3%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	LS/JA	>=52.0%	-	●	2019/20	**73.3%**	**61.2%**	Staff Survey	
					2018/19	64.0%	65.1%		
WRES indicator 1 - Percentage of BME staff in the overall workforce	LS/JA	No Target	-		2019/20	-	-	9.7%	
					2018/19			9.8%	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target	-		2019/20	-	-	3.6%	
					2018/19			3.2%	
Total agency cap (£k)	BM	3816	**2736**	●	2019/20	**1158**	**1220**	**358**	
					2018/19	-	-	-	
Percentage Spend on Temporary Staff	BM	No Target	6.2%	●	2019/20	6.2%	6.2%	5.8%	
					2018/19	7.8%	7.1%	6.1%	

1. Retention

The overall trend continues to be positive with turnover reporting at 13.3% which is a slight rise from last month but is still below the 2019/20 outturn target of 14.5%. The stability rate is 86.4% which is above the target of 85%.

The Trust's turnover is visually presented in the graph below:-



Staff leaving within the first 12 months of employment is 17.8% which is below target of 20%. Further analysis including feedback from leavers with less than 12 months service has been considered at the trust Resourcing Steering group and work is now underway to improve our approach to onboarding and induction of new staff.

Work to improve our recruitment, health and wellbeing offer, approach to talent management, workforce planning, leadership and management development and staff engagement should further support an increase in stability levels and turnover rates during 2019/20. This joined up approach to retention has been recently recognised through the Trust securing a nomination in the NHSI/E Burdett awards where we have been shortlisted in the retention team of the year award with the approach to retention recognised as a joined up one across a number of workforce and OD interventions.

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

2. Health and Wellbeing (HWB)

The Overall sickness absence rate, continues to remain lower than in previous years, although at 5.3%, we are starting to see the traditional seasonal variation where sickness absence rates start to increase from October onwards. Long term absence has shown a slight increase and will continue to be pro-actively managed and supported by calling Case Conferences as appropriate and to continue with a people before process approach in supporting staff, with long term conditions. Short term absence remains relatively stable.

Ongoing promotion of the range of health and wellbeing support that staff can access continues to take place through a range of medium, such as staff stories, blogs, Feel Good Pledge and Latest news on Elsie.

Regular updates on progress being made around specific HWB pieces of work and linking these to national HWB days will continue to take place to re-inforce what LCH is doing to support staffs health and wellbeing.

3. Appraisal Rates

This month has seen a marginal increase in the overall Appraisal Rate, which currently stands at **86.2%**. There is a notable and welcome increase in the Corporate Directorate rate (+4.7%); Specialist Business Unit (+2%) and Operations (+1.5%) are also continuing to report steady improvements. Monitoring is ongoing to investigate the teams reporting declining compliance to explore the causes and offer support.

Appraisal skills development continues to be available either as part of the Leading LCH and Essential Management programme or as a bespoke training session.

AfC Staff Appraisal Rate (12 Month Rolling - %)

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul - 19	Aug - 19	Sep - 19	Oct - 19
Overall	Imp Traj to 95%	84.2%	82.9%	81.1%	83.7%	84.6%	85.4%	87.2%	85.6%	**86.2%**
Adult Business unit		88.2%	86.1%	80.8%	86.0%	87.7%	88.7%	88.9%	83.5%	**83.1%**
Children's Business Unit		79.9%	78.5%	77.9%	80.3%	80.5%	85.3%	89.5%	91.3%	**90.9%**
Corporate Directorate		83.2%	78.3%	79.3%	82.8%	88.9%	86.1%	85.1%	80.4%	**85.1%**
Operations		90.6%	89.2%	86.8%	87.5%	88.7%	89.1%	93.5%	93.6%	**95.1%**
Specialist Business Unit		82.5%	82.5%	83.4%	83.4%	83.0%	79.6%	80.3%	80.6%	**82.6%**

4. Statutory & Mandatory Training

The overall compliance rate this month has risen to **91.5%.**

The successful migration of Infection Prevention & Control Training was completed in October, ensuring this now meets Core Skills Training Framework (CSTF) national standards, and competency requirements on ESR have been reviewed and updated.

The ODI and Workforce Information Teams are working closely with SMEs for remaining training areas to support them through this process over forthcoming months and ensuring compliance with the CSTF which has now been mandated nationally and as part of the ongoing roll out of streamlining across the NHS.

Statutory & Mandatory Training Compliance Rate

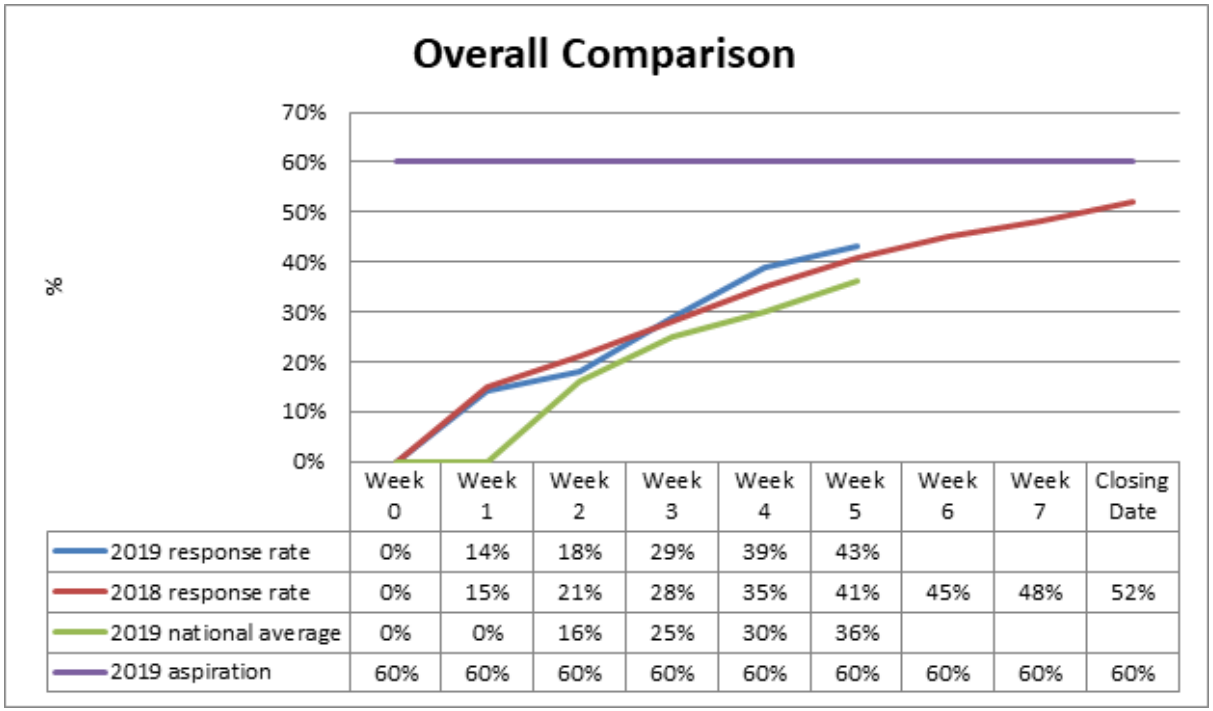
		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul - 19	Aug - 19	Sep - 19	Oct - 19
Overall	Imp Traj to 95%	93.5%	92.5%	93.5%	94.4%	93.8%	85.3%	87.4%	90.9%	91.5%
Adult Business unit		92.6%	91.6%	92.7%	93.8%	93.5%	84.1%	85.9%	90.9%	91.0%
Children's Business Unit		94.2%	92.7%	93.5%	94.5%	94.0%	88.8%	90.1%	91.1%	92.6%
Corporate Directorate		95.4%	94.2%	95.3%	96.0%	95.0%	84.9%	87.1%	90.6%	90.8%
Operations		93.7%	92.8%	94.2%	94.9%	93.0%	86.8%	90.5%	91.0%	93.3%
Specialist Business Unit		94.0%	93.7%	93.9%	94.2%	93.7%	82.6%	85.7%	91.0%	91.3%

5. Staff Engagement

The NHS National Staff survey commenced October 7th 2019 and is due to close on 27th November 2019.

The response rate at Week 5 is 43% (1315 staff) against a national average response rate of 36%, and the 2019 trajectory is slightly ahead of that for 2018, at this point. (Comparison table below shows further detail).

There has been a good level of engagement so far across the organisation with a few teams achieving over 70% response rate, including a neighbourhood team which currently stands at 94%.



	Week 0	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Closing Date
2019 response rate	0%	14%	18%	29%	39%	43%			
2018 response rate	0%	15%	21%	28%	35%	41%	45%	48%	52%
2019 national average	0%	0%	16%	25%	30%	36%			
2019 aspiration	60%	60%	60%	60%	60%	60%	60%	60%	60%

Additionally and importantly work on engagement with staff continues every day at LCH both corporately through forums including Leaders Network, 50 Voices, JNCF and JNC as well as at a local business unit level. Business Units recently reported as part of their Q2 business plan review to SMT the range and plethora of staff engagement initiatives on offer.

Finance – October 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	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	12 Month Trend
Net surplus (-)/Deficit (+) (£m) - YTD	BM	-0.8	-0.8	●	*2019/20*	0.0	-0.7	-0.8	
Capital expenditure in comparison to plan (£k)	BM	390	682	●	*2019/20*	223	230	229	
CIP delivery (£k)	BM	1352	1234	●	*2019/20*	529	529	176	

Income & Expenditure Summary

At the end of October the Trust's year to date financial position is better than planned. The overall position assumes the Provider Sustainability Funding allocation as the Trust continues to forecast delivery of the control total and will therefore be able to claim this funding from NHS Improvement.

Income

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. However, there are some relatively small risks that should be noted although they are being mitigated in the management of the Trust's overall forecast year end position.

Contract income continues to be fractionally less than planned as a penalty has been incurred for police custody contract in respect of missed shifts. It is assumed that some missed shifts will continue throughout the year. The value of the penalty remains at a forecast shortfall of £53k as management's review of staffing has maximised shift coverage and reduced the previously anticipated financial impact.

A further income risks is emerging in respect of the 0-19 service where income is dependent on achieving a staff in post target. There is a risk given known resignations that the 95% target will not be achieved for the final quarter of the year. The potential penalty is £67k.

Non-contract income is marginally less than plan this month; this is circa £30k in respect of salary recharges for the operational management team and a further £37k in respect of MSK AQP and OAT income being less than planned.

The year to date and forecast position assumes all CQUIN income is achieved. At this stage in the year the biggest CQUIN risk is achievement of the mental health data requirements the forecast is amber and the financial risk is £78k. The flu vaccination target, which this year has increased to 80% of staff is also a risk, based on last year's performance the potential impact is circa £13k. The Trust is also unlikely to deliver the CQUIN associated with 6 monthly reviews of stroke patients however as this is an integrated pathway the Trust cannot deliver this CQUIN in isolation. Commissioners are aware of the system issues and the Trust will not be penalised as a result.

The Trust has received £751k additional funding for the pay award for staff working in services commissioned by Leeds City Council; at this time this is a non recurrent adjustment, national discussions are ongoing as to the potential recurrent impact.

Pay and Non-pay Expenditure & Vacancies

Overall pay expenditure is £0.3m underspent at the end of October. Vacancies stand at 58 WTE, 8 less than in September and there has been a reduction in agency expenditure for the month.

Significantly, the forecast for the Children's BU has been updated to reflect current pay expenditure and this has brought its forecast back to a balanced position. Previous reports have highlighted the level of overspending in the BU so this improvement is good news.

Pay expenditure to the end of October is less than planned for all directorates apart from the Children's BU which is £0.3m overspent and Estates £0.1m over. Children's BU pay overspending continues to be driven by paediatric and CAMHS locum medical staff, Speech & Language Therapy services and Hannah House. This is being offset by underspending on non-pay. The overspending in Estates is in respect of the previous year's Admin Review CIP which is not being delivered this year.

There has been a small reduction in agency staffing expenditure again this moth and the Trust continues to be significantly under the cap set by NHS Improvement.

Of the net 58 WTE vacancies this month 24 of these are in the Adult BU, 9 less than last month mostly as a result of the new cohort of nurses commencing; and 32 in the Corporate and Estates Directorates.

Non-pay is a net £0.1m overspent at the end of October. The position has improved on last month as there has been less expenditure on continence products and premises costs this month; last month saw a number of one-off premises costs. Non-pay and reserves are expected to remain £0.1m overspent at the end of the year.

The Corporate Directorate continues to report an overspending for the year to date. This is in respect of historic cost savings plans relating to the roadmap contribution of £0.5m and corporate CIPs of £0.3m, along with new savings requirements of £0.2m for procurement and £0.2m unidentified savings from the 2019/20 planning round that are reported here. The procurement savings target should be delivered as the year progresses; the

remaining risks will be mitigated by the non recurrent additional income for the pay award costs and contribution from new services. The overall Corporate Directorate position is £0.2m overspend at October as the non-pay overspending is being mitigated by underspending on pay.

All uncommitted reserves have been released into the financial position and at the end of October reserves are marginally over-committed. There continues to be no central pot to mitigate financial overspends or support additional ad-hoc expenditure this year and BUs and Directorates will need to exercise strong financial management and manage to agreed outturns if the Trust is to achieve its control total surplus.

The most material area to address is the general savings requirements where the current forecast is £0.9m overspend; this will be mitigated by the additional pay award and contribution income.

Delivery of Cost Improvement Plans

Delivery of the identified CIPs remains strong. The position is consistent with previous month's in that the £0.2m unidentified savings agreed through the planning process are not being achieved and overall savings remain 9% less than planned.

Capital Expenditure

The Trust has an initial planned capital resource limit (CRL) of £2.0m for the year.

Capital expenditure is now running £0.3m more than planned at this time in the year; all of this relates to estates expenditure. The capital expenditure position continues to be closely monitored and the overspending is due to a timing issue in respect of estates projects where expenditure on refurbishing health centres and Stockdale House has started earlier than anticipated, the position will correct as the year progresses, this is not a financial risk.

Cash

The Trust's cash position remains very strong with £30m in the bank at the end of October; this is £2.6m more than was planned and is due to the payment of PSF for last year and the balances on working capital.

Better Payment Practice Code

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

Use of Resources Risk Rating

The Trust's risk rating at the end of this month is 1 overall, which is the lowest risk. All metrics score 1 this is consistent with last month.

Appendix 1 – October 2019

Service Specific Measures with Contractual Financial Sanctions

Leeds Community Healthcare NHS Trust

Measures with Financial Sanctions	Responsible Director	Threshold - YTD	YTD	Forecast	Financial Year	Q1	Q2	Potential Financial Impact
0-19 - % of infants who had a face to face newborn visit within 14 days of birth.	SP	>=87%	92%	●	*2019/20*	91%	92%	
0-19 - % of 6-8 week reviews completed within 12 weeks of birth.	SP	>=83%	94%	●	*2019/20*	95%	94%	
0-19 - % of 12 month reviews completed within 12 months.	SP	>=80%	80%	●	*2019/20*	81%	80%	
0-19 - Number of PBB Programmes commenced	SP	43	36	●	*2019/20*	17	19	0.25% of contract value (annual)
0-19 - Number of HENRY Programmes commenced	SP	43	44	●	*2019/20*	20	24	0.25% of contract value (annual)
0-19 - Percentage of actual staff in post against funded establishment	SP	95%	100.3%	●	*2019/20*	97.0%	99.0%	
0-19 - % of 0-19 staff (excluding SPA) co-located in Children's Centres	SP	>=25%	0.0%	●	*2019/20*	0.0%	0.0%	Agreement that sanction waived for 2019/20
0-19 - Roll Out of Chat Health to secondary schools	SP	>=70%	89.0%	●	*2019/20*	89.0%	96.0%	
LSH - HIV testing uptake on first appointment in MSM with unknown status	SP	>=85%	85.8%	●	*2019/20*	87.9%	83.8%	
LSH - Number of people accessing EHC and leaving with a form of contraception.	SP	>=58.4%	67.1%	●	*2019/20*	66.9%	67.3%	
LSH - Service should diagnose 85% towards the chlamydia diagnosis rate in 15-24 year olds	SP	1731	1971	●	*2019/20*	1058	1971	
LSH - Percentage of clients requesting an appointment to be seen within 48 hours of contacting the service unless they choose to opt out.	SP	>=90%	87.9%	●	*2019/20*	89.2%	86.6%	20% of incentive budget; £9,752.19 per month
PolCust - % of calls attended within 60 minutes	SP	>=95%	91.9%	●	*2019/20*	91.6%	92.2%	0.50% deduction from monthly invoice
PolCust - Provision of a full rota	SP	100%	99.6%	●	*2019/20*	99.7%	99.6%	£350 deduction per missed shift

Appendix 2 – October 2019

Retention Background Data

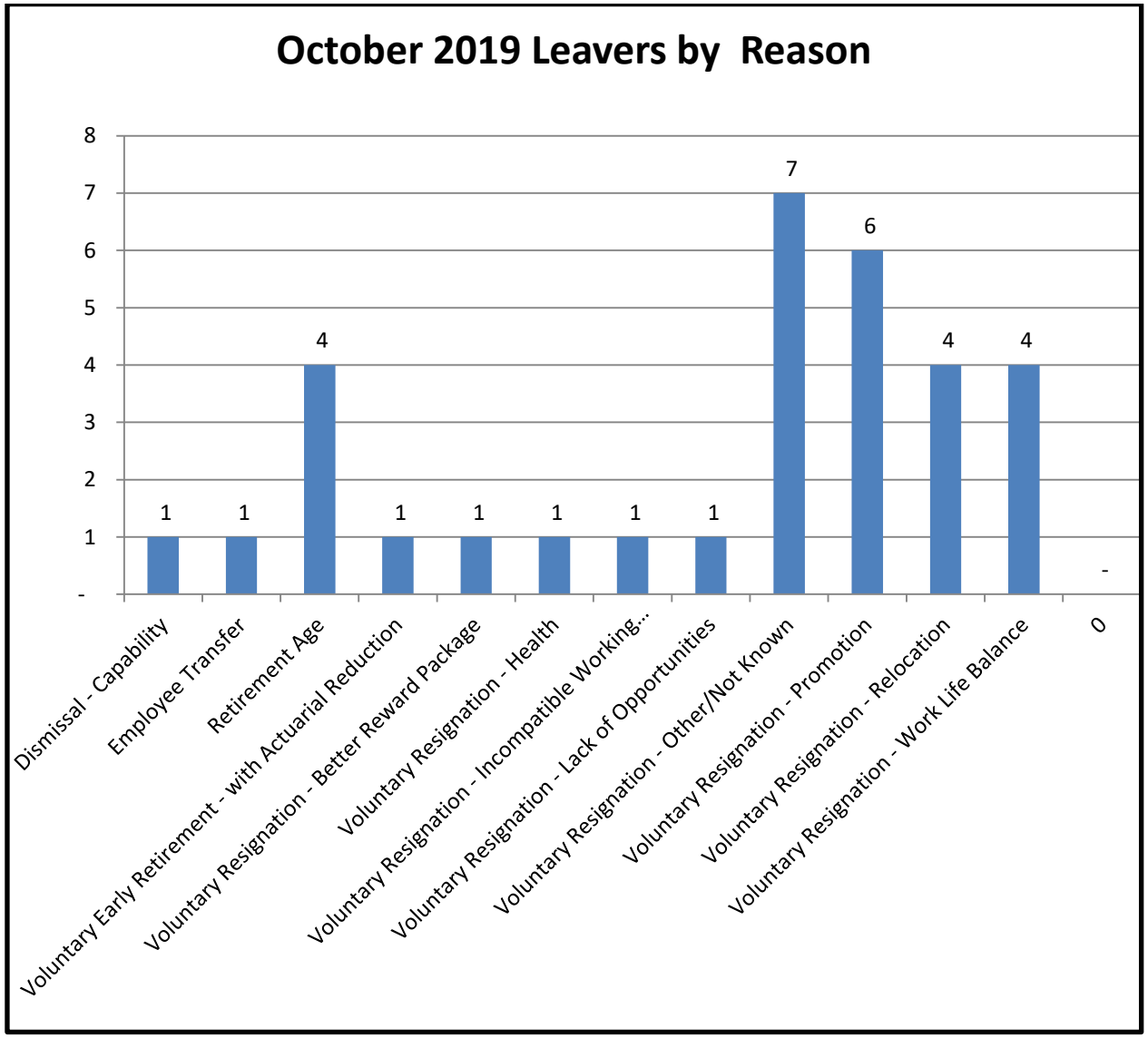
Leeds Community Healthcare NHS Trust

In October 2019 there were 32 leavers across the Trust.

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

Business Unit	October 19 Leavers
Adult Business unit	12
Children's Business Unit	9
Corporate	4
Specialist Business Unit	6
Executive Directors	0
Operations	1
Grand Total	**32**

Staff Group	October 19 Leavers
Clinical Services & Healthcare Scientist	5
Additional Prof Scientific & Technical	4
Administrative and Clerical	9
Allied Health Professionals	1
Nursing and Midwifery Registered	13
Medical and Dental	0
Estates	0
Grand Total	**32**


October 2019 Leavers by Reason
8
7
6
5
4
3
2
1
-
1
1
4
1
1
1
1
1
7
6
4
4
-
Dismissal - Capability
Employee Transfer
Retirement Age
Voluntary Early Retirement - with Actuarial Reduction
Voluntary Resignation - Better Reward Package
Voluntary Resignation - Health
Voluntary Resignation - Incompatible Working...
Voluntary Resignation - Lack of Opportunities
Voluntary Resignation - Other/Not Known
Voluntary Resignation - Promotion
Voluntary Resignation - Relocation
Voluntary Resignation - Work Life Balance
0

Appendix 3 – October 2019

Key Indicators by Neighbourhood Team

Leeds Community Healthcare NHS Trust

Peformance Summary at a Glance by Category by Neighbourhood Team - September 2019										
	Activity					Quality	Workforce			
Service	% Variance from Profile - Face to Face Contacts	Number of Face to Face Contacts	FF Contacts 12 Month	Number of Referrals	Referrals 12 Month Average	Percentage of Community Respondents That Would Recommend	Appraisal Rate (% In Date - Target	Clinical Statutory and Mandatory Training (% in date - Target 95%)	Sickness (% FTE - Target < 5.8%)	Universal Statutory and Mandatory Training (% in date -
Armley Neighbourhood	3.8%	5429	5155	152	162	100.0%	92.3%	85.2%	2.9%	88.4%
Beeston Neighbourhood	-20.7%	2539	2439	77	88	82.8%	96.9%	94.2%	0.8%	92.7%
Chapeltown Neighbourhoo	-18.4%	4327	4834	172	157	72.7%	98.0%	91.4%	6.1%	92.0%
Holt Park Neighbourhood	-4.7%	2719	2629	114	103	100.0%	91.4%	86.2%	4.1%	89.4%
Kippax Neighbourhood	2.5%	4208	4337	136	136	n/a	86.7%	76.6%	8.8%	86.3%
Meanwood Neighbourhooc	-2.1%	5583	5768	212	204	85.7%	87.8%	88.4%	7.1%	85.8%
Middleton Neighbourhood	20.8%	6563	6468	192	181	100.0%	82.7%	83.8%	4.0%	88.0%
Morley Neighbourhood	5.4%	4460	4501	122	141	96.6%	100.0%	92.6%	4.7%	92.5%
Pudsey Neighbourhood	14.1%	4490	4700	118	127	91.7%	81.8%	81.9%	9.0%	84.9%
Seacroft Neighbourhood	-0.7%	5057	5610	218	200	100.0%	81.1%	87.4%	6.5%	89.6%
Wetherby Neighbourhood	-31.7%	2037	2120	92	92	100.0%	94.4%	90.6%	1.9%	94.2%
Woodsley Neighbourhood	3.3%	4786	4947	124	129	100.0%	79.2%	92.4%	5.6%	88.1%
Yeadon Neighbourhood	-10.0%	4546	4602	161	159	100.0%	97.9%	89.6%	3.0%	86.9%

Appendix 4 – October 2019

Detailed Financial Data 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	£0.8m	£0.1m	£1.7m	G
Remain with EFL of £0.53m			£0.5m	G
Remain within CRL of £2.0m	£0.7m	£0.3m	£2.0m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	98%	3%	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	£0.98m	-	£1.68m	G
CIP Savings £0.64m planned non recurrent in year	£0.25m	-31%	£0.44m	R

Table 2 Income & Expenditure Summary	October Plan WTE	October Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m	Forecast Variance Last Month £m
Income									
Contract Income			(85.9)	(85.9)	0.0	(145.3)	(145.2)	0.1	0.1
Other Income			(7.2)	(7.2)	0.1	(12.0)	(11.9)	0.1	0.1
Total Income			***(93.1)***	***(93.0)***	***0.1***	***(157.3)***	***(157.1)***	***0.2***	***0.2***
Expenditure									
Pay	2,786.1	2,728.4	66.9	66.6	(0.3)	113.5	113.3	(0.2)	0.1
Non pay			23.6	23.7	0.1	38.8	39.0	0.2	0.6
Reserves & Non Recurrent			0.2	0.3	0.0	0.4	0.3	(0.1)	(0.9)
Total Expenditure	***2,786.1***	***2,728.4***	***90.7***	***90.6***	***(0.1)***	***152.7***	***152.6***	***(0.1)***	***(0.1)***
EBITDA	**2,786.1**	**2,728.4**	**(2.4)**	**(2.5)**	**(0.1)**	**(4.5)**	**(4.5)**	**0.0**	**0.0**
Depreciation			1.2	1.2	(0.0)	2.0	2.0	0.0	0.0
Public Dividend Capital			0.5	0.5	(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			(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)	(0.0)
Retained Net Surplus	**2,786.1**	**2,728.4**	**(0.8)**	**(0.9)**	**(0.1)**	**(1.7)**	**(1.7)**	**0.0**	**0.0**
	Variance =	**(57.7)**							

Table 3 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	YTD Actuals £k
Directly employed staff	8,932	8,571	8,546	8,542	8,558	8,737	8,797	60,683
Seconded staff costs	229	252	226	267	241	376	213	1,804
Bank staff	232	156	211	200	198	165	200	1,362
Agency staff	392	306	460	384	424	413	358	2,736
Total Pay Costs	**9,785**	**9,285**	**9,443**	**9,393**	**9,421**	**9,691**	**9,568**	**66,585**

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	481	502	21	24	
Clinical Supplies & Services	6,240	5,966	(274)	(195)	
General Supplies & Services	2,977	2,944	(32)	(30)	
Establishment Expenses	3,482	3,427	(55)	(13)	
Premises	9,056	8,937	(119)	75	
Other non pay	1,353	1,929	576	489	
Total Non Pay Costs	**23,588**	**23,706**	**117**	**351**	**188**

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	85	85	0	145	145	0	0%
Non Pay Inflation	201	201	0	345	345	0	0%
MSK Radiology	58	58	0	100	100	0	0%
IAPT - NR vacancies	35	35	0	60	60	0	0%
Dental - M&S Disposables	23	23	0	40	40	0	0%
ABU Non Pay	67	67	0	115	115	0	0%
Adults Community Geriatricians	50	50	0	85	85	0	0%
Infection control	9	9	0	15	15	0	0%
Interest received on cash at bank	35	35	0	60	60	0	0%
Contribution from new investments	525	525	0	900	900	0	0%
IT Kit	146	146	0	250	250	0	0%
Un-identified CIP agreed by SMT	117	0	(117)	200	0	(200)	-100%
Total Efficiency Savings Delivery	**1,350**	**1,234**	**(117)**	**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	40.7	736.0	738.2	2.3	24.6	24.4	(0.2)
Childrens Services	30.7	702.7	705.4	2.6	18.0	18.1	0.1
Adults Services	42.6	902.3	877.9	(24.4)	24.9	24.6	(0.3)
Ops Management & Equipment	1.9	58.2	51.9	(6.3)	1.1	1.1	0.0
Service Line Totals	**115.9**	**2,399.2**	**2,373.4**	**(25.8)**	**68.6**	**68.3**	**(0.3)**
Corporate Support & Estates	29.3	386.8	355.0	(31.8)	17.4	17.6	0.1
Total All Services	**145.2**	**2,786.1**	**2,728.4**	**(57.7)**	**86.0**	**85.9**	**(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	0.2	0.5	0.4	0.6	1.1	0.5
Equipment/IT	0.0	(0.0)	(0.0)	1.0	0.5	(0.4)
Electronic Patient Records	0.2	0.1	(0.1)	0.5	0.3	(0.2)
Totals	**0.4**	**0.7**	**0.3**	**2.0**	**1.9**	**(0.1)**

Table 8 Statement of Financial Position	Plan 31/10/19 £m	Actual 31/10/19 £m	Variance 31/10/19 £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	28.5	28.8	0.4	*29.3*	29.2	29.3	0.1
Intangible Assets	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Assets	**28.5**	**28.8**	**0.4**	***29.3***	**29.2**	**29.3**	**0.1**
Current Assets							
Trade and Other Receivables	8.4	9.8	1.4	*9.4*	9.2	9.2	0.0
Cash and Cash Equivalents	27.5	30.0	2.6	*26.5*	26.8	28.3	1.5
Total Current Assets	**35.9**	**39.9**	**4.0**	*35.9*	**36.0**	**37.5**	**1.5**
TOTAL ASSETS	**64.4**	**68.7**	**4.3**	***65.3***	**65.2**	**66.8**	**1.6**
Current Liabilities							
Trade and Other Payables	(10.8)	(13.4)	(2.6)	*(10.9)*	(10.9)	(10.9)	0.0
Provisions	(0.4)	(0.5)	(0.1)	*(0.6)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(11.2)**	**(13.8)**	**(2.6)**	***(11.5)***	**(11.3)**	**(11.3)**	**0.0**
Net Current Assets/(Liabilities)	**24.7**	**26.1**	**1.3**	***24.5***	**24.7**	**26.3**	**1.5**
TOTAL ASSETS LESS CURRENT LIABILITIES	**53.2**	**54.9**	**1.7**	***53.8***	**53.9**	**55.6**	**1.6**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	***0.0***	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**53.2**	**54.9**	**1.7**	**53.8**	**53.9**	**55.6**	**1.6**
TAXPAYERS EQUITY							
Public Dividend Capital	0.4	0.4	(0.0)	*0.4*	0.4	0.4	0.0
Retained Earnings Reserve	22.2	23.9	1.7	*22.9*	23.0	24.6	1.6
General Fund	18.5	18.5	0.0	*18.5*	18.5	18.5	0.0
Revaluation Reserve	12.0	12.0	(0.0)	*12.0*	12.0	12.0	(0.0)
TOTAL EQUITY	**53.2**	**54.9**	**1.7**	**53.8**	**53.9**	**55.6**	**1.6**

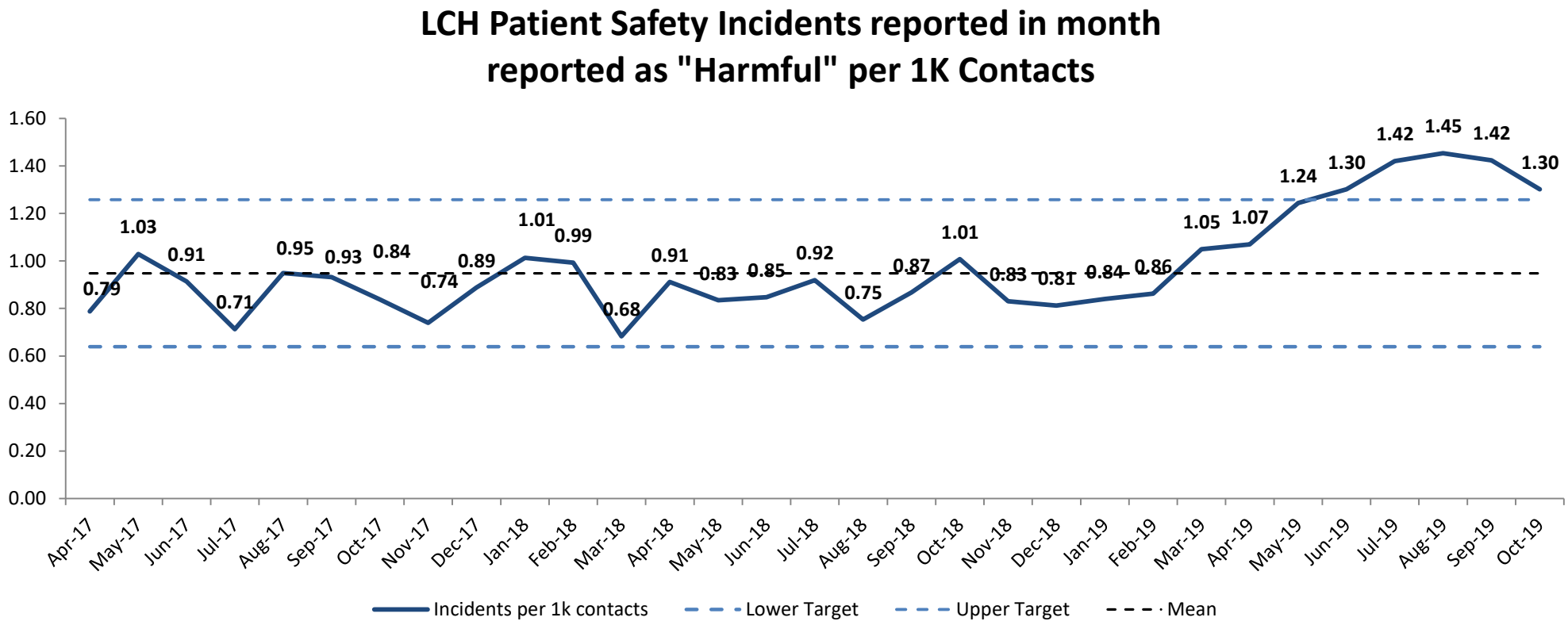
Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	98%	95%	G
Non NHS Invoices			
By Number	97%	95%	G
By Value	98%	95%	G

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	61	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	-28%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

Appendix 5 – October 2019

Patient Safety Incidents

Leeds Community Healthcare NHS Trust



Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (83)

Meeting: Trust Board 6 December 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 on 4 October 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 4 October 2019

- No risks score 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
- Four new risks scoring 12

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by 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 BAF 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 (October 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 which score of 15 (extreme) or above on the Trust risk register as at 8 November 2019.

2.2 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 four new risks scoring 12 reported since October 2019

Risk 984	Initial risk score **15** (high)	Current risk score **12** (high)	Target risk score **3** (low)
Title: Six week waiting list breach risk in children's audiology Delays in recruitment and current sickness absence have resulted in insufficient staff capacity to meet service demands. There is a risk that children's audiology service may breach its 6 week waiting times and 18 week targets. As a result there may be delays in the identification and subsequent interventions for hearing loss,			

and increase in parental complaints, pressures of work may affect staff wellbeing, and there is a potential for financial penalties

.

Controls in place are:

- 4-stage breach mitigation plan in place to identify and reduce breaches as far as possible.
- Better forecasting in place to identify any spikes in demand and add further capacity.

Planned actions include:

- Recruitment to post has started.
- Where possible, increase clinical capacity within existing staff resource.
- Additional capacity to meet demand in place (recruitment)

Risk 985	Initial risk score **16** (high)	Current risk score **12** (high)	Target risk score **3** (low)

Title: Deprivation of Liberty for 16 and 17 year olds

Current working practices mean that parents are able to authorise the detention of children residing in Hannah House. In October 2019, a supreme court judge ruled that parents are no longer able to consent for their 16/17 year old's deprivation of liberty.

There is a risk that the Trust is now acting against legal precedence and thereby contravening the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13. As a result of this, the Trust may be exposed to litigation, fines and reputational damage.

Controls in place:

- Staff/service managers are aware of the new judgement ruling and that there will be changes.
- Trust has designated lead for mental capacity who links into Mental Health Act Governance Group and Safeguarding Committee
- Mental Capacity Act training part of statutory and mandatory requirements
- Trust has access to legal advice as needed

Planned actions include:

- Identify all 16 and 17 year olds who use Hannah House respite provision, who lack capacity to consent to their deprivations of liberty.
- Establish if those identified also have packages of care in the community setting (which also amounts to a deprivation of liberty) and who funds those packages.
- Approach funders to ask if they are (or have) seeking legal authorisations, if

so ask for respite provision at Hannah House to be included in their applications.

- If no community packages identified or responsible bodies seeking their own legal authorisation, Trust to consider to make own applications to Court of Protection (financial cost associated with this).

Risk 989	Initial risk score **15** (high)	Current risk score **12** (high)	Target risk score **3** (low)

Title: Reduced capacity in the Infant Mental Health Service (IMHS)

Due to vacancies, staff sickness and an increase in referrals, there is reduced staff capacity within the Infant Mental Health Team. There is a risk that waiting times may increase which could have an impact on the 12 week Community CAMHS waiting target [SLA agreement].

Controls in place:

- Referral process includes 'expectation of refer' discussions.
- Weekly triage meeting – reviewing all new referrals and those of waiting list.
- Service to prioritise urgent cases.
- All families continue to have GP and universal services so while waiting to see IMHT they still have health services support.
- Weekly review of waiting list – reporting to Service Manager and part of monthly Quality and Performance Panel

Planned actions include:

- Advertising Band 7 post
- Seeking agreement for a Band 4
- To discuss with colleagues from PHINS additional temporary support, thus supporting IMHS senior clinicians taking on team manager responsibilities

Risk 990	Initial risk score **15** (high)	Current risk score **12** (high)	Target risk score **3 (low)**

Title: Unable to meet 10 working day turnaround of dictated medical letters

Due to long term vacancies and sickness absence within the admin/secretarial team, there is a risk that letters following paediatric clinic appointments, may not be typed in a timely manner. This could result in a delay of up to 6 weeks for the letters to be sent to family/GP which means full information not available to colleagues within LCH/GP's, LTHT and families.
The impact of this could be that a child may receive inappropriate medical care due to time delay. Additionally there may be a rising number of complaints from families and other professionals, there is an increase in demand on paediatricians time

Controls in place:

- Paediatricians are documenting medication changes clearly in tabbed journal
- Letters to GP's where there are medication and prescribing changes are being expedited
- Where possible Doctors are writing their own letters and/or minimising content
- Additional secretarial hours are being contracted through CLaSS/Task master
- Moving workload (typing) around the city to ensure that evening spacing of clinics

Planned actions include:

- Actively managing sickness with support from HR
- Recruitment to vacant posts
- Extend use of CLaSS secretaries until below 2 week wait time
- Plan trajectory to achieve a 2 week wait time
- Review current capacity to maintain a 2 week time frame
- Moving to digital dictation with a clear start date
- Identify best practice in other areas around managing letters and review current systems in light of this include possible use of new SOPS
- To work with CLaSS to increase available admin support with audio typing skills

4.0 Risks escalated to a score of 12 (high)

4.1 No risks have been escalated to a score of 12 since October 2019

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

5.1 No risks have been de-escalated from a score of 12 since October 2019

6.0 Closed risks previously scoring 12

6.1 No risks have been closed, which previously scored 12

7.0 Risks with an out of date review date

7.1 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.

8.0 Board Assurance Framework Summary

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

8.2 Definitions:

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

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

8.4 The 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.

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

8.6 Since the last BAF report in October 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 2.1 (achieving internal projects) has moved further into reasonable. The draft estate strategy, Change Board report, EPR update, and initial draft of the digital strategy all provided Business Committee with reasonable assurance.

- BAF risk 4.3 (governance arrangements for partnerships) has moved into reasonable). The draft Standards of Partnership Governance were reviewed by the Business Committee, and provided substantial assurance that, if the standards are applied to new or existing partnership arrangements, then partnerships will be governed more effectively

Negative assurance movement (indicating a worsening situation)

There has been no negative movement.

8.7 The attached BAF summary reflects the amended assurance levels.

9.0 Recommendation

9.1 The Board is recommended to:

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

Board Assurance Framework Summary December 2019

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score				Current Level of Assurance (denoted by ◆).					
Strategic Goal	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	No	Limited	Reasonable	Substantial	Assurance - additional Infomation	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 patient safety may be compromised, leading to harm. The Trust may also experience intervention or damage to reputation and relationships	SL	QC	3	4	12				◆		Serious incident (AY) report to Quality Committee provided limited assurance. Mortality Report provided Quality Committee with reasonable assurance.	
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, the impact will be diminished safety and effectiveness of patient care leading to an increased risk of patient harm	SL	QC	2	4	8					◆	Performance Brief, winter planning report and Quality Strategy implementation plan progress provided Quality Committee with reasonable assurance	
	RISK 1.4 If the Trust does not engage patients and the public effectively, the impact will be that services may not reflect the needs of the population they serve.	SL	QC	4	3	12				◆			
	Risk 1.5 If there are insufficient clinical governance arrangements put in place as new care models develop and evolve, the impact will be on patient safety and quality of care provided.	RB	QC	3	3	9	**NEW**			◆			
Provide sustainable services	**RISK 2.1** If the Trust does not deliver 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	3	3	9					◆	New Estates Strategy, Change Board report, EPR update report and New Digital Strategy provided Business Committee with reasonable assurance	➡
	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	2	3	6					◆		
	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	3	6					◆		
	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	3	4	12				◆			

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 team triangulation report provided the Business Committee with reasonable assurance	
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	JA/LS	BC	3	3	9							Workforce Strategy (health and wellbeing) provided the Business Commirttee with reasonable assurance.	
	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	3	3	9								
	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								
	Risk 3.5 If the Trust does not further develop and embed a suitable health and safety management system then staff, patients and public safety maybe compromised, leading to work related injuries and/or ill health. The Trust may not be compliant with legislation and could experience regulatory interventions, litigation and adverse media attention.	BM	BC	4	3	12	**NEW**							
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 (ICS) 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	TB	2	3	6								
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners, health organisations, City Council and third sector organisations, then it may not be successful in developing and implementing new models or care as outlined in the NHS Long Term Plan. 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							Standards of Partnership Governance provided the Business Committee with substantial assurance	
	RISK 4.4 If there is insufficient capacity across the Trust to deliver the key workstreams of system change programmes, then organisational priorities may not be delivered.	TS	BC	3	3	9								

Appendix Two: Glossary- BAF risk assurance levels

For each source of assurance that is identified, the Committees have rated what each tells them about the effectiveness of the controls. The Committees use the following BAF risk assurance levels:

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

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (84)

Meeting: Trust Board 6 December 2019	**Category of paper**	
Report title: CAMHS New Care Models	**For approval**	
Responsible director: Executive Director of Finance & Resources **Report author:** Clinical Lead for CAMHS New Care Model	**For assurance**	✓
Previously considered by Not applicable	**For information**	

Purpose of the report

This report provides the Board with a comprehensive update on the work of the CAMHS New Care Model (NCM), highlighting the achievements, the challenges and the risks.

Main issues for consideration

The aims of the NCM are:

- Children and young people (CYP) should be cared for in the least restrictive environment
- Inappropriate admissions are reduced
- Length of stay will be optimised
- Capacity will be increased in community intensive and crisis CAMHS
- CYP do not need to travel further than 25 miles with the development of the new-build in-patient unit.

The report describes progress against these aims, showing quantitative and qualitative achievements. Significant regional stakeholder development and engagement has been achieved, with recognition through invitations to present at national events. Challenges have been faced, particularly this financial year and the report describes the action taken and the results of that action. Risks are described as the work continues as we move towards an anticipated move from New Care Models pilot status to a new Provider Collaborative contract anticipated for October 2020.

Recommendation

The Board is recommended to note the achievements of the West Yorkshire CAMHS New Care Model and take assurance that the challenges that have been faced are being met and ongoing risks being addresses by mitigating actions.

West Yorkshire CAMHS New Care Model

1. Purpose of the Report

1.1. This report is to provide an update on the West Yorkshire Tertiary (In-patient and Intensive Community) Child and Adolescent Mental Health New Care Model (CAMHS NCM). The context is twofold: the disappointing performance of the NCM over the summer period; and the need to convert the pilot NCM into a 'business as usual' Provider Collaborative. The report will describe the progress, achievements and challenges over the last 18 months with robust consideration of clinical, financial and reputational risks.

2. Background

2.1. Tertiary CAMHS NCMs[1] were introduced by NHS England in response to the Mental Health Taskforce's independent report, the Five Year Forward View[2] on transformation of mental health care. West Yorkshire commissioners and providers came together in 2016 to bid to be a NCM pilot site; we were successful in becoming a Wave 2 site[3], "going live" on 1 April 2018. Initial evaluation of all the CAMHS NCM sites led to an early commitment by NHS England to roll out the initiative with a view to all areas becoming Tertiary CAMHS Provider Collaboratives[4] by 2023.

2.2. There were three key drivers for the Tertiary CAMHS NCM initiative:

1. to address the unintended consequence of the change in 2013[5] from locally to nationally commissioned CAMHS inpatient units: this change essentially meant that there was a strong financial disincentive for CCGs to fund alternatives to, and step-up/step-down from, hospital admission. With the inpatient CAMHS budget located within NHS England, a prolonged hospital stay rather than a prolonged community alternative was a financial gain to CCGs.

2. to respond to a growing body of moderate quality research evidence [6,7,8,9,10]. In essence, young people may be equally as effectively and safely managed in specialist and intensive community CAMHS whilst avoiding some of the negative sequalae of an inpatient stay. Clinical outcomes are no worse for young people looked after at home rather than in hospital. However, young people managed in the community are more likely than those admitted to hospital to return to their own schools, and be spending more time in education, training and work. None of the studies report an increase in 'serious incidents' or never events among the non-admitted groups. Whilst too short an admission, or too precipitant a discharge can lead to re-admission, prolonged inpatient stays ('delayed discharges') are also harmful, with some clinicians reporting young people's clinical risks increasing rather than decreasing especially when a suitable step-down pathway or placement cannot be found in a timely manner.

3. to respond to the voice of young people and their families. For over 15 years [11,12,13] young people have been talking about how they would like to have more choice about where and how they are treated when they have a serious mental illness, and throughout this time, researchers have been documenting their views. Young people and their families are realistic about the need for admission to an adolescent mental health unit. However, they would like the admission to be close to home, for as short a time as possible, for the admission to be goal-oriented and recovery-focused, and for a robust discharge

plan to be considered from day one of admission. Young people report that despite "brilliant staff" they can feel very socially isolated in hospital, missing their family and friends, and having limited opportunities for hobbies and activities, and little or restricted access to social media.

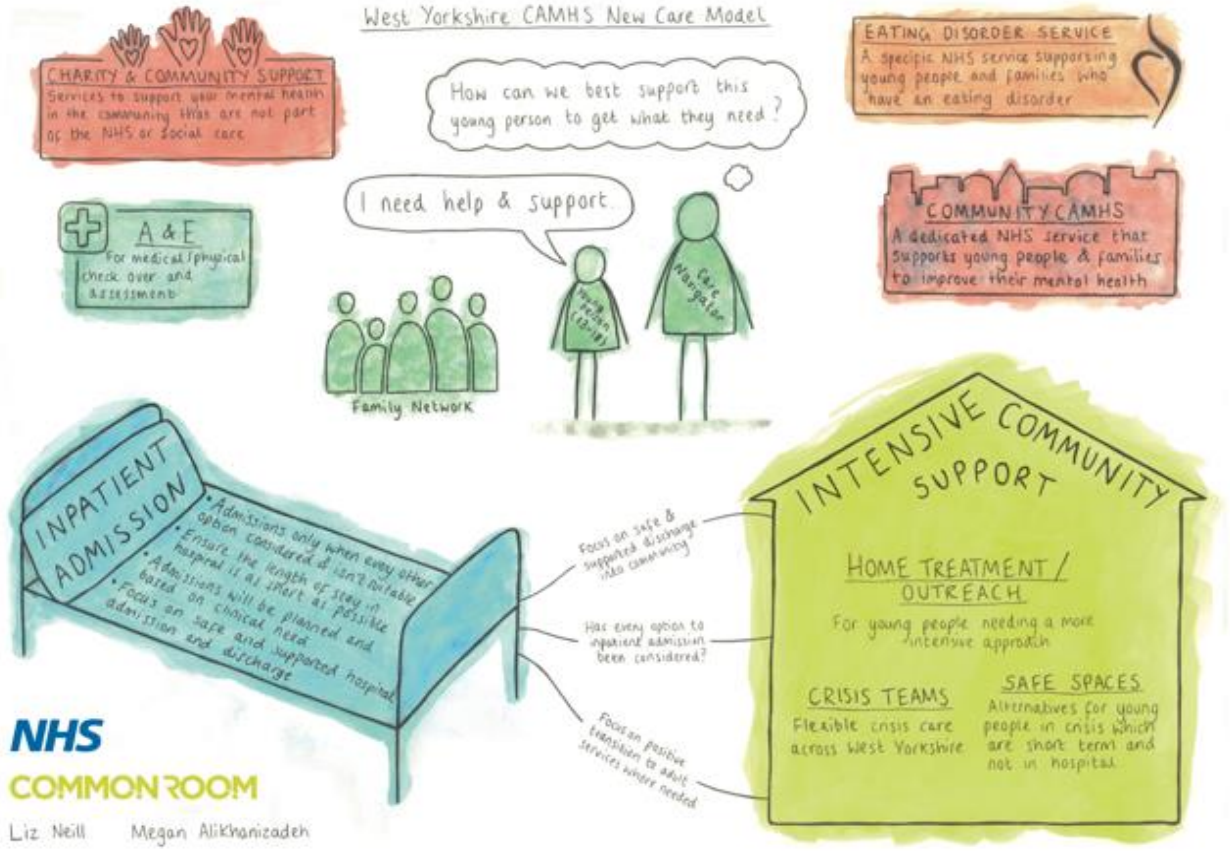
3. Aims of the WY CAMHS NCM

3.1. We aimed to ensure that across WY:

- Children and young people (CYP) should be cared for in the least restrictive environment, supported in their home and local community wherever possible with fewer admitted to inpatient beds
- Inappropriate admissions are reduced for CYP admitted to the WY in-patient unit - when they do need to be admitted, this will be in WY, based on clinical need, for as short a period possible, with effective transition between community and hospital
- Length of stay will be optimised for CYP admitted to the WY In-patient unit with a reduction in "delayed discharges" and "drift" in discharge planning.
- Capacity will be increased in community intensive and crisis CAMHS so that all areas in WY are "levelled up" and inequalities between the areas reduced. This will be achieved through "save to invest" with monies saved through reduced bed usage being diverted directly into new posts in CAMHS crisis and intensive teams
- CYP do not need to travel further than 25 miles with the development of the new-build in-patient unit with its expanded bed base of 16 Generic Adolescent and 6 Psychiatric Intensive Care beds.

4. Clinical Model

4.1. At the heart of our clinical model are the views of young people, elicited and thematically collated for us by CommonRoom UK (2018) and illustrated here:



4.2. Across WY, the NCM is working to ensure that each local place has:

- A crisis team that is fit of purpose and offers an appropriate level of support at all times of the day 365 days a year
- A community intensive service
- Access to a non-health "safer space" to present to in a crisis
- Support from a Care Navigator role

4.3. The Care Navigators' role is adapted from that described in the pilot work of Wakefield District Housing and Clinical Commissioning Group[14]. They work in one or more of the five WY areas (Bradford/Airedale, Calderdale, Huddersfield/Kirklees, Leeds and Wakefield) and are supported and supervised on a weekly basis (as a minimum) by the NCM Clinical Lead. Whilst not holding clinical responsibility for a caseload, they focus on all young people in their geographical base who are on the cusp of an admission or have been admitted. They work directly with clinical care coordinators and staff to ensure that admissions are timely, clinically indicated and that all community options have been considered and exhausted; they also ensure that young people leave hospital in a timely manner.

4.4. They do this through [15,16,17,18]:

- providing a safe time and space for clinicians to think through a case;
- drawing on their clinical experience and expertise including their personal experiences of when things went well and when things did not go well.
- Having a detailed and up-to-date knowledge of local issues, and community offers from statutory and VCS organisations that could support a community intensive package for a young person
- challenging cultural norms - "we always do it like that" - in organizations
- acting as "cultural brokers" between organizations who are operating as silos within the broader system
- using skilled negotiation to unlock system stalemates, without taking sides
- identifying and enabling champions of the clinical model to embed change

5. What has been achieved so far

5.1. Key Performance Indicators

The success of the work of the NCM has so far been measured against the following performance targets and this is shown in the table below:

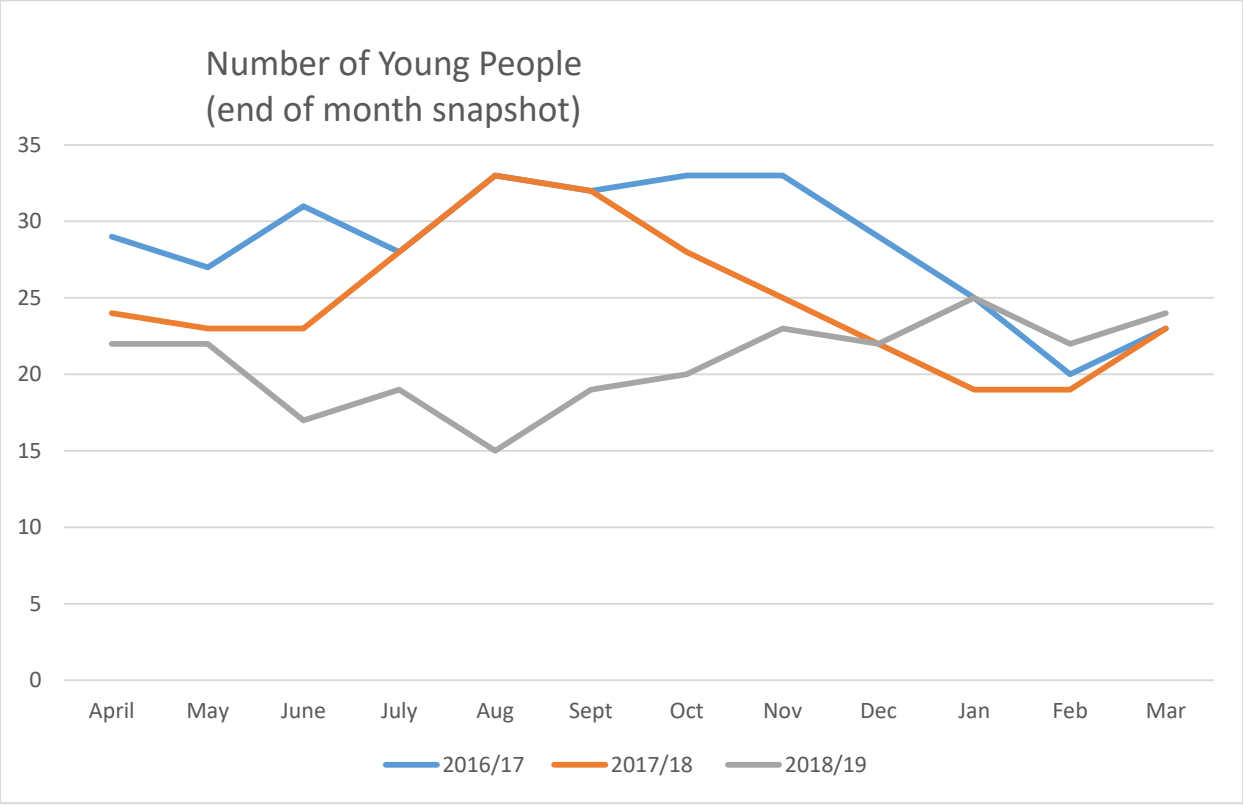
- Reduction in the number of admissions
- Reduction in the use of Out of Area Tier 4 beds (not Little Woodhouse Hall)
- Reduction in median distance travelled from home to hospital
- Reduction in occupied bed days compared to previous years
- Reduction in median length of stay

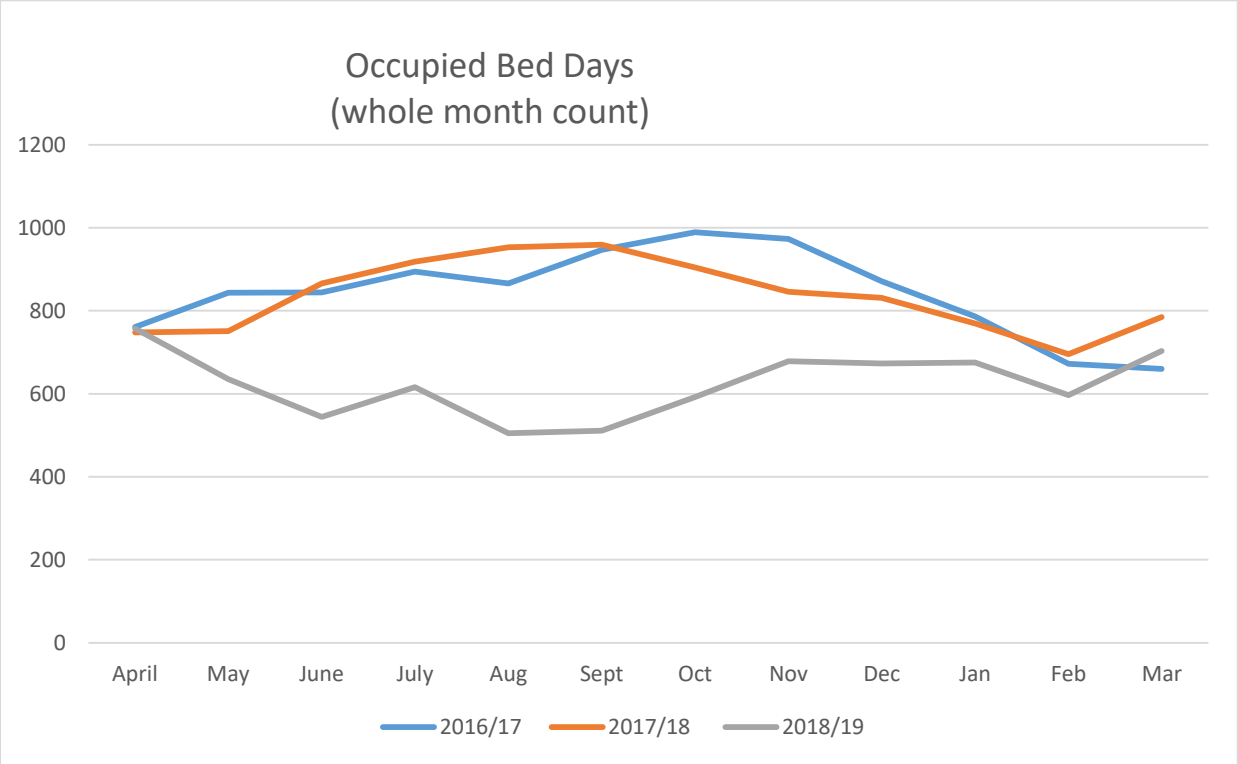
Metric	Baseline (2016/17)	2018/19 target	2018/19 achieved	2019/20 target
Admissions	153	145	124	Reduce by 24 (and shorten 15 others)
Number out of area placements	128	120	93	Reduce by 24
Median distance from home (miles)	36.95	34.5	25.7	34.1
Occupied Bed Days (OBDs)	10,106	9,682	7,486	Reduced 2097-2197
Out of area OBDs	Not known	Not set		
Median length of stay	Not known	Not set	50.5	

[1]The 124 admissions relate to 96 young people. There were 104 discharges during the year

5.2 We used Statistical Process Controls to undertake a comparison with previous years for two key indicators: the number of young people who are in an inpatient bed on the last day of any given month and the number of occupied bed days per month.

These are shown in the two graphs below:


Number of Young People
(end of month snapshot)
35
30
25
20
15
10
5
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2016/17
2017/18
2018/19


Occupied Bed Days
(whole month count)
1200
1000
800
600
400
200
0
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
2016/17
2017/18
2018/19

5.3. Additional achievements:

- Invested over half a million pounds in local NHS CAMHs services – mainly in Community Intensive Services and Crisis Services in CAMHS
- Developed an inpatient network for those units we work with and linked to the new St Mary's build
- Made links with CAMHS commissioners, social care, TCP boards and many other stakeholders
- Safely avoided admission for at least 31 young people, many of whom have now been looked after in the community for a number of months and are doing well

5.4. Positive self-reporting of patient and family experience

We have engaged with families and young people from day one of the project to find out what young people wanted from the NCM clinical model to add to the data collected by individual inpatient units and CAMHS teams on how they are performing from a user perspective. We have asked about the impact of services on young people and how they and their families are supported by crisis, home/community treatment and inpatient services. Below is an amalgamated case study showing how the CAMHS NCM has a positive impact on children and young people in WY.

Sammy (not her real name) was a 15-year-old girl who had been losing weight for 6 weeks and had dropped 2 clothes sizes. She was taken to her local A&E department by her mum after she had fainted three times in school earlier that day. She was admitted for medical stabilisation by the paediatricians, who were concerned about her physical health. They asked local CAMHS Team A to see Sammy and assess for a CAMHS inpatient bed. Team A said that they did not see young people who were on the paediatric ward because it was not in their catchment area: it should be CAMHS Team B, who cover the hospital. Team B said that it was unhelpful for them to see Sammy because her care would subsequently fall under Team A. By the end of the week, Sammy had still not seen CAMHS.

The Ward Matron had heard about the New Care Model and contacted the Care Navigator who spoke with the two CAMHS teams and with the access assessment team for the WY inpatient unit. They brokered three-way conversations between them. The result was a face-to-face access assessment, undertaken with the inpatient access assessor, the Care Navigator, and a care coordinator from CAMHS team A with Sammy and her mum. It was agreed that Sammy did not need an inpatient CAMHS bed but could be cared for by the local specialist CAMHS Eating Disorder team, and she was discharged home the same day.

So far Sammy is progressing well, with a NICE-compliant approach to treatment.

5.5. Culture of psychological safety, and learning in partnership

We have ensured that learning and improvement have taken place whenever young people's care has been less than optimal. We use the NCM governance structures to raise concerns and monitor trends, in particular the quarterly NCM Clinical Governance Sub-group, chaired by the NCM Clinical Lead and attended by the three Directors of Nursing of LCH, BDCT and SWYFT. The incident reporting template used is that of LCH. All incidents are reported through the Datix systems of the relevant NHS Trust by the relevant Care Navigator or Clinical Lead as appropriate. The Clinical Lead is an experienced reporter, and trained investigator, for Datix and has undertaken critical friend and reviewer roles in Root Cause Analyses and Serious Incident reviews20.

The Clinical Lead and Care Navigators lead on focused event analyses ("lessons learnt") to share learning and good practice.

The Clinical Lead and Care Navigators promote a culture of admitting their own fallibility and modelling this behaviour to others; being clinically curious; being available to others; and proactively inviting input from the rest of the team and the services they work into i.e. we work to promote the "psychologically safe21" environment where everyone feels safe to raise concerns, admit they don't know the answer, that they got something wrong, and to ask someone for help. We demonstrate this in our weekly team supervision, where everyone is an equal contributor, everyone learns from one another's (very varied) experience.

5.6. Investment

From the financial baseline figure of £7.7 million over £1.2 million has been invested in clinical services in the local area: mainly strengthening the crisis and intensive home treatment aspects of community-based services. This has paid for the CAMHS NCM team and it has been agreed with NHS England that some of the money is to support costs associated with the children and young people's inpatient build at the St Mary's site. Such investment proposals, working with local providers and commissioners, are agreed through the West Yorkshire New Care Models Programme Board, which reports to the West Yorkshire Mental Health Services Collaborative which itself reports to the West Yorkshire and Harrogate ICS.

The gap analysis of community crisis and intensive services across West Yorkshire, was undertaken by the clinical lead and project lead, and showed clear evidence of the need for investment in all local place-based services. To ensure that all services were strengthened to support the additional work that the NCM was going to ask them to undertake (particularly supporting some of the more complex young people for longer) the first tranche of investment was money supporting additional clinical staff recruitment in each area and some non-recurrent pump-priming investment.

This money was allocated as shown below:

Provider	Investment made (£k recurrent)	Number of additional wte employed
Bradford District Care Foundation Trust	107	3
South West Yorkshire Partnership Foundation Trust	193	4
Leeds Community Healthcare NHS Trust	201	5.6
Core NCM team	270	3.4

Through our excellent relationships with community teams and commissioners we have been able to have a synergistic effect from this investment. Below is an example of how this has created change:

In Leeds, the CAMHS service has worked to identify what resources they already use to respond to young people in crisis. They have added some of this resource to the money invested from CAMHS NCM and, with new investment from the CCG, a separate crisis team is up and running which will soon be expanded to offer a service 08.00 – midnight.

6. Independent Evaluation (Niche Consulting)19

6.1. An independent evaluation of all the New Care Models was commissioned by NHS England after a competitive tendering process. Broadly, the report found that whilst adult secure new care models were struggling to deliver on their targets, most CAMHS pilot sites were delivering. The report found "good evidence" that almost all children and young people's NCM areas treat more young people closer to home than they previously did; non-NCM areas are lagging behind NCM areas in this regard. There was also "good evidence" that children and young people's (CYP) NCM sites are producing significant savings in inpatient costs. The narrative from the evaluation speaks of "a strong sense that the [NCM] initiative is producing a greater willingness to regard organisations previously seen as competitors as partners in a process of service improvement and there is a parallel "strong, increased sense of ownership and empowerment….for local services to achieve changes in the way [they] work.

7. Verbal feedback

"It has been such a pleasure working with you and your team" - Children's Social Worker (2019)

"Thanks for your considerable help - thank you again!" CCG Strategic Children's Commissioner (2018)

Your leadership, support and guidance in this matter has been very much welcomed by our staff and, I am sure, by the young person and their family. Director of Nursing (2017)

"A huge thank you for your help and support today in ensuring that a vulnerable patient got to the right place for their needs….it was sorted within 3 hours – from first contact to the transport arriving….a great example of problem solving and working together to the benefit of the patient….not a "turf war" in sight. If this is a sign of the future working of the New Care Models I believe there is an exciting future in store." Consultant Surgeon (2017)

8. Other allied work

8.1. Local Authority

We have been formally supported by the Directors of Children's services in all the Local Authorities across WY. Rob Mayall, Local Authority Advisor to the Yorkshire & the Humber Clinical Network CYPMH Improvement Team has been nominated by the Directors of Childrens Services to represent and feedback to them on the working of the NCM and he attends our Partnership Group and Programme Board meetings Work in individual areas, either through contact made through the children's health commissioners or through meetings such as Lessons Learnt meetings

8.2. Voluntary sector

Engagement with the voluntary sector is largely place based and is one of the key roles of the Care Navigators. They understand and have a full map of

service provision across the whole of their patch. We have been able to effectively map the offer including close working with SaferSpace which is run by Creative Support in Bradford and The Market Place in Leeds. Both services have been able to offer support to young people from WY as part of their overall pathway of care.

8.3. Inpatient units/Tier 4

Working with NHSE case managers we have developed good working relationships with our inpatient colleagues, not only in Little Woodhouse Hall (the current Tier 4 service in Leeds) but with all of the inpatient units that we use regularly. This has been helped by a reduction in the number of units being used (with the drive to bring young people as close as home as possible).

We have convened regional conferences to ensure a close connection and dialogue between outpatient and inpatient services. This has helped to identify areas of practice development. For example, NCM are facilitating a regional discussion on shared “good practice’, based on Royal College of Psychiatrists’ Quality Network in In-patient CAMH guidance, which make explicit a regionally agreed set of responsibilities for inpatient and outpatient services in relation to admission, care planning and review and discharge.

8.4. Crisis and intensive home/community treatment teams

Much of the investment in year 1 of the pilot was to strengthen the response from crisis and intensive home/community treatment teams. Care Navigators lead a regular meeting with key clinicians and managers from each team across WY. This meeting has produced extremely positive results with the sharing of good practice and challenges and also open sharing of existing protocols and ways of working. This network has been particularly helpful to the those establishing new teams.

8.5. NHSE

We have established clear and positive relationships with NHSE/I CAMHS Case Managers and Mental Health Supplier Leads. There is representation from NHSE/I staff in all levels of the governance structure for the CAMHS NCM. This puts us in a really strong position to understand the challenges faced by each team and work together to resolve them. It has also provided the NCM with an accurate insight into what NHSE do and how we need to plan to take on the roles currently discharged by them. The national and regional NHSE teams have also supported processes to share good practice and we have had particularly good relationships with the Wave 1 CAMHS site in the Tees, Esk and Wear Valley areas, as well as sharing our learning with other areas moving toward becoming a provider collaborative.

The Clinical Lead (AWD) sits on the Provider Collaborative and Alternative to Admission sub-group of the Children and Young People’s Clinical Reference Group (NHSE/I), giving us the invaluable opportunity to share our concerns and our learning directly with our NHSE/I national team colleagues, to influence the shape of provider collaboratives going forward, and to take learning from the other NCMs represented on the group.

8.6. Yorkshire & the Humber Strategic Clinical Network (CYPMH) Improvement Team)

We have very close links with the regional Clinical Network CYPMH team. Their Local Authority Advisor (Rob Mayall) acts on behalf of the WY Assistant Directors of Children's Services on our NCM Steering Group. The NCM clinical lead (AWD) is also Clinical Advisor to the Clinical Network CYPMH team. In 2019/20 we will be able to use the outcomes of mapping of CYP Eating Disorder services across WY to inform ways to improve teams in supporting our young people who have an eating disorder.

8.7. Whole CAMHS commissioning pilot in West Yorkshire

The success of the NCM in year 1 has led to opportunity to successfully bid to be part of the CAMHS whole pathway commissioning pilot. The work to develop the whole commissioning pilot has identified three cohorts of our most vulnerable young people where we will build on the relationships established in the NCM to further improve services for CYP. These are: young people in crisis (self-defined); those who are 'looked after' by the Local Authority; and those who have neurological developmental difficulties. We received £100,000 from NHSE/I to set up a project team and a Project Lead has recently been appointed.

8.8. External Presentations

North East/Yorkshire and Humber Mental Health Conference, 15 June 2018, York
Health Care Expo, 26 June 2019, London
Northern Regional Good Practice Forum, NHSE/I, 18 September 2019, Leeds
Health Service Journal Mental Health Summit, 29 November 2019, Leeds

9. Our Challenges and what action we have already taken

9.1. The last few months have been more challenging for the pilot. Whilst the number of admissions has not increased, the number of discharges has fallen, meaning that overall length of stay and number of occupied bed days has increased, and we have not only not made the financial savings we saw in the first year of the pilot but went into deficit in late summer.

9.2. The clinical lead (AWD) interrogated the Specialised Mental Health database, from which our activity and finance are drawn, and looked for trends across area, mental health unit, and diagnostic category, and triangulated this with the weekly NCM Team Supervision notes. The project lead (RG) undertook the financial analysis and projection. AWD and RG then discussed the causative factors together in early September, and then shared their proposed remedial plan with the Lead Director and Deputy Director of Finance at the NCM monthly Management Meeting and the plan was agreed. The reasoning and the plan itself were shared with the Care Navigators to action.

Reasons identified as leading to the increase in occupied bed days and the actions taken

Identified problem	**Action taken and mitigations**
Reduced presence of Care Navigators on the ground: the excellent work on the inpatient unit network and crisis network did however mean they had less time to attend crucial meetings such as Care Programme Approach (clinical planning meetings) where they can have most impact.	All non-essential activity of care navigators was stopped temporarily pending a reduction in OBDs. The care navigators focused on attending Care Programme Approach (multidisciplinary planning) meetings
Identified problem	**Action taken and mitigations**
Personnel changes within the care navigator team.	Two new members have joined the team and the care navigator has returned from maternity leave; team focus and morale have already increased
Drift from core purpose of the pilot	We remind ourselves of our core rationale each week in team supervision and we will hold 6-monthly team days
Need for more effective cross-cover within the care navigator group for planned and unplanned absence	Clinical Lead addresses this in weekly supervision. Project Support Officer will provide visual timetable of holiday cover over key holiday periods
Increasing proportion of Clinical Lead and Project Lead time taken up with relevant but not “core” business: Whole pathway commissioning work, preparing Provider Collaborative bid	Clinical Lead and Project Lead will prioritise “core” business

Identified problem	Action taken and mitigations
More frequent lack of clinical formulation of patients in the inpatient units leading to poor discharge planning and extended stay	Care Navigators will challenge when clinical formulation of patients is out-of-date, not comprehensive, or not done.
Community crisis and intensive teams unable to spend the savings we generated because they failed to recruit and retain staff and so the teams remained understaffed and not well able to support discharge from hospital. This in turn led to low morale in some teams, and further lack of confidence in managing higher risk young people.	NCM team can contribute to innovative strategic thinking on workforce Planning through the Clinical Lead in her as Clinical Advisor, Yorkshire & the Humber Clinical Network CYPMH Improvement Team.
Reduced availability of the NHS England Case Managers due to one of them being seconded to provide clinical advice to the West Lane Hospital CAMHS inpatient service in Middlesbrough (rated inadequate and closed by the CQC in August)	We have discussed this with the NHSE/I Specialised Commissioning Team who are aware of the shortfall of case managers' time but there is no short-term change
Too much focus in the wider children and young people's mental health system on "we need to escalate problems" but not on actually "doing the work" to keep young people flowing through the system.	Clinical Lead and Project Lead will address this within the wider system

10. Progress against the action we have already taken

10.1. We are pleased to report that the number of young people in beds has dropped to the levels we saw last year and in the early part of 2019. At the start of September, there were 26 young people in beds; as of 28 October, there were 17 young people in beds although that number has risen in November. Initial review suggests that is at least part due to staffing concerns in a particular area of West Yorkshire.

10.2. Although the position remains variable, the current forecast outturn against the NCM budget this year is an underspend of £250k.

11. Risks

11.1. The key risks highlighted in the original business case to NHSE remain. We have added in new risks relating to any possible changes being suggested to the agreement of the financial envelope and cohort for TCP young people, the financial baseline and the unknown quantity final bed day costs and clinical model for the inpatient build at St Mary's.

Risks	Mitigating actions
Impact on care from non-admission or delayed admission	We monitor on a weekly basis the young people who as a result of the NCM approach are not admitted to hospital but remain in the community, to ensure that they do not receive suboptimal care as a result.
The patient cohort will not be the same in future years as in previous years	Ongoing review of live patient cohort data
Future funding does not recognise demographic increases in demand	Close working with NHSE to understand the financial envelop and patient demand, capacity and flow together
We cannot recruit staff to community roles due to the lag in releasing savings and creating a short term nature to job offers	Different approaches to recruitment will be tried offering posts as soon as savings are available
We cannot recruit staff to fill the gaps in teams identified and invested in	Working together across the patch to ensure that we have a co-ordinated approach to recruitment, and creative thinking about the type of roles developed using NCM investment
The Community Eating Disorder Services (CEDS-CYP) in each of the place based CAMHS are not fully able to respond to the needs of their cohort	We have started conversations with commissioners and providers to ensure that CEDS-CYP are fully functioning by March 2018. Some areas have already achieved this
Local areas (CCGs) disinvest from services as the NCM develops and invests in local services	We have agreements from health commissioners and providers that there will be no disinvestment during the lifetime of the project. We are exploring how we access local authority commissioners to ensure the same
The TCP cohort activity and finance is not accurately baselined	Those already identified as in the TCP cohort will be analysed in order to assure ourselves of areas where improvements could be made. National agreements on associated funding will be monitored closely.
The reduction in the financial baseline makes the proposed model unaffordable	If the financial baseline is reduced the investment in community alternatives will have to also be reduced. We will be unable to deliver the performance figures outlined above. This will significantly reduce the opportunities for improvements in services for young people
The clinical model at the St Mary's site is not robust enough to meet the needs of the majority of WY's young people	Robust work to engage a variety of clinical stakeholders in developing the clinical model is starting. This will ensure that the clinical pathways mean that admissions are reduced and that young people are cared for within WY

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Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (85)

Meeting Trust Board 6 December 2019	**Category of paper** *(please tick)*	
Report title Serious Incident Summary Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident and Risk Assurance Manager	**For assurance**	✓
Previously considered by: N/A	**For information**	

Purpose of the report

The attached report provides the Board of Directors with assurance that Serious Incidents (SI's) are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

Where process issues have been identified, this report also provides assurance that actions have been taken to address these.

The individual learning from these incidents pertaining to specific staff, Business Units and services have been shared with them for reflection, improvement and discussion.

Main issues for consideration

The Trust reported 16 Serious Incidents (SI's) in Q2 2019-20. One incident was de-logged following investigation.

The Trust had no never events in Q2 2019-20

In Q2 it has been identified that delays have occurred in the timeframe for reporting on Strategic Executive Information System (StEIS). Actions are in place to address this for Q3

In Q2 it has been identified, and previously escalated through the exception report, that we were not fully compliant with Duty of Candour requirements. Actions have taken place to address this for Q3

Recommendations

The Board are recommended to:

- Receive and note the contents of this paper
- The author would be grateful for feedback on the revised report structure

1. Introduction

1.1 A report on Serious Incidents (SI) is produced quarterly to provide assurance that they are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

1.2 This paper looks specifically at those incidents that are considered as SI's following the guidance from the NHS England's 'Serious Incident Framework" published in March 2015.

1.3 SI reports are reviewed by a review panel chaired by the Executive Director of Nursing and Allied Health Professionals (or deputy). The investigator presents the reports to the panel and the panel are responsible for reviewing all reports against minimum reporting requirements and in accordance with the expected timescales within the Serious Incident Framework.

2. Patient Safety Incidents in 2019/20 Q2

2.1 There were a total of 1172 incidents (internal to LCH) reported on Datix® in Q2 2019/20 of which 1037 (88.48%) were patient safety incidents. The breakdown of these incidents by harm is depicted in the table in Appendix 1. A positive reporting culture is demonstrated with 83.5% of Q2 2019-20 incidents being low or no harm incidents.

2.2 The incident categories for those patient safety incidents reported in Q2 2019/20 as moderate harm, severe harm or death are provided in Appendix 2.

3. Serious Incidents declared in Q2 2019/20

3.1 The Trust declared 16 serious incidents in Q2 2019/20; 8 in July, 6 in August and 2 in September. These are detailed within the table below. However it is to be noted that the absconsion SI related to Little Woodhouse Hall in August has been de-logged as this did not meet serious incident criteria.

Datix category	July 2019	Aug 2019	Sept 2019	Total
Medical Device	1	0	0	1
Pressure Ulcers	7	2	2	11
Implementation of Care	0	1	0	1
Abscond from 24 hour care	0	1	0	1
Skin Trauma	0	1	0	1
Unwitnessed fall	0	1	0	1
Total	8	6	2	16

3.2 All the above, with the exception of the de-logged incident were concluded to be Avoidable to LCH.

3.3 Reporting of SI's on StEIS should be completed within 2 working days of a potential SI being identified. It has been identified, in Q3 2019-20 that there has been a delay in the StEIS reporting of SI's. This has been related to the lack of robust processes.

3.4 The Clinical Governance Team have reviewed all moderate and above harm incidents and have confirmed that all potential serious incidents have been reported on StEIS.

3.5 A number of initiatives have been put in place within Q3 to prevent any further recurrence of this. The agreed process moving forward is that the decision to report on StEIS is made at the point of the 72 hour review, and not once avoidability has been determined, as has been the case historically. It is acknowledged this may lead to an increase in requests to de-log serious incidents following investigation which is a more common and more robust practice.

3.6 The 72 hour review report for Pressure Ulcers has been revised, to reflect changes in the process, and is more explicit in the recording of further investigation and reporting requirements. This report has been agreed by LCH Pressure Ulcer steering Group and is to be approved by PSEGG in November 2019. The intention if this evaluates positively will be to undertake the same process for all moderate harm incidents.

4. CCG Deadline Extensions

4.1 Submission extensions beyond the expected 60 days can be requested for a number of valid reasons, such as annual leave, a witness leaving the Trust and the involvement of more than one Trust or agency. In Q2 2019-20 no extension requests were requested.

5. Duty of Candour compliance

Of the 16 SI's reported in Q2 2019-20 all patients (100%) received an initial verbal apology in line with Duty of Candour requirements. Due to confusion with the implemented Duty of Candour processes it has been identified that not all patients received an initial Duty of Candour letter within the dictated 10 days. Significant development has taken place to reflect the amended Duty of Candour policy and clearer Duty of Candour processes.

6. Learning from SI's in Q2 2019-20

6.1 Of the 16 reported SI's from Q2 2019-20, 2 Neighbourhood Teams have been identified to have had 3 avoidable Pressure Ulcer SIs. This information has been shared with the Adult Business Unit leadership team and operational support is in place. Pressure ulcer themes are discussed at the Pressure Ulcer Steering Group who hold responsibility for delivery on the Trust's action plan for reducing pressure ulcers.

6.2 With the exception of the above there are no other recurrent themes or trends in relation to service areas.

6.3 Of the 16 completed SI investigations the recurrent top themes of learning are; case management; failure to identify risks; delays in assessment; communication breakdown and documentation. These themes are being addressed through a number of approaches within Neighbourhood Teams, these being: caseload reviews, case management training, clinical supervision, embedding the caseload cluster working training, embedding the deteriorating patient guidance and the use of NEWS2, updated caseload cluster handover guidance and on-going recruitment.

7. Coroners Inquests

Three inquests, requiring LCH representation were heard in Q2 2019-20. The table below summarises these cases, for information.

Case	Outcome
Death in hospital after admission with suspected necrotising fasciitis	Death by natural causes
Death in hospital following admission with an infected pressure ulcer	Death by natural causes
Death by hanging following discharge from Custody Suite	Open conclusion. No areas of concern regarding the Trust's involvement

APPENDIX 1:

Table of total incidents in Q2 2019-20 by level of harm

LEVEL OF HARM	NUMBER OF INCIDENTS
NO	479 (46.1%)
LOW	388 (37.4%)
MODERATE	130 (12.5%)
SEVERE	22 (2.1%)
DEATH	18 (1.7%)
TOTAL	**1037**

APPENDIX 2:

Table of Incident categories for moderate harm, severe harm and death in Q2 2019-20

Datix Category	Jul 2019	Aug 2019	Sep 2019	Total
Abusive, violent, disruptive or self-harming behaviour	1	2	2	5
Access, Appointment, Admission, Transfer, Discharge	0	1	1	2
Accident that may result in personal injury	18	12	12	42
Diagnosis, failed or delayed	0	1	0	1
Implementation of care or ongoing monitoring/review	2	2	0	4
Medical device/equipment	1	0	0	1
Medication	0	0	1	1
Skin Damage	37	32	26	95
Treatment, procedure	0	1	0	1
Other - please specify in description	8	5	5	18
Total	67	56	47	170

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (86)

Meeting: Trust Board 6 December 2019	**Category of paper** *(please tick)*	
Report title: Patient Safety and Experience Six Monthly Report.	**For approval**	
Responsible director: Executive Director of Nursing and Allied Health Professionals **Report author:** Incident and Risk Assurance Manager, Patient Experience and Engagement Lead.	**For assurance**	✓
Previously considered by: Quality Committee 25 November 2019	**For discussion**	

PURPOSE OF THE REPORT

This report provides the annual update of Patient Experience and the management of Patient Safety Incidents within Leeds Community Healthcare NHS Trust (LCH).

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

The report summarises the outcomes, themes, actions and learning from Patient Safety & Serious Incident investigations closed within the organisation during 1 April 19 to 30 September 19; as well as progress against action plans.

MAIN ISSUES FOR CONSIDERATION

The report provides a review of Complaints and concerns, Serious Incidents, feedback via the Friends and Family Test, and wider feedback for the 6 month period 1 April 2019 to 30 September 2019; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years, and where relevant, within a city-wide perspective and nationally. It later analyses identified themes in greater detail and triangulates information where possible to identify commonalities across all sources of intelligence.

Areas for concern:

- There has been an increase in information gathered from FFT survey, however this is still limited in some areas
- Complaint numbers are relatively low but themes remain consistent with the previous six month period
- Learning is being used for service change and improvement, however this is not consistent.
- In Q2 it was identified that delays occurred in the timeframe for reporting on Strategic

Executive Information System (StEIS).
- In Q2 it was identified, that we were not fully compliant with Duty of Candour requirements.

Actions:

- Use of FFT will be reviewed; particularly to focus on new guidance that has now been released to be in use by 1st April 2020.
- The Engagement strategy has now been approved; work is ongoing to develop an Operational plan to implement the strategy by January 2020.
- Training is planned to support learning from complaints and patient experience, along with a Patient Experience bulletin to be published for Q3.
- Work is ongoing to embed the changes introduced to the 72 hour process, through a more robust governance processes for monitoring and escalating to ensure a timely reporting on StEIS. A panel approach to reviewing the reports and a vision to use digital approach to ensure we have the right people involved in those early discussions
- The Duty of Candour Policy has been updated and approved by the Policy group and was ratified by SMT in October 2019

RECOMMENDATIONS

The Board is recommended to:

- Receive this report
- Note the updated information

1.0 BACKGROUND

1.1 This report will be focusing on the themes and learning emerging from incidents and patient feedback, and how we share this across the Trust to ensure continuous quality improvement as a result of the learning.

1.2 The Quality Committee will continue to receive a 6 monthly report of notable exceptions, assurance, improvement, lessons learned and a full range of quarterly data in relation to patient safety incidents & patient experience.

2.0 PATIENT SAFETY

2.1 During quarter 2 of 2019/20 an internal review of the 72 hour report review process and compliance with the statutory duty of candour process has been undertaken. Whilst the review identified compliance with statutory Duty of Candour requirements it has been identified that some confusion exists amongst clinical staff in relation to professional and statutory requirements. To date, this has been addressed through a Duty of Candour focus at the PSEGG workshop in October 2019 and is being considered in a review of guidance around the 72 hour report process. This is being monitored by the Clinical Governance Team through a Datix dashboard.

2.2 A review of the 72 hour reporting process identified delays in services completing the reports and therefore in the Clinical Governance team receiving completed reports for review. The team is currently trialling a more inclusive and robust process of reviewing the 72 hour reports – initially just for pressure ulcers – through a weekly decision meeting. This will provide greater assurances of how potential Serious Incident (SI) decisions are made. Two meetings have taken place to date with agreed core membership. Future plans are to evolve these in to Skype meetings so that 72 hour report authors can also attend 'virtually' from their bases. If this evaluates positively the plan will be for all 72 hour reports to follow this process.

2.3 Within the above piece of work, a revised 72 hr reporting process (Appendix A) and 72 hr report form (for pressure ulcers) are also out for comments

2.4 Further assurance work is scheduled for completion in Q3 2019/20 with a deep dive being undertaken to review the quality and accuracy of closed incidents. This will be reported on in more detail in the Q3/Q4 Clinical Governance paper.

2.5 Following the presentation at the October 2019 Quality Committee workshop further staff engagement has been conducted. Early discussions around the implementation of a 'Just Culture' as the foundation of the Patient Safety Strategy, Patient engagement strategy and Workforce processes are now starting to develop. As a result a working group has been established and the Organisational Development and Improvement Team are supporting some qualitative data collection of staff feedback on our current processes to inform the next steps. Further updates are expected at Quality Committee in February 2020.

2.6 30 SI's have been reported over Quarter 1 & 2 of 2019/20**.** Full details are provided in appendix B.

3.0 ACTIONS AND LEARNING TO IMPROVE SERVICES

3.1 The most frequently reported LCH patient safety incidents recorded in this timeframe are:

- Slips, trips and falls 303 (15.1%)
- Medication (all subcategories) 297 (14.8%)
- Pressure ulcers 263 (13.1%)

3.2 Themes emerging from internal concise and comprehensive serious incident investigation reports completed April to September 2019 identified assessment delays, failure to identify risks and documentation standards – missing information as the top three themes.

3.3 Measures to address these recurring themes are a focus of the work plans for the Falls Reduction Steering Group and the Pressure Ulcer Steering Group. The specific sections below show more detail in relation to how we are learning from these.

3.4 Alongside the dissemination of learning, themes are identified and triangulated against other information sources, such as complaints, feedback and involvement. This information is reviewed by the Trust's Patient Safety and Experience Governance Group (PSEGG). A recent PSEGG workshop showcased an LCH approach to sharing learning through the FABU-LEEDS (Learning from Excellence) approach. Leaflets were provided to attendees to encourage wider sharing of this initiative.

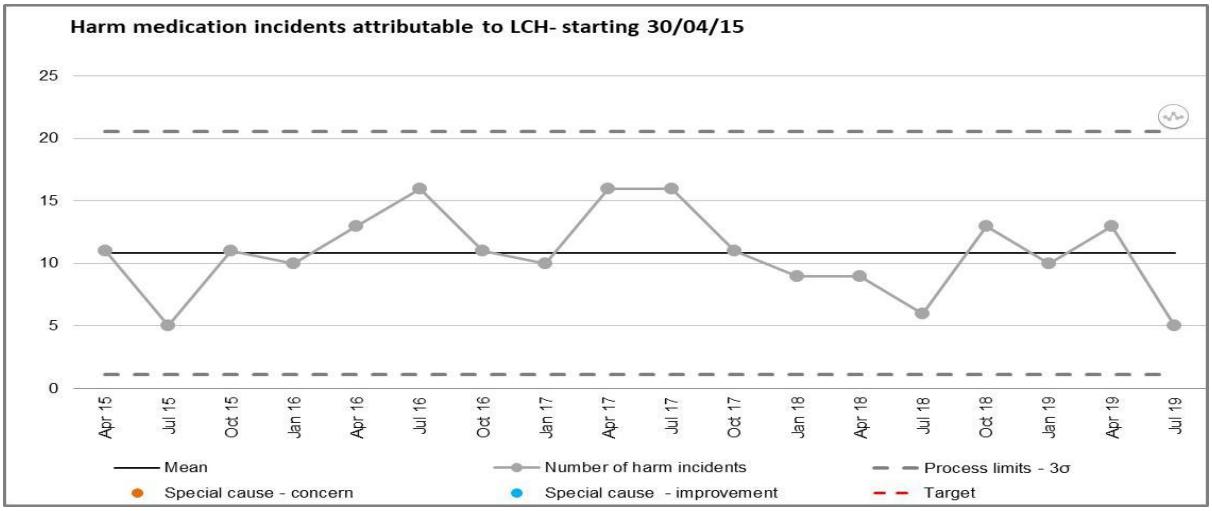
3.5 Following recent data cleansing and analysis of all incidents reported within the first two quarters of 2019/20 it was identified that the categorisation of MASD and DTI were sometimes miss-recorded by reporters, handlers and investigators. The Clinical Governance Team has paid increased attention to the quality and accuracy of incident validation to correct any misinterpretation. This includes amending of incident severity, patient type, patient safety incident status; re-categorising when wound prevention suggest incorrect category or skin damage type has been chosen etc.

3.6 Following some concerns raised by investigators using the patient safety investigation templates, the Incident manager has reviewed and revised these templates in line with feedback received. The revised templates support investigators in the completion of the document by providing prompts and improved questioning. The revised templates have been disseminated and are in use within the incident investigation process. The templates include list of themes which will allow for early identification of emerging themes from services, Business Units across the Trust. This will support learning which can be shared.

4.0 MEDICATION FOCUS

4.1 A total of 477 incidents involving medication were reported during this 6 month reporting period, of this 339 (71%) were attributable to LCH and this remains within normal variation (see graph below). Most incidents attributable to LCH are reported by the Adult Business Unit and medicine not administered on time i.e. either omitted or delayed (138) is the most commonly reported type of error in LCH Care.

4.2 Over this reporting period over 94.7% of medication incidents attributable to LCH caused no harm to patients. A graph highlighting the number of harm incident attributable to LCH since April 2015 can be found below



4.3 The number of medication incidents resulting in harm and attributable to the Adult Business Unit was 15 in the period April to September 2019. There were no moderate or major harm medication incidents reported in this time in LCH care.

4.4 Of the 15 harm incidents:

- Five involved insulin
- Five involved Opioids or other Controlled Drugs used in Palliative Care
- Two involved anticoagulants/warfarin
- Two involved double doses of prescribed medicines administered in error
- One involved a wound after an injectionLevomepromazine injection administered. A red lump immediately developed and this developed into a wound with slough. Investigation revealed that patient has scratched the injection site which probably contributed to the development of the wound

4.5 Insulin, Opiods/Palliative Care Medicines and Warfarin are the three riskiest medicines LCH administer in terms of likelihood to cause a harm related incident. Therefore by focusing on these three categories, and reducing the number of errors involving them, will have the greatest impact in reducing the number of harm incidents attributable to medication.

4.6 In June 2019 a new updated Injectable Diabetic Medication Chart (PM2i) was introduced throughout the Neighbourhood Teams. It is relatively early days but initial feedback on the impact of the chart is positive. The NTs have feedback they have found the chart easier to use and have commented that the information on commonly used insulins on the back covers is helpful. Further data from subsequent quarters will provide evidence if the number of incidents where the chart may have been contributory has reduced.

4.7 The medicines management training session for nurses in their preceptorship period and those new to the trust now incorporates a specific section devoted to insulin safety and awareness of risks when administering insulin.

4.8 Leaning from Incidents memos on;

- Incorrect dose of haloperidol
- Incorrect mixing of Ketorolac with an incompatible medicine via a syringe driver
- Ensuring unwanted controlled drugs are disposed of in a timely manner and not left in syringe driver boxes have been produced in this period and shared across the organisation.

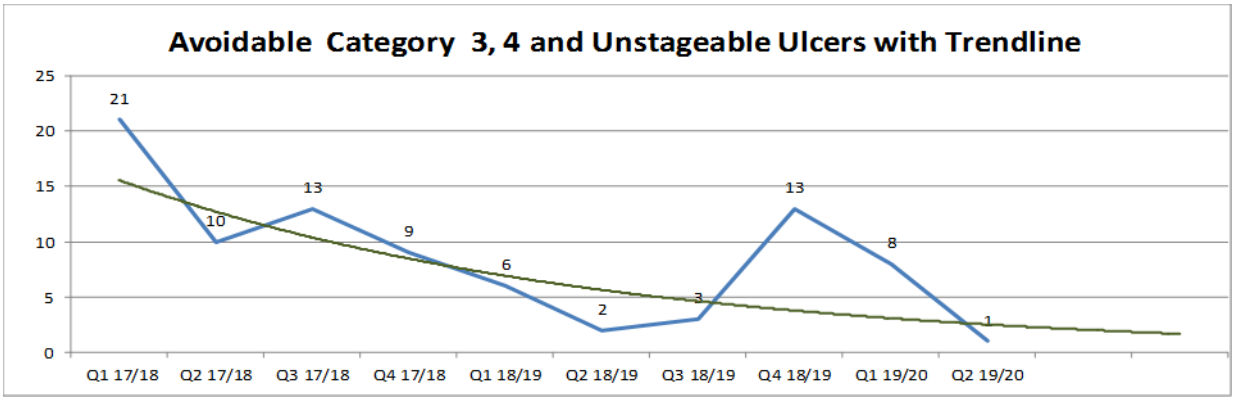
5.0 PRESSURE ULCER FOCUS

All Category 3, 4 and Unstageable pressure ulcers are subject to a 72 hour review and where there is felt to be an opportunity for learning a more in-depth root cause analysis is undertaken and these are discussed and validated at an SI review meeting.

As an output of LCH Pressure Ulcer steering group a more detailed review of deep tissue injury incidents will be undertaken by the Wound Prevention and Management Service (WPaMS) prior to consideration of future review requirements to enhance learning and improvement.

5.1 Incidence of avoidable pressure ulcers – Category 3, 4 and unstageable.

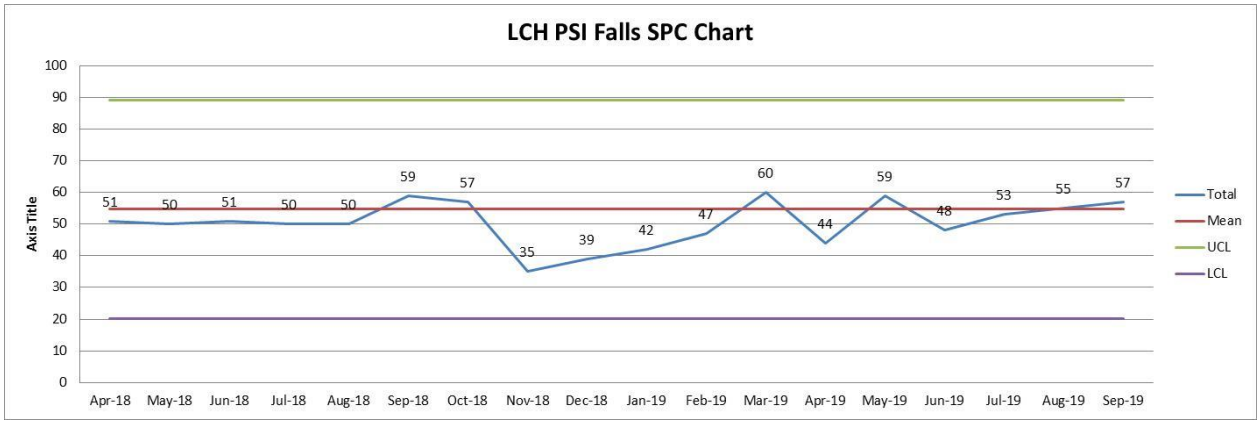
A comparison of closed pressure ulcer incidents from the full years 2017/18 & 2018/19 and Quarter 1 & 2 of 2019/20 shows a significant reduction in the last Quarter following a peak in the preceding 6 months. This will be monitored by the Clinical Governance team as a rise is anticipated due to an implementation of a more robust process.



The figures for avoidable incidents in Q1 and Q2 below:

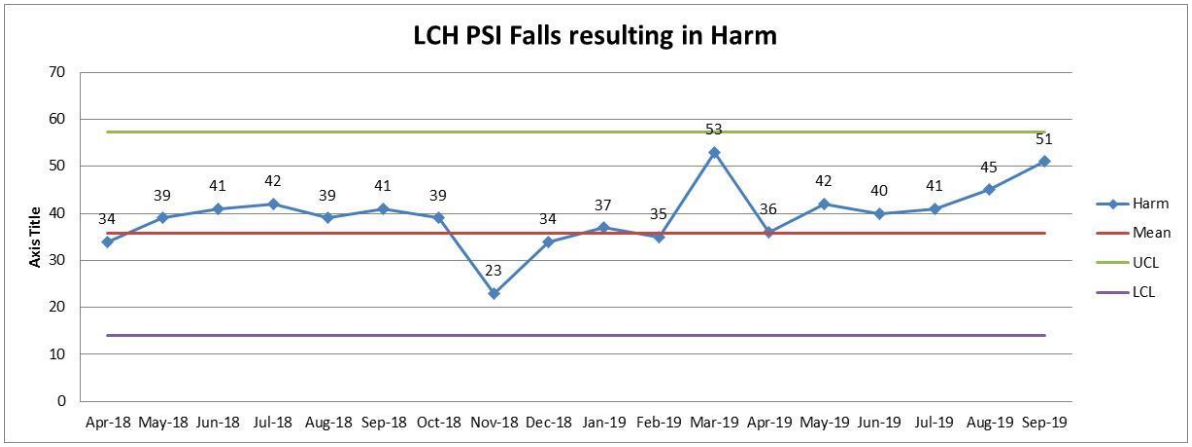
	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	18/19 Q2	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Category 3	6	3	2	2	1	2	0	7	2	1
Category 4	0	2	3	0	0	0	0	2	0	0
Unstageable	12	4	7	7	4	0	3	4	6	0
Total	21	10	13	9	6	2	3	13	8	1

6.0 FALLS FOCUS



6.1 The above SPC shows that overall the number of falls reported has fluctuated but remains within expected levels. However, the number of falls resulting in harm (below) has shown a steady rise since June 19. This increase has been noted across the recovery hubs, see section 6.2

We continue to investigate these using the same approach as for pressure ulcers. We aim to process these through the same 72 hour report review panel if the trial with pressure ulcers is successful.



6.2 Falls within Recovery Hubs

The Recovery Hubs have a frail population and more than half of those admitted have come in having had a fall (or multiple falls) at home. Thus most people in the hubs have a high risk of further falls, often complicated by cognitive impairment. Falls prevention technology such as bed and chair sensors only alert staff to when the person has already got up and it is recognised that may be too late to prevent a fall.

A review of the Fall Safe Care Bundle has been undertaken and compliance has been evidenced around the different elements. Work is on the way to review each fall hub monthly and to provide training if required

7.0 CENTRAL ALERTING SYSTEM (CAS) SAFETY ALERTS

There were 21 alerts issued where a response was required from the organisation during Quarter 1 & 2 2019/20. Of these, there were 2 breaches in an LCH response within the identified timeframe. . This had no impact in relation to the timely distribution and service level actions, the delay was closing the alert on the central system 3 and 5 days post deadline respectively.

8.0 NEVER EVENTS

There were no never events recorded during this 6 month reporting period.

9.0 LCH PATIENT EXPERIENCE

LCH collects patient experience feedback through a variety of channels but they are all recorded centrally between two different systems. Complaints, concerns, enquiries and compliments are collected / recorded within the Datix® system held by the Trust. The Friends and Family Test (FFT) and the comments provided with it are collected via an external system provided by Membership Engagement Services (MES).

10.0 COMPLAINTS, CONCERNS & COMPLIMENTS

10.1 The Trust acknowledged and responded to all received complaints within the statutory timeframes (3 and 180 working days respectively). Of the complaints closed to date, 37% were not upheld; 41% were partially upheld and 22% were fully upheld. Although these figures are not entirely in line with the national averages which are roughly a third for each category, they are not too dissimilar to cause concern.

10.2 The response times for complaints in the first six months of the year have seen significant improvement to this time last year when only 36% had been responded to within the LCH

target timeframe of 40 working days or less. This year so far, 63 (67.7%) closed complaints have been responded to within the 40 working day timeframe.

10.3 Work is ongoing to update both the overall complaints process and the Patient Experience Team internal administration processes to streamline the management of complaints as we work towards reducing the response timeframe to 25 days or less; with the exception of complex or multi agency complaints. This will be implemented as part of a review of the Patient Experience: Dealing with Compliments, Concerns and Complaints Policy and will be in place by April 2020.

10.4 From 1 April – 30 September 2019, LCH received 120 complaints which were managed under the 2009 regulations; to date 85 have been closed. In addition to these, the Trust closed 19 complaints received in 2018/19 and carried over into this financial year.

11.0 INTERNAL AUDIT

11.1 In response to an Internal Audit that was completed in early 2018 there have been some developments to the process relating to the identification, reporting and management of complaints, including how lessons learned are dealt with, communicated and disseminated across the Trust.

11.2 Two main internal audit actions were identified and an update on the actions is provided below.

11.2.1 **Enhancements to processes are made and these are communicated to staff, as well as the Patient Experience: Dealing with Compliments, Concerns and Complaints Policy being updated to reflect the developments:**

- An addition to the Complaint Investigator Checklist has been that staff are recording the actions consistently as part of the investigation process; this updated checklist has been circulated to all investigators.
- The Patient Experience Team will embed the process for recording 'Learning from…' through Community Talk, within PSEGG meetings and as part of the PSEGG workshop held at the end of October 2019.
- A Patient experience bulletin is being developed with the first edition being planned for Quarter 3 2019/20; this will include sharing learning from concerns, complaints and compliments.
- The complaints training content is currently under review, and training sessions are booked for December 2019 and January 2020.
- Links with quality and clinical leads are now embedded within the complaint process to allow for continuous communication and sharing of information and learning.

11.2.2 **The importance of fully completing Action Plans on Datix® for every upheld or partially upheld complaint has been communicated to all staff involved in Complaints Management and is being monitored by the Patient Experience Team**:

- The Actions function is switched on but is not currently being used consistently. This will form part of the updated complaint training package.

- The PET will continue to notify investigators to complete the Action Plan, and will escalate to identified Clinical and Quality Lead when this is not being done.
- Guidance will be shared in the Quarter 3 Patient Experience Bulletin and this will uploaded onto Elsie.
- These action plans will be tracked and pulled for reporting to PSEGG from 1st October 2019. This monitoring will provide information for escalation where actions are not completed within expected timeframes.

12.0 PATIENT EXPERIENCE (COMPLAINTS) TRAINING

Training sessions for staff have been booked in for December 2019 and January 2020. Further session will be booked throughout the year 2020, with staff being able to book onto this on ESR. The content of the training will be reviewed in November 19 to reflect updated processes within the wider complaint process.

13.0 OVERARCHING THEMES

This section provides an overview of the categorisation of issues raised to date. The relatively low numbers of different types of feedback the Trust receives makes it difficult to complete a thematic review over a short period of time.

13.1 The top five subjects within LCH's complaints for period 1st April 2019- 30th September 2019 ranked in the following order:

- Clinical Judgement / Treatment
- Management of operations/treatment
- Appointment issues
- Attitude, conduct, cultural and dignity issues (includes Staff attitude and communication)
- Communication issues with the patient

13.2 There is some consistency with national themes which show clinical treatment, communications, and patient care; including nutrition/hydration, and values and behaviour as the top 4 themes of complaint nationally.

13.3 The top 5 themes for LCH over the last 6 months are consistent with the previous 6 months with the addition of Management of operations/treatment which has replaced confidentiality of information.

	ABU	CBU	SBU	Operational support services	Corporate & HQ functions
Clinical	11	10	19	0	0

judgement/Treatment					
Appointment	3	5	14	0	0
Management of operations/treatment	5	7	6	1	0
Communication issues with the patient	1	3	5	0	1
Attitude, conduct, cultural and dignity issues	4	0	3	0	0

13.4 **Trends within clinical judgement/ poor treatment**

13.4.1 The “top line” subject of clinical judgement / poor treatment has consistently been in the top three subject areas for complaints at LCH for the past five years. This is in line with the information reported nationally.

13.4.2 The number of complaints related to clinical judgement is similar across adult and children’s services. The number of complaints is significantly higher for the Specialist Business Unit which is not unusual or unexpected. The structure and variety of services within the Business Unit means that Specialist Services have high patient contact numbers and are seeing patients with complex, long term conditions. In the case of the population served by one service; they can be particularly challenging and reluctant to participate with the very structured environment the teams work in.

13.4.3 In the first six months of the year, the Specialist Services noted to have issues raised for clinical judgement / poor treatment are the MSK, IAPT and Custody Suite services.

13.4.4 This subject area incorporates the following sub-subjects clinical / professional opinion, coordination of treatment, wound care, poor treatment, delay, service eligibility criteria. Most sub-subject areas, like the main subjects, are relatively broad so the detail of complaints within them can and do vary significantly although there can be commonalities in specific services and sometimes across services or Business Units. When this is the case and work is done or potential issues for other services identified, this is highlighted to those services. For example the changes to the CUCS team practices have led to an increase in complaints which are around clinical or professional opinion and new patient prescriptions. Work has been done with the service in light of the complaints received and the learning from that will be shared as and when other services undergo criteria review to improve overall patient experience in the future.

13.4.5 A further example of learning within a service that has been shared across teams involved staff being reminded not to use personal phones for work purposes, including to take photographs. In the example case it transpired that the staff member had full patient consent for the actions they took and the staff member was praised for quick thinking. As well as sharing the example of good practice around quick thinking, the teams were

reminded of the information governance implications and that photographs taken on personal phones cannot be added to clinical records.

13.4.6 Often complaints in this subject area and the area of Management of Operations, can stem from patients or their representatives not understanding how a service works or what exactly a specific visit or care plan will entail. More work to look at how services are setting expectations and communicating clearly with patients and their families from the receipt of initial referral, through to discharge or onward referral may help to reduce complaints in this area.

13.5 Trends with Management of operations/treatment

13.5.1 This top line subject area often has significant overlap with “Clinical judgement / poor treatment” in the content of complaints however the expected overlap is not present in the complaints received so far this year. Only two complaints have both subjects selected. It has been noted that many complaints only have one subject selected rather than the multiple subjects that would be expected for most complaints. This is a training issue which will be addressed within the Patient Experience Team moving forward.

13.5.2 The number of complaints related to the Management of Operations or Treatment is lowest in Children’s Services and highest in Specialist Services. The differences in the numbers recorded for each business unit in this area is not unusual, despite there potentially being more complaints that could have elements relevant to this subject area that have not been correctly recorded.

13.5.3 Sub subjects within the category include coordination of treatment, service eligibility criteria, continuity of care, and delay. Themes noted within these complaints include communication between internal teams and with external partners or other providers as these sub-subjects are often seen in multi-agency complaints or in situations where patients are being seen by multiple community teams or services.

13.5.4 Learning in one ABU case related to communication both with a family and between teams providing care to a palliative patient. The importance of sharing information between day and Twilight / Night services was highlighted following the investigation. In order to support patients who are receiving end of life care and may deteriorate rapidly, action was taken to ensure that all Neighbourhood Teams have a fully stocked “Comfort Pack” at every base. This contains all items including sheets and continence products that may be needed to help support patients and their families at short notice.

13.5.5 The ICAN service has seen the issue of administration delays which have affected clinic letters from Paediatricians be reported through complaints. The service has implemented a structured plan which includes recruitment and a more comprehensive process of sharing administration between the different hub teams across the city.

13.6 Trends within appointment issues

13.6.1 Appointment issues remain within the top three subjects for the Trust which is reflective of nationally reported issues. This subject area has one of the largest numbers of sub-subjects and it is one of the areas where the descriptions are more specific. They include failure / delay in referral process, waiting time for appointment, urgent appointment not available when required, out-patient cancellation, unable to get an appointment, staff member fails to attend / is late, and appointment recording error.

13.6.2 The number of complaints related to Appointments is lowest in Adult Services and highest in Specialist Services. As noted earlier, it is not unexpected that the SBU would see the highest rates within the categories and particularly this one due to the number and types of clinics run buy the different services.

13.6.3 Themes within this subject area relate to patients not being able to reach / contact services or clinics; not meeting (or agreeing with) service general or emergency criteria and waiting times for appointments both initially and at follow up.

All services have different approaches to managing appointments. Due to the nature and structure of Trust services, this is something that is unlikely to change as a “one size fits all” approach would not work. Appointment issues will continue to feature in complaints and concerns but where particular patterns are noted within a particular service or location, these are always escalated in a timely manner.

14.0 NOTICEABLE THEMES

14.1 As part of the complaint audit process and monthly reporting key themes and areas to note are monitored. Any complaints or concerns that require immediate attention are escalated immediately to the Clinical and Quality Leads for each business unit via Datix, Email and telephone. Where required, this will also be escalated to the relevant Director and/or Chief Executive. This is also consistent with any themes or trends that are noticed; to ensure information is shared with the service and senior management, and that support is offered by the PET where appropriate.

14.2 When being sent to investigators, all complaints are now also sent to the Clinical or Quality Leads for each business unit so they have an ongoing awareness and oversight of themes and numbers of incoming complaints and concerns.

14.3 Within the last six months there has been an audit of complaints for the MSK service following concerns that there were a higher number of complaints related to staff attitude for the service. The internal audit aimed to identify any areas for concern; the complaints received over the last 6 months for MSK are consistent with previous 6 month/yearly figures and the findings do not suggest an increase in complaints relating to staff attitude over a 12 month period. There have been 5 complaints related to Attitude for the MSK service between 1 April- 30 September 19; 3 of these were partially upheld.

14.4 MSK has received 14 complaints in total for the last 6 months:

- 11 of these were recorded as Clinical judgement/treatment. Out of these 4 were partially upheld, 2 were not upheld and for the others the outcomes have not be listed.
- Within 1 April – 30 September 2020 MSK received 2 complaints related to Appointments, and 3 complaints related to Communication issues with the patient. Please note that some complaints have been listed as related to more than one theme/area and so there are more recorded themes than number of total complaints.

14.5 For complaint investigations where there has been evidence of poor staff attitude, this has been fed back to the relevant line manager and Clinical Lead to be discussed with the named individual(s) to identify any behaviour concerns or training needs.

14.6 In the six month period 1 April 2019 - September 2019 there has been an increase in complaints received for the Continence, Urology and Colorectal Service (CUCS) related to products and treatment. This is as a result of the service introducing criteria for the supply of products in line with the clinical evidence base around this which would lead to some people no longer receiving their preferred product for clinical reasons. The PET have liaised closely with the service to develop service information on current and upcoming service changes to ensure this is communicated clearly and to manage patient expectations; this has included an updated and easy read Standard Operating Procedure (SOP) and Information for GPs and care providers. To support the staff team, who were receiving a large amount of verbal abuse from dis-satisfied patients, PET have linked the CUC Service Manager with our conflict resolution trainer and facilitated the development of specific training to support the team.

15.0 PATIENT SAFETY, EXPERIENCE, AND GOVERNANCE GROUP

15.1 The latest PSEGG workshop took place in October and focussed on:

- Reviewing proposed changes to the complaint process, introducing the new FFT questions and looking at how we share learning
- Exploring the new Patient Safety Strategy, what this means for staff, what it means for LCH
- Duty of Candour- reintroducing the process, outlining the timeframes and expectations – myth busting, what to do if?
- Learning from incidents including Fabuleeds

36 members of staff attended the workshop. Feedback forms have been circulated to attendees and qualitative feedback will be gathered.

15.2 An aspiration of PSEGG is to introduce an opportunity for members of the public to attend and this concept is being developed as part of the patient engagement and experience strategy. A staff member from Healthwatch Leeds currently attends the PSEGG meeting to represent the People's Voice.

15.3 Learning and feedback from complaints forms agenda items within the PSEGG meeting. An example of this has led to a change in the complaint process to improve how information is shared with staff named or involved within complaint investigations. This now ensures that complaint responses are shared with these staff members before being sent to the complainant and that the relevant people offer staff support for this in line with Just Culture principles which encourage staff involved in investigations to be treated in a consistent, constructive and fair way.

15.4 A consent form now accompanies the complaint plan when sent to all complainants to ask if they are happy for us to contact them 8-12 weeks after they receive their complaint response to gather feedback on our complaint process, these have been sent out since June and we have received 8 consent forms so far. The first contact to gather this feedback will be made at the start of December and learning from this will be reported in future reports

15.5 The importance of fully completing Action Plans on Datix® for every upheld or partially upheld complaint has been communicated to all staff involved in investigating complaints- this is now being monitored and will be included in the monthly patient experience highlight report and will be fed back at PSEGG meetings.

15.6 By the end of Quarter 3 there will be a quarterly patient experience bulletin to share information taken from the Actions and Learning from posters, themes of complaints and compliments, sharing learning and updates on process.

16.0 FRIENDS AND FAMILY TEST (FFT)

16.1 Between 1st April 2019- 30th September 2019 there have been a total of 6,657 Friends and Family Test responses, this is a slight decrease of 443 responses in the previous six month period (1st October 2018- 31st March 2019- total of 7,100 responses). Details of the response rates, levels of satisfaction and themes by business unit are included in appendix 1. The themes common across all FFT comments are identified below.

16.2 **Staff attitude:** There are largely positive comments from patients/families/carers in relation to treatment and attitude of staff across all Business Units. Staff members are described as friendly, professional, caring, helpful and polite.. There are some less positive comments which include staff being described as rude, unwelcoming, abrupt and patronising. These comments in particular relate to Leeds Sexual Health Service, where reception staff were described as “rude and unwelcoming’’ by one service user; Community Neurology Services, one comment describes them as “sometimes patronising”; and North 2 Neighbourhood Team, where a member of nursing staff was described as “rude and abrupt’’ during a phone call with a service user.

16.3 **Communication**: There are positive comments recounting staff being happy to answer any questions patient/families/parents/carers may have and taking the time to do so. There are lots of positive comments relating to staff talking patients through procedures and ensuring this is understood; giving good advice and information that is easy to understand.

There are less positive sub-themes including miscommunication between staff and departments and a lack of responsiveness from staff following phone calls and questions from patients/families. In particular, these comments related to South 1 Neighbourhood Team, with one service user describing “no communication between them [the different nurses]”; Children’s Speech and Language Team there was one comment that advised there was “no reply when advice was needed” and again “no advice, just signposted to websites” was one comment from a service user of the Health Visiting team in Yeadon.

16.4 **Environment/Facilities:** The positive comments received relate to clean, comfortable and welcoming waiting areas and good facilities in children’s play areas. The more negative feedback includes comments around lack of temperature regulation at some sites and difficulties with parking, including parking charges and lack of available spaces in some areas.

16.5 **Co-ordination/Appointments:** The comments for this are mixed; this depends on each individual’s experience of the difference aspects of the theme; Positive comments include those around punctuality and efficiency of appointments and people were appreciative of being seen in a timely manner, Less positive experiences include cancelled appointments, lengthy waiting times and the need for some patients to chase appointment dates/times. These particular experiences included cancelled appointments with MSK, Children’s Speech and Language Therapy and West 1 Neighbourhood Team, with comments describing cancellations due to staff sickness, short notice cancellations and not being informed of cancelled visits until late in the day.
One service user accessing the Podiatry service in Otley describes a delay due to lack of staff and accessible appointments and in both of the Cardiac Services and Children’s Speech and Language Therapy, Service Users commented that they had to chase appointments themselves.

16.6 **Clinical Quality and Professionalism:** There are positive comments which describe staff as competent, expert professionals, going above and beyond to help patients, providing excellent care and attention to detail. There are some less positive experiences which describe a lack of care and support from staff. One service user commented of the North 2 Neighbourhood Team that they felt there was a “lack of care by the service and GP. No consideration of patient or elderly carer”. Also of the North 2 and West 1 Neighbourhood Teams, comments such as “no support due to personal circumstances” and “not given any help or support”, were received, and one comment was received in relation to CAMHS Community stating, “Not enough help for young people or their parents”.

16.7 The difficulty when feeding back to the service teams is of course that FFT data is entirely anonymised; therefore it is not possible to identify the individual service user/carer/relative that has made the comments or provided feedback. However if a comment is received that is particularly concerning, this is highlighted to the appropriate service team directly by PET to encourage further investigation wherever possible. All service teams now have several staff members who have access to the FFT data and are encouraged to review comments monthly and share them during team meetings, use them as part of service

team Quality Boards, ‘You Said, We Did’ posters and develop actions where necessary.

17.0 LEARNING FROM FFT

17.1 Currently, any compliments or concerns that are received via the FFT are recorded on Datix and fed back to the appropriate service lead/manager or picked up with our Complaints team should they require further investigation. Teams discuss and share the learning from service user feedback at a local and at service level; transferable learning is shared across the business unit at business unit celebration events, within leadership networks and through relevant communication streams; such as service posters and newsletters. An example of this is the Nutrition & Dietetics service who have created a Feedback Poster using MES; the poster outlines the current FFT response rate, recommendation rate as well as comments and a ‘You Said, We Did’ section highlighting improvements made within the service based on patient feedback.

17.2 Learning from FFT is a key focus within the Patient engagement staff champion group meetings where members are asked to share how they are capturing and sharing feedback within services, and the feedback that they have received.

17.3 The Health & Homeless Inclusion Team are now completing FFT cards with patients being seen at SJUH and St George’s Crypt. The FFT has been adapted to include a question asking patients ‘Were you treated with respect and kindness by our team?’. This means we are starting to reach parts of the Gypsy/Traveller community and those who are classed as homeless, these are two groups of people who we would previously not receive any FFT responses for. From the 1 July to 30 September there have been 3 FFT responses, providing a response rate of 3.61%. 100% of these respondents would recommend the service to their family or friends.

17.4 A national review of the FFT has taken place by NHS England and Improvement. The updated FFT guidance has been released to be implemented by April 2020. The updated question will be- ‘Overall, how was your experience of our service?’ with updated responses of ‘Very good, Good, Neither good nor poor, Poor, Very poor, Don’t know’. Guidance has been release with suggested updated framing texts such as ‘Thinking about your recent visit/appointment…’ and ‘Thinking about the service we provide…’. Providers will still be required to submit monthly numerical to FFT data to NHS digital for national publication.

17.5 As part of the new FFT guidance, the Patient Experience Team (PET) will review the Trusts use of FFT and work with services to make this more effective.

17.6 There have been changes to how we calculate the FFT response rate figure; to date the denominator used to calculate the FFT response rates has been based on a figure that is unreflective of the number of responses we would expect. In some cases this had led to response rates that are lower than the actual position. Improvements have been implemented that increase the accuracy of the denominator figures and these are now

based on the number of patients finishing treatment in each service and are updated on a monthly basis.

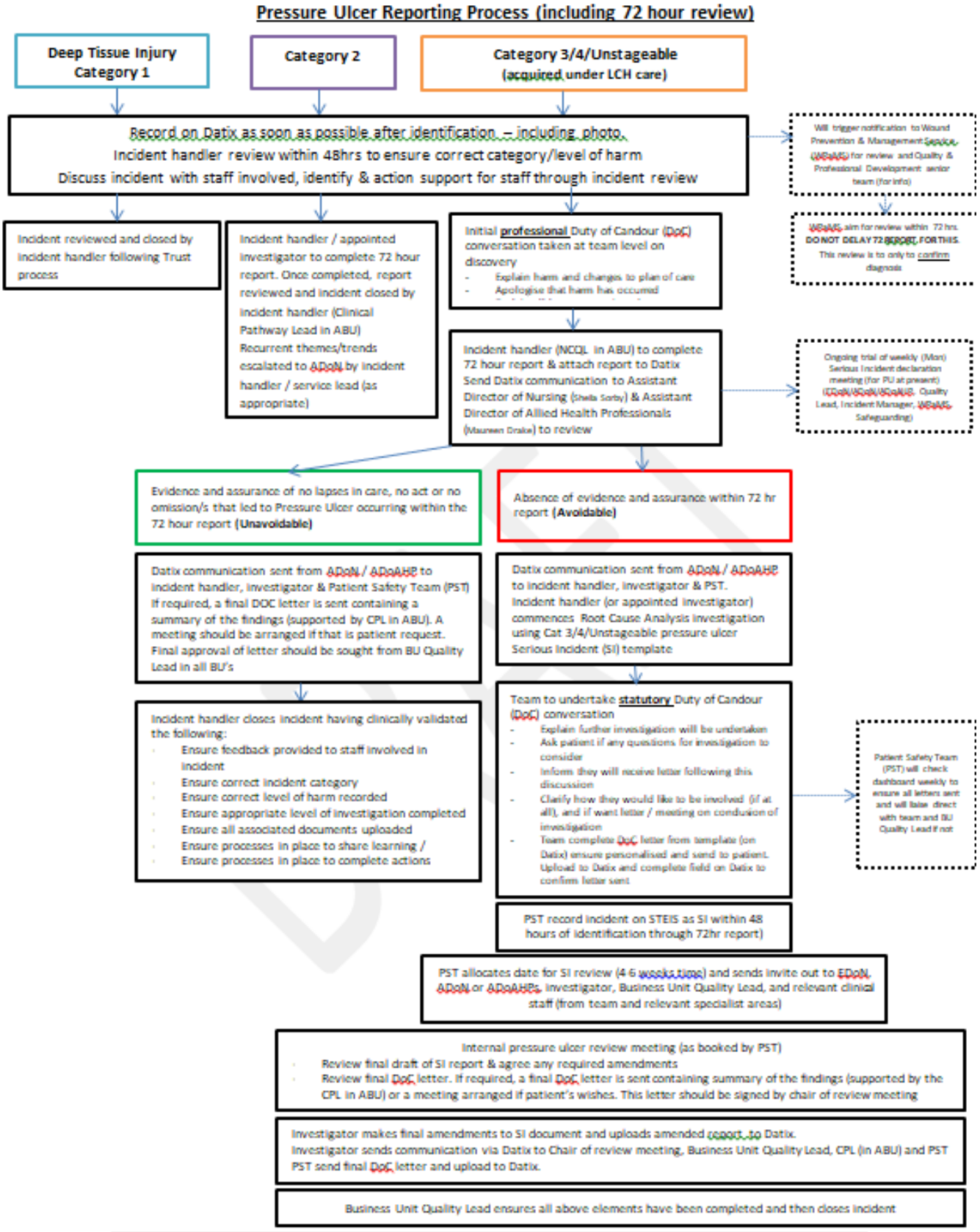
17.7 There are ongoing updates to the Membership experience system (MES) including new processes and feedback tools such as Heat Maps, feedback posters and service team FFT summaries.

17.8 MES training took place in 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. Examples of how services are using this are the monthly updated Quality Boards based in some Neighbourhood team offices, and the monthly poster displayed in the Nutrition and Dietetics service.

17.9 A chart showing the positive nature of comments received across services and highlights common feedback themes and categories can be seen in Appendix D.

17.10 Some examples of FFT comments received from service users between July and December 2018 can be seen in Appendix E.

Appendix A: Proposed Pressure Ulcer Reporting process



Appendix B

1) Serious Incidents reported between April and September 2019

Thirty two serious incidents (SI's) were reported on StEIS between April and September 2019. 2 of these subsequently had de-log requests made and agreed by the CCG, resulting in 30 confirmed SI's. These were:

- A patient who self-referred to IAPT with no red-flags and subsequently died whilst on the waiting list. Level 2 mortality form indicated the death did not fit the SI criteria.
- An inpatient at Little Woodhouse Hall disclosed to staff that she had taken an overdose whilst on leave. The SI report identified no acts or omissions in care and care planning and the review panel concluded this did not meet the SI criteria.

The table below provides a summary of the 30 SI categories, 19 (63.3%) of which were Pressure Ulcers.

Incidents reported to STEIS by date added							
	Apr 2019	**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**	**Total**
Appointment	0	0	1	0	0	0	1
Management of reatment	0	0	1	0	0	0	1
Discharge	0	0	0	0	1	0	1
Implementation of care	0	0	0	1	0	0	1
Medical device/equipment	0	0	0	0	0	1	1
Unexpected Death	0	0	1	0	0	0	1
Self-harm during 24-hour care	0	1	1	0	0	0	2
Slips, trips, falls and collisions	0	0	1	0	1	0	2
Pressure sore / decubitus ulcer	2	2	4	7	2	2	19
Traumatic Skin Damage (tear)	0	0	0	0	1	0	1

Of the 30 SI's, 23 have been concluded. 5/23 investigations concluded there were no acts or omissions in care (unavoidable). 18/23 investigations concluded LCH actions could have prevented the incident (avoidable). See table below.

Seven were still in the process of being investigated at the end of September. All were within the timescale set by the CCG for submission and no extensions have been required.

The 13 pressure ulcers all related to Category 3 and unstageable ulcers. There were no avoidable category 4 pressure ulcers in this reporting period. These figures are comparable to the previous reporting period where 12 pressure ulcers were found to be avoidable, one of which was a category 4 in severity.

There has been a substantial improvement in the number of avoidable falls which has reduced from 10 in the previous reporting period, to 2 incidences in this reporting period.

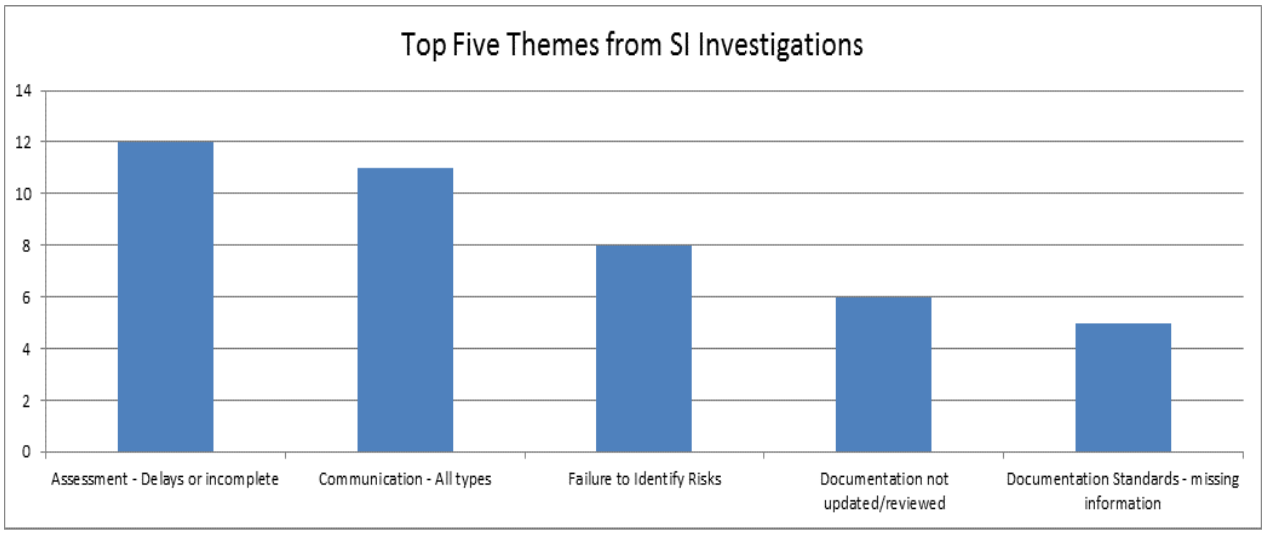
	Avoidable to LCH	Unavoidable to LCH	Total
Treatment failure or error	1	1	2
Unexpected Death	0	1	1
Patient's case notes or records	1	0	1
Self-harm during 24-hour care	0	1	1
Slips, trips, falls and collisions	2	0	2
Pressure sore / decubitus ulcer	13	2	15
Traumatic Skin Damage (tear)	1	0	1
Total	18	5	23

	Avoidable to LCH	Unavoidable to LCH	Total
North 2 - Adult Neighbourhood Services	6	1	7
West 2 - Adult Neighbourhood Services	5	0	5
South 2 - Adult Neighbourhood Services	3	0	3
Patient Flow Services	1	1	2
Homeless and Health Inclusion Team (HHIT)	0	1	1
Youth Offender Healthcare	0	1	1
West 1 - Adult Neighbourhood Services	1	0	1
Leeds Sexual Health Service	0	1	1
South 1 - Adult Neighbourhood Services	1	0	1
Nutrition and Dietetics (Adult & Child)	1	0	1
Total	18	5	23

2) Investigation outcomes and themes

Changes have been made to both Datix and the SI investigation template with the consistent reporting of learning themes. A more detailed breakdown of this will be provided in the next thematic report.

Themes emerging from concluded SI investigation reports identify learning in relation to assessments, communication, a failure to identify risks and documentation.



Appendix C

The Complaint Numbers

From 1 April – 30 September 2019, LCH received 120 complaints which were managed under the 2009 regulations; to date 85 have been closed. In addition to these, the Trust closed 19 complaints received in 2018/19 and carried over into this financial year.

To date the Trust has received 199 concerns and a total of 37 enquiries – 15 regarding LCH services and 22 about other NHS or local services. The number of concerns recorded is a marked increase and exceeds the number recorded for this time last year. It is noted that the number of contacts recorded as Enquiries has significantly decreased in comparison to the same time last year. This has been attributed to a training issue within the Patient Experience Team. The matter has been rectified; however it is likely to be the reason for the disparate numbers of recorded concerns and enquires in comparison to previous years.

To the end of September 2019, Trust services had also received 923 compliments. It is noted that only 15 of these are as yet unapproved – this means they have not yet been checked and updated by the receiving services. This is a marked improvement on this time last year when almost a third of the received compliments had not been approved. Of the compliments received, 77.6% were given by patients or carers, which is a drop in comparison to this time last year (83%). It has been noted that of the 923 compliments recorded, 878 (95%) recorded who the compliment was received from.

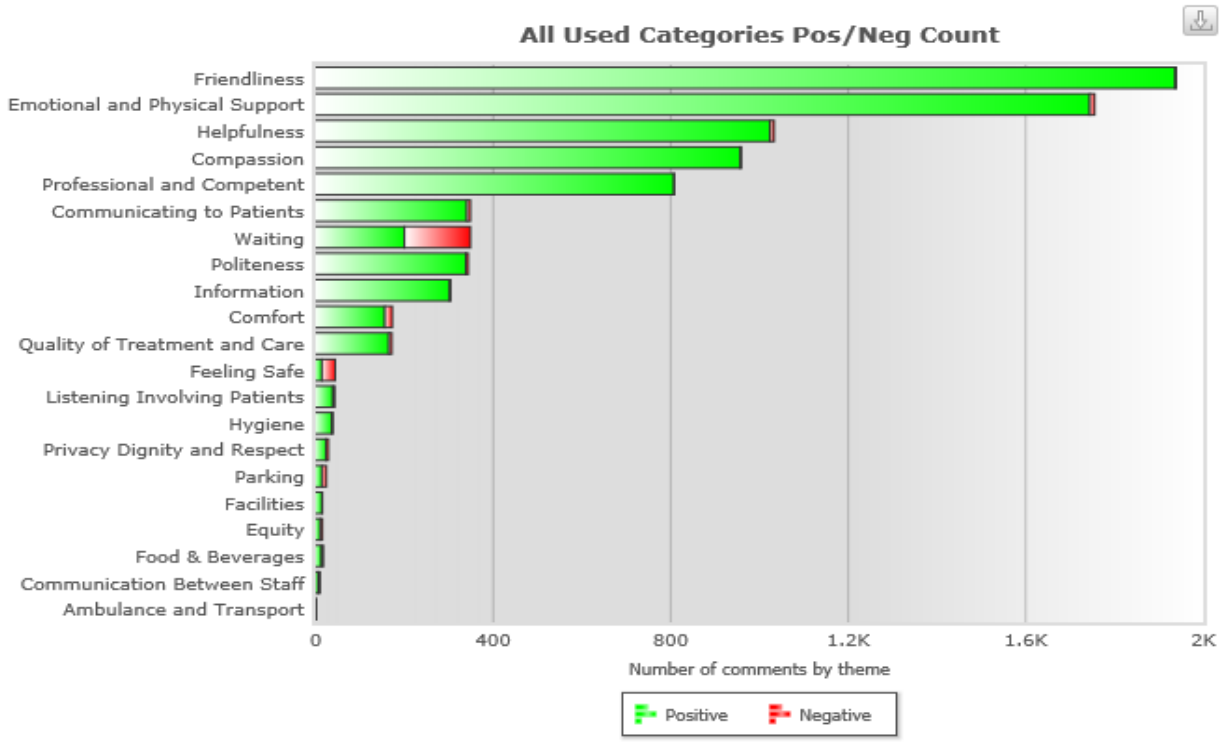
To put the feedback figures in this paper in context, the Trust made over 700,000 patient contacts in the first half of the year. The reported figure this time last year was just under 764,000 contacts. The figures are broken down by Business Unit below:

The below table shows the breakdown of both FFT response and recommendation percentages for each business unit, including our inpatient services;

Business Unit	Response Rate %	Recommended Rate %
Adult Business Unit	10.81%	94.74%
Children Business Unit	10.62%	97.78%
Specialist Business Unit	6%	95.78%
Trust-wide Community	7.54%	96.08%
Trust-wide Inpatient	35.71%	64.44%

Appendix D

Chart Below showing positive comments By Theme



Appendix E

Some examples of FTT comments received from service users between July and December 2018 are;

Adult Business Unit

“I have been very pleased with all the nurses that I've had to look after me. Can I just point out it is good to be told by phone that your appointment cannot be kept. It saves worrying. “

“I am very satisfied with their care, attention and dedication to their duty. I think the staff are FIRST CLASS!!”

“Occasional breakdowns in communication between admin and nursing staff.”

“The support and kindness I have received from the nurses was second to none. They should be very proud of themselves and the help they give to the community. Thank you.”

“I am 83 years old and just managing to look after myself with the help from your staff. It would be better if the same nurse came on each visit at a regular time.”

“It was a pleasure to see caring, helpful staff who genuinely appeared to care about their patient.”

Children’s Services

“Very friendly and informative, immense awareness of child development.”

“Nurses are caring and try their best to find solutions. But there needs to be more staff.”

“Educating us all as a family, to eat healthier and how to make better choices.”

“Very friendly. Communicate well. I've had a very positive experience bringing my child here.”

“You are all really talkative and you distract us when the needle goes in. Well done!”

“Advise parents towards treatments that may help their child that the NHS do not provide.”

Specialist Services

“Knowing you are here to help us on the road to recovery, feeling confident about ourselves. The talk on various topics which is to our benefit. Taking me out of my comfort zone and seeing things from a different point of view.”

“The kind and friendly approach and the advice I was given to manage things myself.”

“I thought it was absolutely wonderful that I was actually assessed in my own home. Thank you very much.”

“Listened to me. Gave me choices of what medicines I could take and the best way of taking my medicines.”

“Reduce waiting times. I had to pay for physio while waiting for an appointment.”

“I work full time and there are none of the follow on programmes that are outside of working hours or an evening. "Health Circuit" program would be a great addition.”

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (87)

Meeting: Trust Board 6 December 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 Quality Committee 25 November 2019	**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 work stream. The report covers the period from 24 May 2019 to 6 December 2019.

Main issues for consideration

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 the period covered 22 LCH staff members have met directly with the FTSUG and raised concerns
- The recent national FTSUG Index identifies open culture in NHS Trusts. Leeds Community Healthcare Trust is 6th.
- Emerging current themes are leadership, behaviours, culture, race, disability, gender 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 Freedom To Speak Up Guardian, basic activity data and recommendations on the role and its development.

2.0 Background

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

2.2 CQC guidance published in March 2016, in response to the Francis recommendations, indicated that trusts should identify or appoint a 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 receives strong ongoing support from the chief executive, directors, NEDS and the wider trust. A clear form of work has been established and is operating well. The work has three forms. The first is individual staff approaching the FTSUG to discuss and formally raise concerns. The second is managers inviting the FTSUG to work in their teams so staff can be heard to enable better team cultures. The third is the invite to be part of change projects such as the 0-19 work and the Admin Review, as an additional source of support to staff.

3.2 The FTSUG attends the regional network meetings across Yorkshire and the Humber. The FTSUG also works with the National Guardian Office in developing Speaking Up in General Practice.

3.3 This report covers the period from the last Board report in May 2019.

4.0 Activity data

4.1 The table below shows the volume and type of activity with which the Freedom To Speak Up Guardian has been engaged between May 2019 and November 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, texts	5 (two staff raised one issue)	Culture, leadership, behaviours
Children's	Emails and face to face	11 (two issues were raised respectively by two staff each)	Culture, disabilities and work adjustments, confidentiality, rota issues, admin issues
Corporate	Face to face and email	2	Culture, behaviours and Transgender support
Specialist	Emails	3	Culture, behaviours and leadership
Other	Emails and face to face	2 One staff member raised issues around BAME inclusion across the trust. The other was supporting a non LCH staff person share a concern relating to LCH staff in the base they work in	Culture and behaviours / bullying

4.2 22 trust staff members have met directly with the FTSUG and had a concern formally raised. These figures do not include work with teams.. Three of these staff colleagues who raised concerns were from BAME communities and two raised issues relating to race. Two staff members raised an issue of disability and work. One issue raised by a staff member concerned Transgender support

5.0 Themes

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

- Culture / behaviour – a sense that our agreed values and behaviours are not always lived out visibly in certain teams. Contrary behaviours are reported.

- Morale – reports of low morale in certain teams. Staff talking about leaving or colleagues who have left.

- Staff are naming disability, race and gender issues.

- Leadership – staff mention managers / leaders who do not treat them as colleagues. They report languages and behaviours that are not supportive, inclusive or valuing. Linked to this is the need for clear communication.

5.2 The assurances around the role are three fold – national reporting, organisational spread and local comparison.

- We are reporting quarterly to the National Guardian Office and into our own Trust to the Board and Quality Committee twice a year. Secondly, the role is meeting staff from across the trust and at different roles / levels. The FTSUG has worked with staff in this period from all the three business units and corporate services. Different occupational groups have approached the FTSUG. The last assurance is local comparison .There is no data here because there is a new national reporting system for FTSUG's and we do not have the information yet for local comparison for this period.

5.3 The following are current plans and events.

- The work to develop the FTSUG role in General Practice in Leeds in collaboration with the Leeds GP Confederation has started. This is one of the national vanguards for this work. This has support nationally, regionally and locally. We had the training for FTSUG's in 15 practices in Leeds on November 7th 2019. The next step is the creation of a citywide model incorporating work, governance, structure, support and evaluation measures

- The recent FTSUG Index indicates open inclusive culture for trusts. It is based on questions in the NHS Staff Survey. Leeds Community Healthcare featured 6th out of 180 trusts for its culture.

6.0 Conclusions

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

- The FTSUG work continues to receive positive support from the Trust and its leadership

- The FTSUG role allows staff voices to be heard in the Trust. The role continues to illustrate the importance of workplace culture and leadership

- The work continues to reflect the importance of safe spaces, empathic listening and full inclusion of the staff voice in the organisation

- The three forms of Freedom Guardian work are operating well. The freedom and strong support given to the role and its work is a positive achievement for the trust. It is a sign of the commitment of the Chief Executive and Board to hearing and understanding the voice of all our staff

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 (88)

Meeting Trust Board 6 December 2019	**Category of paper** *(please tick)*	
Report title Quarterly Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director Dr Ruth Burnett, Executive Medical Director **Report author** Dr Turlough Mills, Guardian of Safe Working Hours	**For assurance**	✓
Previously considered by Quality Committee 25 November 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

- One exception report from a CAMHS trainee in relation to working beyond contracted hours.
- Paediatric trainees continue to report concerns with the LTHT acute rota
- Work continues to facilitate improved engagement with trainees across all specalities across the Trust, in conjunction with the JDC Staffside Chair and Executive Medical Director.

Recommendations

- Trust Board are recommended to support the GfSWH and Deputy Medical Director in discussion with LTHT to improve the training experience for paediatric trainees
- Recognise the work underway to engage trainee doctors and dentists within LCH NHS Trust and to promote the role of the GfSWH

Quarterly Report of the Guardian of Safe Working Hours

1.0 Purpose of this report

1.1 To provide Quality Committee 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.

3.0 Quarterly Report of Guardian of Safe Working Hours

There are 21 Junior Doctors and Dentists employed throughout the Trust (in different specialities) as detailed in the table below. Doctors and Dentists are mostly employed through honorary contracts.

Department	No.	Grade	Status
Adults	0		Employed
CAMHS	3	ST	Employed
	4	CT	Honorary
Community Paediatrics	2	ST	Employed
	6		Honorary
Sexual Health	1	ST	Employed
Dental Services	5		Honorary

QUARTERLY OVERVIEW

Vacancies		There are 2 vacancies in the CAMHS Specialty Trainee (ST) establishment. LCH produce and populate an ST 2nd on call rota in CAMHS.					
Rota Gaps (number of nights uncovered)		August		September		October	
		CT	ST	CT	ST	CT	ST
	Gaps	n/a	20	n/a	21	n/a	20
	Internal Cover	n/a	10	n/a	14	n/a	3
	External cover	n/a	10	n/a	7	n/a	17
	Unfilled	n/a	0	n/a	0	n/a	0
Exception reports (ER)		0	|0	1	0	0	0
Fines		None.					
Patient Safety Issues		None					
Junior Doctor Forum		September 2019					

Rota gaps

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

External locums have been sourced directly by the Trust to populate the CAMHS 2nd on call rota. The CAMHS Clinical Lead and HR are developing a CAMHS second on call locum bank and locums are now predominantly sourced internally. This increases the consistency of care provided and ensures familiarity with Trust policy and procedure.

Implementing the role of GSWH

Exception reports

One exception report received from a trainee who worked 50 minutes beyond contracted hours to complete administrative tasks. This has been resolved at Clinical Supervisor level.

Feedback from trainees

Junior Doctors Forum took place on September 5th 2019. Discussion primarily focussed on fatigue and facilities spend. Suggestions have been collated and will be voted on at the next JDF. A proportion of the spend will be allocated to iPads, tailored to the needs of the Junior Doctors. This will improve their working conditions on-call.

Paediatric trainees are reporting ongoing conflict between their community paediatric experience (LCH placements) and their on-call duties at Leeds Teaching Hospitals Trust. They specifically report that their commitments to the LTHT on-call rota reduce the time they can spend in their community placements. One trainee also reported being put on a specialist rota for which she felt unqualified. This issue has been resolved for that trainee but the wider rota concerns remain.

The GfSWH will be supported by the LCH Deputy Medical Director to discuss concerns with the LTHT paediatrics department.

Update from the BMA

No new updates.

Fatigue and facilities charter

LCH have received a payment of £60, 000 to improve working conditions for junior doctors.

The JNC and JDF have completed a set of proposals for this spend, to be voted on at the next JDF.

Fines

No fines levied by the GfSWH.

Challenges

<u>Engagement</u>

Although paediatric trainees report concerns relating to training, they are not routinely using the exception report system. The GfSWH has suggested to the Head of Community Placements that all missed training opportunities are reported, in line with the new requirement for reviewing exception reporting in the ARCP.

<u>Administrative support</u>

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 NHS Trust 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.

4.0 Impact

4.1 *Quality*

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

6.0 Recommendations

- Trust Board are recommended to support the GfSWH and Deputy Medical Director in discussion with LTHT to improve the training experience for paediatric trainees
- Recognise the work underway to engage trainee doctors and dentists within LCH NHS Trust and to promote the role of the GfSWH

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2019-20 (89)

Meeting Trust Board 6 December 2019	**Category of paper**	
Report title Standards for Partnership Governance (draft)	**For approval**	✓
Responsible director Executive Director of Finance and Resources **Report author** Company Secretary	**For assurance**	
Previously considered by SMT 11 September 2019; Quality Committee 23 September 2019; Business Committee 25 September 2019, Audit Committee 18 October 2019, Quality Committee 25 November 2019 (Clinical accountability section)	**For information**	

Purpose of the report

As part of the internal audit programme 2018-19, Internal Audit reviewed the Trust's partnership arrangements and recommended that governance arrangements should be discussed and agreed before the commencement of partnership working.

This paper presents the proposed standards expected for partnership governance arrangements and the process to support the application of these standards.

Main issues for consideration

NHS Trust Boards are the only bodies corporate within systems with the legal powers to make decisions and are legally accountable for the outcomes of that decision making. Their directors are answerable to the Board even when making decisions under delegated powers and all Board members are liable for the ensuing outcomes. For providers, this means the Board, which embodies the organisation, remains the legitimate unit of decision making. So while system working is likely to impact on the way in which Boards work, it has made Board oversight more important than ever.

In December 2018, the Audit Committee requested that the Company Secretary and Executive Director of Finance and Resources draft a set of governance standards for partnership working, which were to be applied to existing and future arrangements. The proposed standards, and their rationale, were presented to Audit Committee on 26 April 2019.

At the April 2019 meeting, Audit Committee requested additional work on the standards including: an indication of the stage in contract development and agreement when the standards should be introduced and applied, some indication of which standards would apply depending on partnership complexity, and some additional information included in the quality governance standard. The Committee asked for mapping of the current partnership

landscape with an indication of which partnerships would have been asked to follow these standards if they had been available when the partnership was established. The October Audit Committee meeting requested additional information to be included on clinical accountability for patient pathways and an escalation process for the management of contracts. These were added and the Quality Committee reviewed and agreed the amended Clarity of Accountability Standard at its meeting on 25 November 2019.

SMT, and the Business, Quality and Audit Committees have reviewed the proposed process for the application of standards for partnership governance at their meetings in September and October 2019. SMT have agreed the partnership governance framework document approval and sign off levels (see page 5) and roles and responsibilities. Business and Quality Committees have confirmed that the process, if applied to partnership arrangements, will provide assurance to the Board. Audit Committee agreed the Standards for Partnership Governance in principle, subject to the amendments as described above.

The attached draft includes these revised items.

The documentation for two 'partnerships' was tested against the standards to determine whether the standards were in the usable format. Findings from these reviews were that in general the contracts were quite clear about WHAT organisations are responsible for, but they did not detail HOW the responsibilities should be carried out. Additional documentation had been produced to address this, in the form of memorandums of understanding and other collaborative documents. These did not use a standard template and some aspects of governance were omitted.

The conclusion by those tasked to review the documentation was that the standards did provide an essential check to ensure that existing and future governance arrangements were robust.

Next steps, following approval of the Standards for Partnership Governance, is for standard templates to be developed for memorandums of understanding, service level agreements and other types of collaborative documentation, utilising the standards for partnership governance in order to direct authors to produce consistent and robust documents. Business Managers are currently creating a register of all subcontracts, spilt by business unit, to establish the documentation in place for each subcontract.

It is recommended that for all partnership arrangements described in appendix four, scenarios A and B, the Standards of Partnership Governance should be applied. Some consideration will need to be given as to the additional resources required to review existing contracts/subcontracts using the Standards for Partnership Governance and to rectify any identified gaps in governance.

Recommendation

The Board is recommended to:

- Approve the Standards for Partnership Governance
- Support a proposal that the Standards for Partnership Governance, once approved, should be formatted into a Trust policy and procedure for approval through the standard policy approval route. This will ensure the document has a legitimate place in Trust business and will be subject to regular review by the Company Secretary

Standards for Partnership Governance (draft)

1. Introduction

This document describes the standards required to provide a foundation of good corporate governance for partnership arrangements. The term '**Partnership**' is used throughout this document to describe any joint working arrangement for service provision, between LCH and other health and social care organisations, whether or not it is a partnership in the true contractual sense.

A key principle of partnership working is that the whole is greater than the sum of the parts. Partnerships have the potential to tackle complex, cross-cutting issues more effectively, co-ordinate services better, increase capacity and access additional resources, and deploy them more effectively.

Partnerships can be an effective way of addressing some of these issues, which often cannot be tackled alone effectively but there are also risks, as working across organisational boundaries can increase complexity and ambiguity, and reduce accountability. Provider boards must maintain a persistent and unrelenting focus on the safety, quality and cost-effectiveness of the care provided by their own organisations and for which they are accountable in law.

The Trust must ensure that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded, accounted for and spent economically, efficiently and effectively. This applies equally to its partnerships, which have become an increasingly important way of delivering strategic objectives and services but which produce particular risk and governance issues.

This document plays a key role by setting 18 standards by which partnerships should be governed and by establishing the documentation and procedures required in order for the Trust to obtain assurance that each partnership is being managed safely and effectively.

2. Scope

These standards must be applied to existing partnership arrangements and in the establishment of new arrangements. Relationships may be formalised, based on written contracts, or semi-formal, based on trust and each requires important choices and documented decisions about structure, process and governance.

3. Potential risks of partnership working

- Lack of clear purpose or setting unrealistic goals and expectations
- Unaware of the extent of financial and legal implications, such as breach of statutory duty or failure in the exercise of statutory functions
- Financial and time commitments outweigh potential benefits
- Different or conflicting cultures, behaviours and policies lead to conflict, distrust, manipulation or domination
- Lack of clarity over partner expectations and responsibilities
- Inadequate governance and scrutiny over planning, decision-making and management of quality, finance, risk and performance

4. Escalation of risk

Managers and staff involved in partnership working must escalate matters if they feel the partnership is not acting in a way acceptable to the Trust or in the public interest, in the same way as they would escalate issues concerning LCH services.

1. Urgent matters

Urgent matters which may have significant impact on patient or staff safety should be escalated to the appropriate director by the most effective means.

2. Non-urgent matters

Typical escalation route for non-urgent matters:

Role / Group	**Escalation**
Staff members	Escalate issues to line manager in first instance
Team leader, Service Manager, Business Manager	Escalate to Leadership Team
Leadership Team	Escalate to Business Unit Performance Panel
Business Unit Performance Panel	Escalate to Senior Operations Performance Panel
Senior Ops Performance Panel	Escalate to Senior Management Team
Senior Management Team	Escalate to Trust Board

5. Applying **Standards for Partnership Governance**

In order for the Trust to be assured that it is discharging its responsibilities and fulfilling its duties in any partnership arrangement, whether formal or informal, the following standards must be applied as appropriate, with consideration being given to scale and complexity of each partnership arrangement (**see appendix one, two and three**).

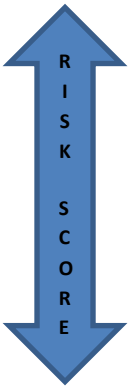
A partnership governance framework document, for example a service level agreement, joint working protocol or memorandum of understanding, must be produced when it has been determined that the partnership warrants additional documentation of its arrangements in order for the Trust to be assured that partnership governance standards are being met.

6. Assessment of scale and complexity

The assessment of scale and complexity of a partnership arrangement is determined by a number of risk factors: the value of the contract, the number of parties involved, the commissioner relationship, ‘political’ implications, and the experience of service delivery of those involved.

Below is a risk scoring system, which takes these factors into account and converts them into an overall risk score, which then generates an appropriate action:

a) Risk score



	Value	Complexity of 'partnership' agreement (figure to include LCH)	Commissioner Relationship	'Political' implications	Experience regarding service delivery
Low (score =1)	**<£100K**	**1- 2 parties**	**Extensive dealings without issue**	**None**	**Extensive experience**
Moderate (score =2)	**≥£100k ≤£500k**	**3 parties involved**	**Limited dealings without issue**	**Minor**	**Limited experience**
High (score = 3)	**≥£500k**	**More than 3 parties involved**	**Unknown or have concerns**	**Major**	**No experience**

b) Action required

Risk Score overall:	Action:	Partnership governance framework document approval:
Less than or equal to **5 (low level risk)**	Requires appropriate governance arrangements to be agreed and documented asap following contract agreement but no later than commencement of service	**Requires SMT approval and sign off**
Score between **6** and **9 (moderate level risk)**	Requires appropriate governance arrangements to be agreed and documented asap before contract agreement	**Requires Business and or Quality Committee approval and sign off**
Score between **10** and **15 (high level risk)**	Requires appropriate governance arrangements to be agreed and documented during bid process	**Requires Board approval and sign off**

Example: *a contract worth £200k (risk score 2), with 3 parties involved (risk score 2), by a commissioner well known and without issue (risk score 1), with no 'political' implications (risk score 1), where we and our partners have extensive experience of service delivery of this nature (risk score 1), would score 7 (2+2+1+1+1) ie a* ***moderate*** *level risk which requires full governance arrangements to be agreed and documented asap before contract agreement. For this example the Partnership governance framework document will requires Committee approval and sign off.*

7. Roles and responsibilities

The Executive Director of Finance and Resources will assess the scale and complexity of the partnership with support from the Contracts Manager and relevant General Manager to determine the additional governance arrangements documentation required and the actions and approval route for the documentation.

The Executive Director of Operations will oversee the production of the draft governance arrangements documentation including the appropriate application of the standards for partnership governance.

SMT will review and approve governance arrangements for low level risks.

Quality Committee and /or Business Committee will review and approve governance arrangements for moderate level risks.

Trust Board will review and approve governance arrangements for high level risks.

8. Procedure for establishment and management of partnerships

A process map for two partnership scenarios is attached at **appendix four** (scenarios A and B). This indicates the point at which there must be an assessment of scale and complexity of the proposed partnership to ascertain the level of risk it presents to the Trust and the subsequent action required. It also indicates the stage in the process at which governance arrangements will be set up and instructs on the application of the standards of partnership governance. The type of partnership governance framework document that is most appropriate can be determined by using the document types guidance (provided at **appendix five**).

Responsibilities for clinical governance for each party must be considered and agreed prior to mobilisation and captured in the partnership governance framework document. A guidance document is attached at **appendix six**.

9. Monitoring arrangements

The Standards for Partnership Governance will be applied at the renewal or extension stage of existing subcontracts.

The subcontract partnership arrangements will be monitored in accordance with the sub-contract management matrix, which outlines who is responsible for managing sub-contracts and the frequency with which contract review meetings should be held. The matrix also acts as an escalation process for contract management (**see appendix seven**).

Business managers will maintain registers of the Trust's subcontracts, including copies of the existing documented arrangements and their review dates. As these subcontracts reach their review date, the Standards for Partnership Governance will be applied to ensure that all arrangements are robust. Monitoring of subcontractors' performance is conducting using the subcontract monitoring form, which documents the subcontract review meeting, and is attached as **appendix eight.**

10. List of appendices

Appendix one	Definitions used within the Standards for Partnership Governance paper
Appendix two	The 18 Standards for Partnership Governance
Appendix three	Glossary of documents referred to in the Standards for Partnership Governance
Appendix four	Establishment of partnerships process map
Appendix five	Partnership arrangements document types
Appendix six	Clinical governance responsibilities
Appendix seven	Responsibilities for management of subcontacts
Appendix eight	Subcontract monitoring form (including escalation route for performance issues)

Appendix One

Standards for Partnership Governance

Definitions

For the purposes of this document only, the following definitions have been used:

*The term '**Partnership**' is used to describe any joint working arrangement for service provision, between LCH and other health and social care organisations, whether or not it is a partnership in the true contractual sense.*

*The term **'Parties'** is used to describe the organisations which form the Partnership*

*The term '**Plan**' is used to describe the strategy and work programme for achieving the parties severally or jointly held objectives.*

*The '**Partnership governance framework document'** described may take the form of a joint working agreement or a memorandum of understanding, depending on the type of arrangement.*

*The term '**Governance group'** refers to any group which jointly supports the Partnership, this could be for example a Partnership Board, a Joint Committee or a Committees in Common approach.*

Capitalised words and expressions within the document shall have the meanings given to them in these definitions.

Standard 1. Approval of Partnership Governance Framework document	
Standard 1	***Documentation required***
(a) A **Partnership governance framework document** has been constructed, agreed and approved by each Party. The **Partnership governance framework document** describes the governance arrangements that will be established to ensure that the Partnership can deliver on its objectives. It identifies the Parties involved, describes how the Partnership will operate, the decision-making processes and how the Partnership's associated committees and workstreams will interact with the Boards and Committees of its statutory partners. (b) The legal or non-legal status of the Partnership is clearly described in the **Partnership governance framework document.** (c) The **Partnership governance framework document** has been approved by the Boards, Governing Bodies and Local Authority Committees/Cabinets of all Partnership organisations, depending on the level of risk. The **Partnership governance framework document** includes the frequency for reviewing the document. *Rationale: Parties should formally agree and record how a Partnership operates, including structure, purpose and aims, activities, roles and responsibilities, membership, regulatory framework and exit strategy to ensure there is a shared understanding and that all parties can be held to account. The status of any partnership needs to be clear - it may be that some parts of the agreement will have the status of a protocol or statement of intent, while other parts are legally binding.*	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.

Standard 2. Aims and Objectives	
Standard 2	***Documentation required***
The overarching aims and objectives of the Partnership are clearly expressed within the **Partnership governance framework document**. *Rationale: There needs to be a shared understanding of what falls within the scope of the Partnership and what it is attempting to achieve. Lack of common understanding makes it less likely that the Partnership will work effectively to deliver its own and individual priorities*	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.
Standard 3. Clarity of Accountability	
Standard 3	***Documentation required***
An overview of governance arrangements has been agreed, and described within the **Partnership governance framework document** by means of a governance structure diagram and supporting narrative, including a clear reporting line from the Partnership Board/Committee to the organisations' individual Boards. The **Partnership governance framework document** makes it clear that each individual organisation within the Partnership, remains at all times accountable for its own decisions and the outcomes of those decisions, in the context of its statutory, regulatory and contractual duties and responsibilities. The **Partnership governance framework document** describes where clinical accountability lies for the collaborative care provided by different providers in the Partnership working together within each clinical pathway. It also makes explicit the duty of individuals to abide by their code of professional conduct and maintain their professional accountability. The **Partnership governance framework document** also describes how such matters will be escalated and resolved where there are differences of opinion and therefore competing arenas of accountability between those responsible	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.

for the clinical pathways and the responsibility of individual professionals. *Rationale: Governance is a not separate work stream but rather a continuing process of ensuring the smooth functioning of the Partnership and the mechanisms to deliver the Plan. Those working within Partnerships have to contend with multiple accountabilities: to the Partnership, to the constituent organisations, and to their own professional code. It is important to establish where the ultimate responsibility and liability rests. Boards are the only bodies corporate within systems with the legal powers to make decisions and are legally accountable for the outcomes of that decision making. In line with NHS England guidance, accountability for performance (financial/ constitutional standards/ Next Steps deliverables/ quality) remains with statutory organisations however, it is recognised that NHS England will increasingly expect an increased focus on system management and collective decision making.*	
Standard 4. Principles and Behaviours for Good Governance	
Standard 4	***Documentation required***
The **Partnership governance framework document** describes the principles and behaviours expected of the Parties involved, based on the following values: • Selflessness, integrity, objectivity, accountability, openness, honesty and leadership by example (Nolan principles) • A commitment to the Partnership based on a belief that statutory organisations will meet their obligations through the Partnership • A focus on population health management • Professionalism in business conduct • Transparency *Rationale: Parties need to work together at the highest level to deliver objectives and domination of the agenda by a particular Party can undermine effectiveness.*	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.

Standard 5. Key Roles and Responsibilities	
Standard 5	***Documentation required***
(a) Within the **Partnership governance framework document**, key roles operating within the Partnership are described. A diagram of programme infrastructure, roles and responsibilities, with supporting narrative is included in the **Partnership governance framework document**. Rules are set out for electing the Chair and Deputy Chair of the Partnership's Governance groups within the **Terms of reference** (b) Membership is aligned to Partnership objectives to provide relevant interests, experience and expertise. Members have appropriate skills and decision making powers. *Rationale: There needs to be clarity around who will provide leadership, steer the development of the Partnership's strategy and vision, ensure that the Partnership board functions efficiently and effectively, and hold parties to account for the delivery of the subsequent programme of work. This will reduce the risk that partner needs will not be met and to prevent uncertainty over accountability*.	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Terms of reference**

Standard 6. Decision Making	
Standard 6	***Documentation required***
(a) Principles of decision-making have been included in the **Partnership governance framework document.** Principles include: • Ensuring that patient/service user safety, high quality clinical and care outcomes and patient / service user experience remain at the heart of decision making and where appropriate service users and the public are involved in decision making, • Ensuring that statutory organisations meet their obligations ***through*** the Partnership and the Plan	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Scheme of delegation.**

• Adherence to the Nolan principles of selflessness, integrity, objectivity, accountability, openness, honesty and leadership by example, • The effective stewardship of public funds, • Adherence to the highest standards of business conduct, and • The principle that decisions are made as close to the people affected as possible, and that the partnership Board and its committees and workstreams are empowered to make decisions where, on the balance of risk, it is safe and appropriate for them to do so. (b) As appropriate, the **Partnership governance framework document** reflects that individuals representing statutory and other organisations must ensure that they have all necessary delegated permissions to bind the organisation on whose behalf they act when making decisions within the Partnership, including its committees and workstreams. The **Partnership governance framework document** states that decision making must remain with each organisation unless authority is delegated to the Partnership. (c) Each organisation has been directed to reflect any delegation of decisions within its own **scheme of delegation** documents. Decisions required by any Governance group must be made in line with the approved **terms of reference** of that group. (d) The **Partnership governance framework document** makes it clear that any decision not commanding consensus within the Partnership must be referred to the Boards of statutory organisations and/or the regulator as appropriate. (e) The **Partnership governance framework document** recognises that there is no legal mechanism for majority voting or for compelling organisations to submit to plans that their Boards in all conscience cannot endorse. (f) Escalation processes have been established and recorded in the **Partnership governance framework document**, and will apply in the event that any group within the Partnership is unable to reach consensus. Rationale: *Parties need to understand the autonomy they have to make decisions on*	**Terms of reference.**

behalf of the organisation they represent. Clear lines of accountability and transparent decision-making processes ensure decisions are within a Partnership's authority, properly considered and approved and subject to scrutiny and supervision. **6.1 Urgent Decisions** (a) The urgent decision making process is described in the **Partnership governance framework document.** (b) In the event that a local council forms part of a Partnership arrangement, it is recognised in the **Partnership governance framework document** that any urgent decisions required to be taken by the local council as a result of any decision exercised by Partnership are subject to the individual council's constitutional arrangements. Rationale: *Due to the nature of the business cycle of individual organisations there may be a requirement for Urgent Decisions to be taken. Urgent decisions can only be taken in accordance with each organisation's scheme of delegation. Urgent decisions should be recorded appropriately and reported to the Partnership organisations for formal ratification at the next available meeting.* **6.2 Dispute and Conflict Resolution** (a) The **Partnership governance framework document** confirms that any operational issues connected with the Plan that cannot be resolved locally must be referred to through the escalation process to the Partnership. The **Partnership governance framework document** also makes it explicit that if the Partnership is not able to resolve an issue, then depending on the nature of the dispute or conflict it should be referred either to statutory Boards, governing bodies or committees, or to the appropriate regulator(s). *Rationale: Disputes can break down co-operation and adversely impact on the delivery of agreed aims and objectives therefore a dispute resolution process is required to ensure issues can be quickly escalated and resolved.*	

Standard 7. Managing conflicts of interest	
Standard 7	***Documentation required***
(a) The **terms of reference** for Governance groups detail how conflicts of interest will be managed in line with NHS statutory guidance. (b) The **Terms of Reference** confirm that: • All members of a governance group are asked to declare their personal, professional and organisational conflicts of interest and a **register of interests** is maintained. • Any member with a material interest will either be excluded from the relevant parts of the Governance group meeting *or* join in the discussion but not participate in any decision making. • The Chair of the relevant Governance group has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the Chair may wish to consult a member of a Governing Body or Board who has responsibility for advising on issues relating to conflicts of interest. *Rationale: All members of the Partnership must observe the highest standards of probity in relation to the stewardship of public funds, the management of the Plan, and the conduct of its business. All members should not use their position improperly, confer on, or secure for themselves or any other person, an advantage or disadvantage.*	**Terms of reference** **Register of interests**

Standard 8. Openness and Transparency	
Standard 8	***Documentation required***
(a) The **Partnership governance framework document** describes the frequency that reports regarding its activity are submitted to each Party's Board and confirms that a **Communications strategy** will be devised. (b) The Partnership will demonstrate this standard by agreeing a **communication strategy**, which includes: • Publishing its Plan, including a public facing summary, • Publishing other relevant documentation, and • Working in accordance with the Freedom of Information Act (c) The **Communications Strategy** identifies a lead Party that the communications and engagement functions will be hosted by. *Rationale: There is a great need for effective and strategic communications, with both internal and external stakeholders, to build trust, manage reputation and engage with the organisations priorities, goals and objectives. The Partnership must be committed to openness and transparency in its work, in support of its accountability to patients and public.*	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Communication Strategy**
Standard 9. Quality assurance	
Standard 9	***Documentation required***
The partnership has agreed its approach to quality assurance and included this within the **Partnership governance framework document** to ensure a focus on all three	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider

elements of quality: effectiveness; safety and experience. This includes: • Delivering and demonstrating accountability for quality of clinical outcomes • Quality improvement activity, including innovation and the delivery of excellence • Measuring improvement and compliance with national and professional standards and tracking performance against national and local targets • Reporting, recording and escalating concerns about quality • Capturing and utilising patient and carer feedback to improve quality of care • Monitoring and evaluating actions to improve quality and sustain improvement *Rationale: Boards and senior leaders of health care providers are responsible for ensuring the quality of care delivered by their organisations, including care delivered in partnership. They are ultimately accountable when things go wrong and should be able to address problems that arise because of a lack of systems and processes. It is vital that they are able to monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems.*	agreement/partnership agreement or memorandum of understanding.
Standard 10. Clinical Governance	
Standard 10	***Documentation required***
The **Partnership governance framework document** describes robust clinical governance arrangements for the following areas: incident reporting, incident investigations including deaths and Serious Incidents, reporting to external agencies, Duty of Candour regulatory requirements, complaints and concerns, lessons learnt, safeguarding, research, medicines management, national clinical guidance, safety alerts, and clinical audit. The **Partnership governance framework document** will also document the key Clinical Guidelines, Policies and Procedures that the partnership has agreed to work within.	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. (Note: a separate Clinical Governance Tender/Mobilisation Framework document has previously been developed to provide guidance on considerations for: incident reporting, incident Investigations including

Rationale: Having clear and robust clinical governance arrangements will ensure patient safety and clinical effectiveness, ensure effective management and escalation of incidents and complaints, it will fulfil regulatory requirements, creates confidence in the Partnership and provides an opportunity for service improvement and sharing of good practice.	deaths and Serious Incidents, complaints and concerns, patient experience and engagement, lessons learnt, safeguarding, research, national clinical guidance, safety alerts, clinical audit, quality improvement including peer review process, and statutory and mandatory training). This will be appended to the standards of partnership governance.
Standard 11. Workforce management	
Standard 11	***Documentation required***
The **Partnership governance framework document** describes how each of the following requirements will be carried out, complied with and monitored, and how assurance will be received by the partnership that responsibilities are being met: ***Recruitment processes*** (which satisfies the requirements of the NHS Employers pre-employment check standards) this includes: • Verification of identity checks • Right to work checks • Registration and qualification checks • Employment history and reference checks • Criminal record checks • Occupational health checks • Disclosure and Barring Service (DBS) checks	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.

Professional Registration checks The process for checking professional registration for both pre-employment and during employment is robust and provides assurance that all staff (who are required to be registered with a professional body) are registered in order to practise. There are systems in place to remove any member of staff from the workplace if their registration lapses. ***Induction and training compliance*** Corporate and local induction provision has been agreed. Statutory and mandatory training requirements have been agreed and there is a monitoring system in place to ensure staff are compliant. ***Supervision and appraisal processes*** Responsibility for staff appraisals has been agreed. ***Duty of care*** Health and Safety arrangements (Health and Safety policies and procedures are in place, there is occupational health access, there is a suitable and sufficient risk assessment process and there is cooperation and coordination relating to known risks eg lone working, moving and handling, violence and aggression, slips, trips and falls, infection control and prevention, control of substances hazardous to health (COSHH)) A system is in place to ensure that workers rostered hours are compliant with the Working Time Directive. ***Insurance*** There is a process to ensure Parties evidence that they each hold appropriate and adequate indemnity scheme cover for the activities they are involved in for example Liabilities to Third Parties cover which typically covers employers' and public liability claims from staff, patients and members of the public, and Clinical Negligence cover. ***Freedom to speak up*** There are arrangements in place to enable staff to raise concerns, and a mechanism for raising staff awareness of these arrangements.	

Rationale: Robust, appropriate workforce management arrangements are essential to ensure that, as far as reasonably possible, patients and that staff are kept safe, and they are qualified, trained, suitable, motivated and competent to perform their role. It will fulfil the statutory obligations of each organisation within the partnership. *The Health and Safety at Work etc Act applies to all work activities. It requires employers to ensure, so far as is reasonably practicable, the health and safety of:* • *their employees;* • *other people at work on their site, including contractors;* • *Members of the public who may be affected by their work.*	
Standard 12. Performance reporting and monitoring	
Standard 12	***Documentation required***
(a) The **Partnership governance framework document** describes the performance reporting mechanism that captures the various targets that relate to the Plan and to the Partnership's objectives. (b) The **Partnership governance framework document** describes how intelligence provided on performance of the partnership is to be made available to all Parties involved. (c) **Terms of reference** for **Governance Groups** detail how frequently performance information reports will be presented for monitoring purposes and describes the Governance group's escalation process for alerting each Party's Board to risks and issues by exception. *Rationale: A monitoring process for reporting on progress on outcomes and performance indicators will ensure that risks to achieving objectives are quickly identified and addressed.*	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Terms of reference**

Standard 13. Risk and gain sharing	
Standard 13	***Documentation required***
A risk and gain sharing agreement is included in the **Partnership governance framework document** which describes each Party's share of profit or loss in the undertaking. *Rationale: A risk and gain share agreement allows Parties to contribute to system-wide change with some protection from a sudden loss in revenue and from unfunded fixed costs, or from an unpaid increase in activity. It is also a way to manage the uncertainty around the immediate impact of new care models over a number of years. Agreements allow Parties to distribute among them any savings or losses resulting from a system change, thus mitigating financial risks.*	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.
Standard 14. Risk management	
Standard 14	***Documentation required***
(a) The **Partnership governance framework document** describes the arrangements the Parties have made to share ownership, management and assurance of risks. (b) The **Partnership governance framework document** describes the requirement for working groups of the Partnership to maintain **risk logs** for their specific areas of work, developing mitigations and solutions as close to the risk as possible. (c) The **Partnership governance framework document** describes the reporting arrangements that will inform the Partnership of the management of identified risks. (d) Risk tolerance levels have been agreed and documented in the **Partnership governance framework document.** An escalation procedure has been established	**Partnership governance framework document :** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Risk log**

for risks exceeding the tolerance and processes are in place for each organisation to assess and determine whether a risk should be included on its own organisation's risk register. *Rationale: Clarity about ownership and management of risks is particularly important in inter-organisational projects. Each organisation must satisfy itself that risks to the strategy in their totality are being managed effectively, not just those risks that the organisation itself has agreed to own and manage. Similarly Boards will want to be assured in respect of the risks owned by their organisation and of the risks owned by partner organisations if there are consequences across the Partnership.*	
Standard 15. Information Governance	
Standard 15	***Documentation required***
A **data protection impact assessment** document has been devised and agreed, detailing demonstration of compliance with the law by:- • Identifying lawful justifications for processing information and • Ensuring transparency about purpose and process • Minimising the use of identifiable data • Ensuring the use of data protection by design and default • Promoting the application of appropriate technical and organisation measures • Adhering to the National Data Guardian's 10 data security standards • Mapping data flows and determining roles and responsibilities • Introducing standards and controls for de-identification and the risk mitigation of re-identification to protect people's identities • Accountability • Breach management An overarching **Information Sharing Framework** has been drafted, will include :- • A written contract between the grouping and (if any) the processor/s	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. **Data Protection Impact Assessment** (A template Data Protection Impact Assessment is to be appended for further reference) **Information Sharing Framework** *NHS England / NHS Improvement have published a draft IG Framework for Integrated Care for a detailed guide to implementing the requirements.*

• A clear data processing map showing purpose and controller and processor at each stage of data flow. • Service level agreements • Standard contract clauses This has been appended to the **Partnership governance framework document** . The **Partnership governance framework document** states that Parties are aware of their data compliance obligations *Rationale* *The legal framework governing the use of personal and confidential data in health care includes* • *the NHS Act 2006,* • *the Health and Social Care Act 2012,* • *the General Data Protection Regulation (GDPR)* • *the Data Protection Act 2018, and* • *the Human Rights Act 1998.* *The law allows personal data to be shared between those offering care directly to patients but the duty to protect personal data, which has been provided in confidence when used for a different purpose, must be maintained. The Board must have oversight and assurance that the Parties are adhering to the GDPR - Article 5 Principles relating to processing of personal data.*	
Standard 16. Plan Delivery (Portfolios and workstreams)	
Standard 16	***Documentation required***
The Partnership has developed a **cycle of business** which will align with the individual organisation's business cycles / decision-making processes. Reporting arrangements relating to Plan's delivery and system performance are clearly defined in the	**Cycle of business** (Board/Committee work plan)

Partnership governance framework document. *Rationale: Alignment of business cycles with those of each Party will ensure timely and effective decision making.*	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.
Standard 17. Resources	
Standard 17	***Documentation required***
(a) The Parties have agreed the resources they each will commit and have documented the arrangements in the **Partnership governance framework document.** This includes how the resources will deliver Partnership objectives in terms of capacity, capability and how they will be used. (b) The Parties have made arrangements for a range of controls and constraints to promote accountability and prevent fraud and mismanagement and documented the arrangements in the **Partnership governance framework document.** (c) The Parties have agreed any arrangements for engaging external resource and advice and documented the arrangements in the **Partnership governance framework document.** (d) A **Financial plan** has been developed and translated into an agreed budget to ensure that resources are allocated in line with aims and objectives. *Rationale: A range of controls and constraints promote accountability and prevent fraud and mismanagement, addressing the need for effective stewardship of public resources.*	**Partnership governance framework document**: Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding. Financial plan

Standard 18. Termination of Involvement	
Standard 18	***Documentation required***
There is a protocol for Parties wishing to leave a partnership, including any notice period or exceptions included in the **Partnership governance framework document.** In the case of a project, a pilot, or a limited timeframe for a partnership, there is also an indication of when this is due to end, and how the project will close included in the **Partnership governance framework document.** *Rationale: Partnership arrangements should include an exit strategy that sets out how Parties can leave a partnership or how it can be dissolved.* **NB** In the event that an extension is made to the life of the partnership, due to revised commissioning requirements, the parties must reassess and if necessary, reapply the standards of partnership governance.	**Partnership governance framework document:** Service level agreements /joint working protocols/ inter-provider agreement/partnership agreement or memorandum of understanding.

Appendix Three

Glossary of document types referred to in the Standards of Partnership Governance:

Communication Strategy
A communications strategy reflects the Partnership's objectives, identifies stakeholders, describes the types of key communication messages required, and determines communication methods.

Data Protection Impact Assessment
A Data Protection Impact Assessment (DPIA) is a process to help identify and minimise data protection risks. It is good practice to do a DPIA for major programmes which requires the processing of personal data.

Information Sharing Agreement
An information sharing agreement provides a framework for the secure and confidential obtaining, holding, recording, storing and sharing of information between participating partner agencies or organisations.

Service level agreements/Joint working protocols/ Inter-provider agreement/partnership agreement
See appendix five for definition (A standard template SLA is being developed and will be appended to the Standards of Partnership Governance).

Memorandum of Understanding (MOU)
See appendix five for definition. (A standard template MOU is being developed and will be appended to the Standards of Partnership Governance).

Register of interests
A register of personal, professional and organisational conflicts of interest of all members of the Governance group.

Risk Tolerance
A risk tolerance is the level of risk, if exceeded will trigger a response – usually an escalation process.

Risk Log
A Risk Log is a tool for documenting risks, and actions to manage each risk.

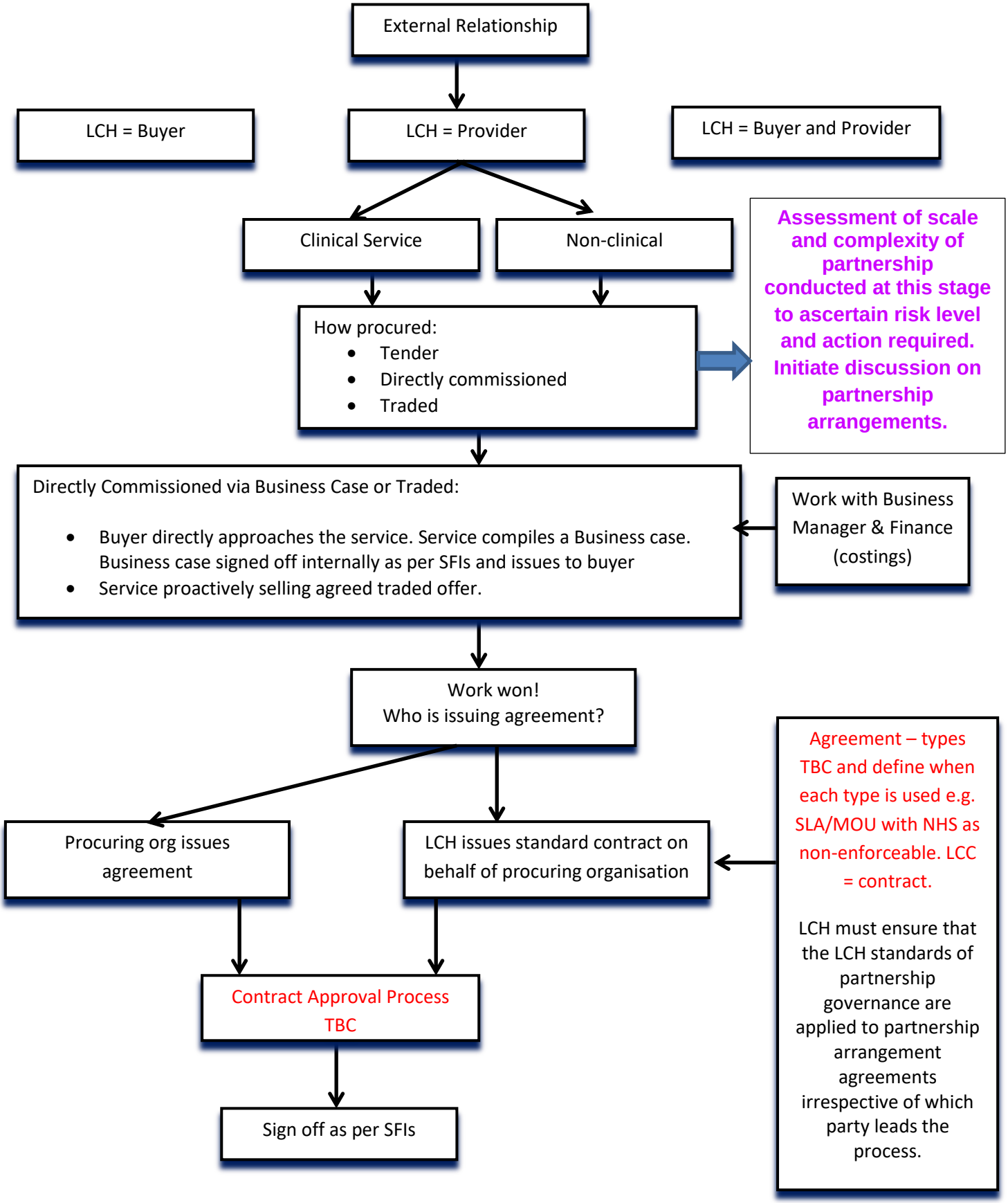
Scheme of delegation
A scheme of delegation sets down the authority delegated by the Board of an organisation to individuals or committees.

Terms of Reference
Terms of reference define the purpose and structures of a project, committee, meeting, negotiation, or any similar collection of people who have agreed to work together to accomplish a shared goal.

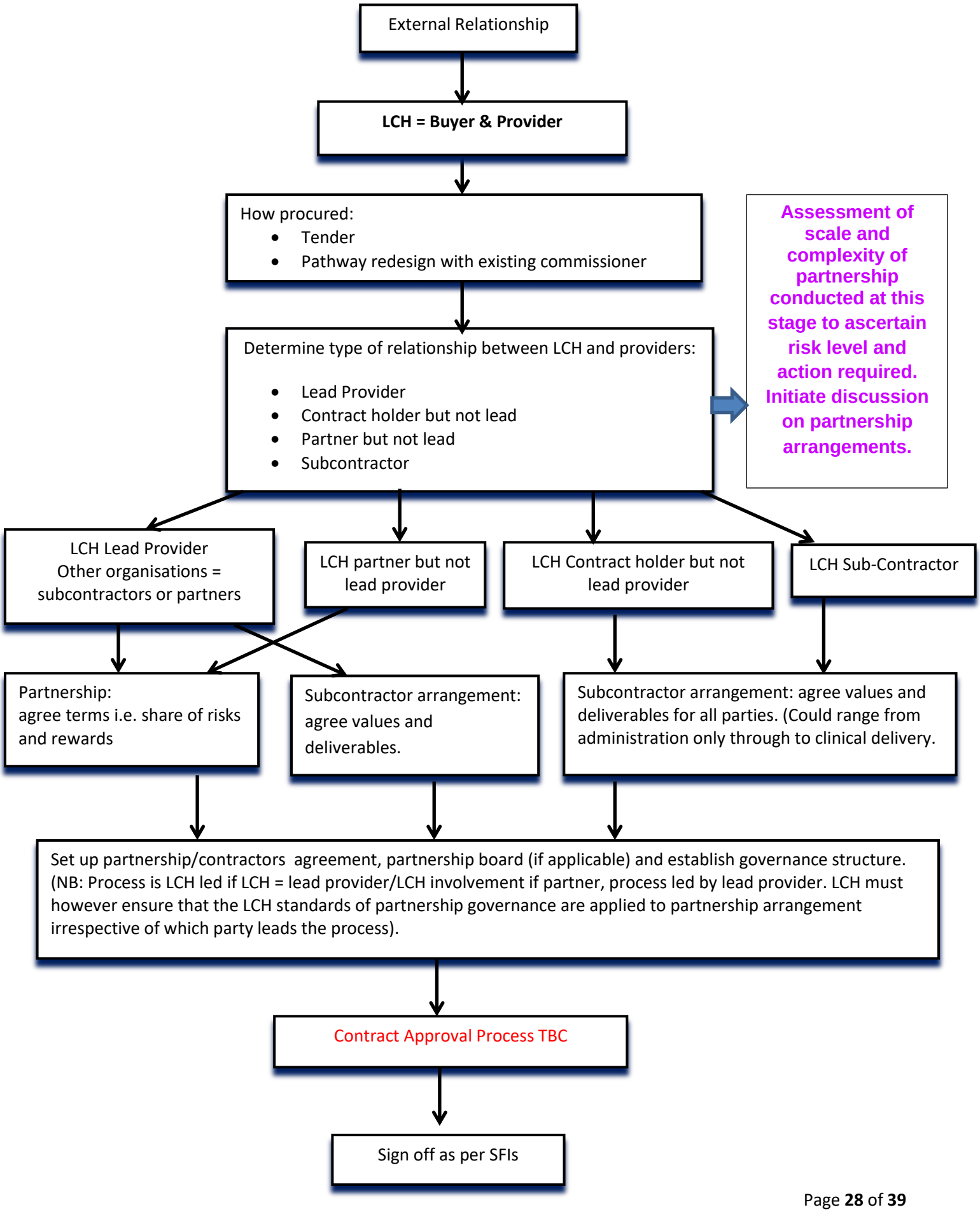
Appendix Four

Establishment and Management of Partnerships – Process Map

A) Scenario: Another organisation procures a service, which includes LCH working in partnership with others



B) Scenario: LCH commissioned to provide a service, working in partnership with others



Appendix Five

Partnership arrangements document types

Type of document	
Contract/subcontract	**Contract** – Legally (ie in Court of Law) enforceable agreement. An agreement with a non NHS Commissioner (Police, Council, School) or with a private sector supplier would be classed as a contract. Generally defined as having 4 key elements: • Offer • Acceptance • Consideration (payment or benefit of some kind) • intent to create legal relations Generally, whenever money is passing between organisations, some form of contract should be in place. Various forms of contract can be used so it is important to check that an acceptable form of contract is being used (Contract Manager for funding contracts, Procurement Manager for the buying of goods or services).
NHS Contract	**NHS Contract** – This is defined in the NHS Act 2006 and further updated in later legislation. These exist between a non-Foundation Trust and a NHS Commissioner (CCG or NHSE). They are not a legal contract as it can't be taken to a court of law when in dispute. Ultimate test is arbitration via the Secretary of State. These are used for all of our services that are commissioned within the NHS. The contract is set at a national level and can be found on the NHS England website. The Trust has no concerns using this type of contract, but the content still needs signing off by Contract Manager.
Service level agreement Joint working protocol Inter-provider agreement Partnership agreement Same document type, different names	**Service Level Agreement (SLA) -** A service-level agreement is an agreement between two or more parties, where one is the customer and the others are service providers. This can be a legally binding formal or an informal "contract" (for example, internal department relationships). The agreement may involve separate organisations, or different teams within one organisation. An example of this would be the CAMHS support into Youth Offending Services at the Council. The service is funded / contracted by the CCG but the Trust has an SLA with the Council covering the level of service both parties can expect. A standard pro forma is being developed.
Memorandum of Understanding (MOU)	**Memorandum of Understanding (MOU)** - a MOU is typically a legally non-binding agreement between two (or more) parties, that outlines terms and details of a mutual

	understanding or agreement, noting each party's requirements and responsibilities -- but without establishing a formal, legally enforceable contract. A MOU can be used: • Before a contract – e.g. a MOU could be used to outline how the Trust would bid for a service with a partner. If the bid was successful the Trust would replace the MoU with a contract; • After a contract to provide a user friendly agreement of how all parties will work together. It doesn't cover the exchange of any money or give either party rights to demand things from the other party. Such issues would be covered in the head contract. E.g. LCH has a MOU with Meanwood HC outlining how they will work together on a daily basis with the legal details covered in the head contract. • Alone with no contract; the most common example being between LCH services. E.g. The Trust has a MOU in place in Specialist between Wetherby YOI healthcare team and its MSK, Podiatry and Dental Services A standard pro forma is being developed.

Appendix Six

CLINICAL GOVERNANCE – TENDER/MOBILISATION FRAMEWORK

Clinical Governance considerations include: Incident Reporting, incident Investigations including Deaths and Serious Incidents, complaints and concerns, patient experience and engagement, lessons learnt, safeguarding, research, national clinical guidance, safety alerts, clinical audit, Quality Improvement including peer review process and statutory and mandatory training

The prime consideration is LCH has responsibility for LCH staff, services, premises and equipment and therefore when identifying areas of responsibility it is helpful to explore the beginning and end point of LCH responsibility within a contract. However due consideration of responsibilities and a joint approach to learning, information sharing and assurance processes, through a robust governance process, should always be agreed at the outset. Always consider the registration requirements of any new or amended service including CQC registration requirements.

1. PRIMARY (LCH SINGLE PROVIDER)	2.PARTNERSHIP	3.LCH AS A SUBCONTRACT	4. SUBCONTRACTS TO LCH
Primary Accountability: LCH would hold primary responsibility for the service and contact and therefore will be responsible for reporting to external agencies as required ie CQC, Commissioner, MHRA, ICO, Health & Safety Executive (HSE). (See section 3&4 for exceptions if there are any sub-contact arrangements in place)	**Primary Accountability:** LCH would be responsible for the elements of care and service which falls within our regulated activity and LCH staff. Responsibility of reporting to external agencies would follow the same principles. LCH has a responsibility for reporting RIDDOR incidents to the HSE when its employees have been harmed by a work related incident. In addition, if the incident occurred at an LCH owned or LCH primary leaseholder buildings, LCH would have a duty to report certain types of RIDDOR incidents. See HSE website for RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) reporting requirements for employers and for those in control of premises. Partner organisations would be responsible for their services, staff, equipment and facilities. However, where the responsibility of reporting falls to more than one provider, a joint decision of who would externally report should be made (example: it could be agreed that the service/organisation identified as the last recorded contact externally reports). External agencies may request all partners to report (ie CQC), this can lead to double reporting within a service which will need to be recognised through any externally required inspections/records)	**Primary Accountability:** The contracted organisation would have primary responsibility for the service and contract and would therefore be responsible for reporting to external agencies. However the exception to this would be any serious incidents/investigations relating to LCH staff member requiring external notification and reporting as per internal processes this would include any reporting to professional bodies. LCH has a responsibility for reporting RIDDOR incidents to the HSE when its employees have been harmed by a work related incident In addition, if the incident occurred at an LCH owned or LCH primary leaseholder buildings, LCH would have a duty to report certain types of RIDDOR incidents (see HSE website). LCH has a duty to report to the MHRA any issues with any equipment belonging to LCH. LCH would be responsible for reporting to the CQC areas related to or affecting LCH registration. LCH would also be required to report anything that would affect LCH's ability to provide the subcontract.	**Primary Accountability:** LCH would hold primary responsibility for the service and contract and therefore will be responsible for reporting to external agencies as required ie CQC, Commissioner, MHRA, ICO. However the exception to this would be if the service was using subcontracted equipment. In this case they would hold responsibility to report unless otherwise agreed. LCH has a responsibility for ensuring that this has been completed and should receive assurance from the sub-contracted organisation. Each organisation has a responsibility for reporting RIDDOR incidents to the HSE when its employees have been harmed by a work related incident. If an incident occurred at an LCH owned or LCH primary leaseholder buildings, LCH would have a duty to report certain types of RIDDOR incidents (see HSE website). LCH would be responsible for reporting to the CQC areas related to or affecting LCH registration. LCH would also be required to report anything that would affect LCH's ability to provide the service including those affected by subcontracts.
Incident Reporting and Investigation All incidents should be reported through the LCH Datix reporting system and follow the LCH processes for investigation.	**Incident Reporting and Investigation** All incidents including SI's relating to, affecting or involving LCH staff or services which falls under the elements above should be reported and managed within the LCH incident and SI process. Partner organisations should be informed through the agreed governance process. Where incidents crossover, include, relate to, affect or involve partner organisations – this should be reported within all related organisations. Any required investigation should be jointly carried out	**Incident Reporting and Investigation** All incidents including SI's would fall under the responsibility of the primary contract holder and follow their policy and process. However, LCH should be aware and included in any investigation relating to, affecting or involving LCH staff, services, premises or equipment. LCH has a duty to report and investigate SI's that involve, relate to or include LCH staff, services, premises or equipment unless otherwise agreed. LCH is responsible for providing assurance that any external reporting has been	**Incident Reporting and Investigation** All incidents including SI's would fall under the responsibility of LCH and therefore should follow the LCH policy and process. However, sub contracted organisations should be aware and included in any investigation relating to, affecting or involving their staff, services, premises or equipment. Sub- contracted organisations have a duty to report and investigate SI's that involve, relate to or include their staff, services, premises or equipment unless otherwise agreed. Sub-

1. PRIMARY (LCH SINGLE PROVIDER)	2.PARTNERSHIP	3.LCH AS A SUBCONTRACT	4. SUBCONTRACTS TO LCH
	by persons identified and agreed within the respective service/organisation with full transparency and joint working. The exception being if one partner agrees to lead the investigation process – feedback and review mechanisms should be agreed at the outset and learning shared and disseminated across all partners established governance mechanisms for escalations and reporting as required within each organisation.	completed and for sharing learning and action plans for monitoring through defined governance processes	contracted organisations are responsible for providing assurance to LCH that any external reporting has been completed and for sharing learning and action plans for monitoring through defined governance processes.
Complaints and Concerns All complaints and concerns raised should follow the LCH policy and procedure for complaints and concerns	**Complaints and Concerns** All complaints and concerns raised relating to, affecting or involving LCH staff or services should follow the LCH policy and process. Partner organisations should be informed of any complaint or concern raised through the governance process agreed. Where complaints or concerns raised include partner colleagues/services – a lead organisation should be agreed who will be responsible for liaising with the complainant, combining responses and sending the final response should be agreed and their process followed. Partner organisations should review the element of the complaint relating to their service or staff and should complete a complaint investigation and feedback the findings for inclusion into the complaint response. Learning should be shared across all partner organisations as applicable through the agreed governance structure and internal mechanisms	**Complaints and Concerns** All complaints and concerns should in the first instance be recorded and managed through the contact holder. LCH should be included and invited to contribute to a complaint response where a complaint is related to, affecting or involving LCH staff, services, premises or equipment. Any complaint or concern raised directly with LCH should be directed to the contracted organisation as applicable unless the complaint directly relates to an LCH member of staff or service. A decision should be made on a case by case basis if LCH will lead on the investigation. Outcomes and learning should be shared within the defined governance process and LCH should give assurance of the complaint process, the outcome and any actions tracked and monitored to completion.	**Complaints and Concerns** All complaints and concerns should in the first instance be recorded and managed through the LCH policy and process. LCH should include and invite, sub-contracted organisations as applicable, to contribute to a complaint response where a complaint is related to, affecting or involving sub contacted staff, services, premises or equipment. Any complaint or concern raised directly with the sub-contracted organisation should be directed to LCH. A decision should be made on a case by case basis if the sub-contracted organisation will lead on the investigation. Outcomes and learning should be shared within the defined governance process and LCH should receive assurance of the complaint process, the outcome and any actions tracked and monitored to completion.
Patient Engagement & Experience LCH would lead and develop patient engagement and experience within the service as defined within the patient experience and engagement plans. LCH would be required to report on any national reporting requirement ie FFT. LCH should ensure that they can comply with any contractual obligation agreed.	**Patient Engagement & Experience** Patient Engagement and Experience initiatives should be discussed and agreed within joint governance mechanism. To discuss and agree any joint projects, organisation or staff specific work to help reduce service user survey fatigue. FFT reporting requirement should be completed by all partners where the national reporting requirement is defined and can be completed by all relevant services.	**Patient Engagement & Experience** Patient engagement and experience initiatives should be discussed within the service provision with joint decision of inclusion. Any patient engagement and experience projects which include or require input of LCH staff or services should be discussed and agreed within the service and defined governance process. Requirements for the management of FFT reporting would sit within the contracted organisation, unless the element of the service which holds the national reporting requirement sits with LCH alone. This should be agreed and defined within mobilisation or tender discussions.	**Patient Engagement & Experience** Patient engagement and experience initiatives should be discussed within the service provision with joint decision of inclusion. Any patient engagement and experience projects which include or require input of LCH staff or services should be discussed and agreed within the service and defined governance process. Requirements for the management of FFT reporting would sit within LCH. This should be agreed and defined within mobilisation or tender discussions.
National Clinical Guidance All new or updated national guidance would be managed in line with LCH policy and process. All relevant update guidance or new guidance relevant to the service should be shared within the service for dissemination across all staff including sub-contracted colleagues.	**National Clinical Guidance** All new or updated national guidance applicable to LCH would be managed in line with LCH policy and process. All relevant updated guidance or new guidance relevant to the service should be shared within the service for dissemination across all staff. Relevant national guidance should be discussed within agreed governance mechanisms to ensure all staff are working within the same guidance/ process or where non-compliance can be discussed and timeline for implementation are agreed or continued non-compliance documented. Any action	**National Clinical Guidance** All new and updated national guidance would follow LCH policy and process to assess relevance and to disseminate to service staff as applicable. Non-compliance and action planning for implementation should be discussed within defined governance processes. LCH would have to provide assurance that the service is working within national guidelines or reasons for non-compliance. Any disparity would have to be explored further within the governance arrangements with consideration of risk.	**National Clinical Guidance** All new and updated national guidance would still be required to following LCH policy and process to assess relevance and to disseminate to service staff as applicable. Subcontracted organisations would have to provide evidence that their staff are working within national guidance or reasons for continued non-compliance. Any disparity would have to be explored further within the governance arrangements with consideration of risk

1. PRIMARY (LCH SINGLE PROVIDER)	2.PARTNERSHIP	3.LCH AS A SUBCONTRACT	4. SUBCONTRACTS TO LCH
	plans for implementation should be tracked through the agreed governance process.		
Safety Alerts All relevant safety alerts should be managed in line with LCH policy and procedures. All relevant safety alerts should be shared within the service for dissemination across all staff including subcontracted colleagues	**Safety Alerts** All relevant safety alerts should be managed in line with LCH policy and procedures. All relevant safety alerts should be shared within the service for dissemination across all staff as applicable	**Safety Alerts** All relevant safety alerts should be managed in line with LCH policy and procedures. All relevant safety alerts should be shared within the service for dissemination across all staff as applicable	**Safety Alerts** All relevant safety alerts should be managed in line with LCH policy and procedures. All relevant safety alerts should be shared within the service for dissemination across all staff including subcontracted colleagues
Clinical Audit All national and local clinical audits would follow LCH policy and process.	**Clinical Audit** All applicable national audits which LCH are eligible to contribute would follow LCH processes and procedures. LCH would only submit data relevant to the service or service specific area which LCH is responsible for. Discussions should be held within the agreed governance mechanism to agree joint national audit contributions including who will sign up and complete the returns. Monitoring and progress should be included in the agreed governance mechanisms. For local clinical audits – the annual audit programme should be agreed within the service and shared with partners through the agreed governance mechanism	**Clinical Audit** All applicable national and local clinical audits would follow LCH policy and process. Audit requirement should be discussed within the defined governance process. Findings and actions should be shared with the contract holder as applicable. Where LCH staff are taking part in clinical audit activity managed by another organisation, discussions should be had with service managers and LCH clinical governance team to determine if LCH should also record the audit activity – this will depend on the LCH contribution to the audit activity.	**Clinical Audit** All applicable national and local clinical audits would follow LCH policy and process. Audit requirement of the subcontracted organisation/ staff should be discussed within the defined governance process. Findings and actions from audits completed by the subcontracted organisation should be shared with LCH. Where subcontracted staff are involved in LCH clinical audit activity they should be acknowledged within the audit documentation and the findings and outcome shared across the teams.
Quality Improvement/Peer Review Process LCH would lead and complete all quality improvement and peer review processes for the service as agreed within the service and organisation. Learning should be shared across the service. LCH would have to provide assurance of any contractual agreement through defined monitoring and reporting process set out in LCH policy.	**Quality Improvement/Peer Review Process** Collaborative and shared approach should be agreed between partner organisations through the agreed governance process. However, LCH may decide to undertake a QI project or peer review for the LCH element of the service provision. This should be shared with partner organisations and any learning and action plans shared through the agreed governance process	**Quality Improvement/Peer Review Process** Consideration of the QI and Peer Review mechanisms and requirements from LCH should be agreed within the mobilisation and contract. Findings and learning should be shared within the defined governance process.	**Quality Improvement/Peer Review Process** Consideration of any QI and Peer Review processes should be agreed within the mobilisation and contract agreement. LCH would lead all quality improvement and peer review processes for the service unless otherwise agreed within the governance process. Findings and actions should be discussed and shared through the agreed governance mechanisms Learning should be shared across the service including subcontracted colleagues.
Clinical Research LCH policy and procedures should be followed. Consideration and agreement should be gained by all parties if the research includes or affects others	**Clinical Research** Any clinical research which includes partners should be discussed and agreed within the agreed governance process along with the lead, monitoring process, escalation and tracking mechanisms.	**Clinical Research** Consideration of clinical research activity should be discussed and agreed within the contract agreement. Any clinical research involving LCH staff, services should be discussed and agreed with the LCH research team for consideration	**Clinical Research** Consideration of clinical research activity should be discussed and agreed within the contract agreement. LCH policy and procedure should be followed for all research activity. If any element of the research activity affects or requires contribution from the subcontracted organisation/staff this should be discussed and agreed within the defined governance process.
Statutory and mandatory Training All staff would have to ensure that they have undertaken all statutory and mandatory training as required. LCH would have to provide assurance and monitoring to ensure that LCH is compliant with the contractual and regulated responsibilities. LCH would also identify and mitigate any risk to compliance.	**Statutory and mandatory Training** LCH will be responsible for ensuring that all LCH staff have undertaken the required statutory and mandatory training required for their role. Management and Clinical supervision should be completed by direct line managers. LCH would have to provide assurance of compliance and receive assurance from partners. Any risk to compliance should be discussed and action plans agreed to mitigate the risk.	**Statutory and mandatory Training** LCH would be responsible for ensuring that all LCH staff have undertaken the required statutory and mandatory training required for their role. Management and Clinical supervision should be completed by direct line managers. LCH would have to provide assurance of compliance levels. Where non- compliance is identified LCH organisation would have to provide assurance of any action plans and consider any risk. Any risk to compliance should be discussed and action plans	**Statutory and mandatory Training** Subcontracted organisation would be responsible for ensuring that all their staff have undertaken the required statutory and mandatory training required for their role. Management and Clinical supervision should be completed by direct line managers. A subcontracted organisation would have to provide assurance of compliance levels. Where non-compliance is identified the subcontracted organisation would have to provide assurance of any action plans and consider any risk. Any risk to

1. PRIMARY (LCH SINGLE PROVIDER)	2.PARTNERSHIP	3.LCH AS A SUBCONTRACT	4. SUBCONTRACTS TO LCH
		agreed to mitigate the risk.	compliance should be discussed and action plans agreed to mitigate the risk. LCH would review any risk for consideration to document on the risk register.
Safeguarding All safeguarding concerns raised within the service would follow the LCH process for reporting, monitoring and escalation as required. Any safeguarding concerns should be raised and discussed with the safeguarding team.	**Safeguarding** Any safeguarding concerns should be raised and follow the defined safeguarding process for that area and shared with partner organisations as required. All organisations are responsible for ensuring that their staff are up to date with safeguarding training and procedures for both adults and children as required.	**Safeguarding** Any safeguarding concerns should be raised and follow the defined safeguarding process for that area and shared as required. All organisations are responsible for ensuring that their staff are up to date with safeguarding training and procedures for both adults and children as required. Any safeguarding concerns should be raised and discussed with the LCH safeguarding team.	**Safeguarding** Any safeguarding concerns should be raised and follow the defined safeguarding process for that area and shared as required. All organisations are responsible for ensuring that their staff are up to date with safeguarding training and procedures for both adults and children as required. Any safeguarding concerns should be raised and discussed with the LCH safeguarding team.
Risk LCH will be responsible for identifying risks. LCH will be responsible for completing, monitoring and reviewing all risk assessments relating to the service and escalate to the Trust's risk register as required, in accordance with the Risk Management Policy and Procedure.	**Risk** All parties will be responsible for identifying risks. LCH would be responsible for managing and escalating any risks relating to LCH provision only. All risks and actions should be shared with partner organisations through the agreed governance process. Jointly owned risks should be included on all parties risk registers as appropriate. All risks and actions should be monitored through the agreed governance process.	**Risk** All parties will be responsible for identifying risks. The contract holder will be responsible for managing and escalating any risks relating to the service. LCH will be responsible for escalating to the contractor any identified risk. The contract holder should share all risks and actions with subcontractor organisations through the agreed governance process. LCH should consider the relevance of all risks and whether they should be escalated onto the LCH risk register. All risks and actions should be discussed through the agreed governance process.	**Risk** All parties will be responsible for identifying risks. Sub-contracted organisations should ensure that LCH are made aware of any identified risks. LCH will be responsible for managing and escalating any risks relating to the service. LCH should share all risks and actions with subcontractor organisations through the agreed governance process. LCH will be responsible for escalating any identified risk. LCH should consider the relevance of all risks and whether they should be escalated onto the LCH risk register. All risks and actions should be discussed through the agreed governance process.
Assurance Required: LCH will have to satisfy itself that all aspects of the service are working within and compliant to the contract agreement.	**Assured Required:** LCH will have to satisfy itself that any partner organisations are working within the terms as set out in the mobilisation/contract agreement. There should be regular governance meetings. LCH would have to provide assurance that it is meeting contractual obligations.	**Assurance Required:** LCH will have to provide assurance that LCH staff and service are working within the terms as set out in the contract agreement through joint governance processes.	**Assurance Required:** LCH will have to satisfy itself that any subcontracts are working within the terms as set out in the mobilisation/contract agreement through joint governance processes.

- Individual and management responsibility should be agreed prior to mobilisation with sharing of report structures with partners and contracted organisations

Appendix Seven

Responsibilities for management of subcontracts

Annual contract £value ↓ / Complexity & Risk →	1. Critical to Business Continuity	2. Financial Penalties	Both 1. and 2.
£<£25k **Annual contract review meeting**	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU)	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU)	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU)
£25k<£<£100k **Annual contract review meeting**	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU)	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU) and Business Manager	Service Manager (ABU/CBU) or Head of Service – Operational/Clinical (SBU) and Business Manager
£100k<£<£250k **6 monthly contract review meeting**	Head of Service (ABU/CBU)/Specialist Portfolio Operational/Clinical Lead, Business Manager and corporate support (Contract Manager/Procurement Manager, Senior Finance Manager)		
£250k<£<£500k **Quarterly contract review meeting**	Head of Service (ABU/CBU)/Specialist Portfolio Operational/Clinical Lead Or General Manager/Clinical Lead, Business Manager and corporate support (Contract Manager, Senior Finance Manager/Deputy DoF)		
£>£500K **Quarterly contract review meeting**	General Manager/Clinical Lead, Business Manager and corporate support (Contract Manager/Procurement Manager Deputy DoF/DoF)		

Contract issues/request for support: Escalate to next level

The above table offers guidance re who is responsible for managing sub-contracts and the frequency with which contract review meetings should be held **as a minimum**. This is based on the following criteria:

- Annual contract value (in line with LCH's SFIs).
- Complexity and risk which is made up of two factors:
  - How critical the contract is to business continuity in terms of quality, patient safety and continuity of care
  - If the contract contains financial penalties

If the contract relates to a new contractual relationship/service or there are any issues/concerns then the frequency of meetings should be increased. Please be aware that the service can call on the support of their Business Manager, Leadership Team, Procurement Manager, Contracts Manager or

Finance team at any time should they need additional support. Contract issues/concerns or requests for further support should be escalated to the next level as outlined above.

Appendix Eight

NHS Leeds Community Healthcare NHS Trust

LCH Subcontract monitoring form

(including escalation route for performance issues)

Organisation / Service(s):	Who / Delivering What	
Date of review meeting:		Q1☐ Q2☐ Q3☐ Q4☐
LCH representatives:		
Sub Contract Representatives:		

1. Activities in previous quarter (incl. review of action log from previous meeting)

Development of the service *Actions undertaken from previous meeting* *Events / Promotions*

2. Achievements & Lessons Learned

Any good news stories *Best Practice identified* *Lessons Learned*

3. Summary of performance/quality against contract indicators

Activity

Targets

Waiting Lists

Spend

Reportable & Non Reportable Incidents

Complaints / Compliments

Penalties / Fines

Contribution to CQUIN or other Bonus Scheme

Any impacts on wider service

4. Issues/Risks - Have there been any issues that have affected the organisation's ability to deliver the service or meet the agreed performance indicators?

Issues within previous quarter
Surgeries / Sessions cancelled *Staff Sickness* *Estate Issues* *Other factors that have affected delivery or patients*
Risks identified for next quarter
Staffing / Recruitment *Demand Levels*
Mitigation of Risks or Any that need escalating

5. Specific Items for Escalation (and escalation route)

(items to escalate to Leadership Team → Business Unit Performance Panel → Senior Ops Performance Panel → SMT)

6. Action Log

Action	Owner (Organisation & Person)	By When

NHS
Leeds Community Healthcare
NHS Trust

Agenda Item 2019-20 (90i)

Meeting Board Meeting **Date:** Friday 6 December 2019	**Category of paper** *(please tick)*	
Report title Healthcare worker flu vaccination best practice management checklist	**For approval**	
Responsible director Steph Lawrence Executive Director of Nursing and Allied Health Professionals **Report author** Liz Grogan, Lead Infection Prevention and Control Specialist	**For assurance**	√
Previously considered by *N/A*	**For information**	√

Purpose of the report

The purpose of this report is to appraise the board of the provisions we have in place for the seasonal staff influenza campaign 2019/2020. The checklist is in response to a letter received from NHS Improvement and NHS England on the 17th September 2019.

The purpose of the checklist is to assure NHS Improvement and NHS England of the plans we have in place to ensure that all of our frontline staff are offered the vaccine and how LCH will achieve the highest possible level of vaccine coverage this winter.

Main issues for consideration

Last year LCH vaccinated 76.9% of frontline staff. This year the national CQUIN target has been raised from 75% to 80%.

The IPC Team have a robust action plan in place to systematically project manage the campaign aiming to achieve 80% of frontline staff vaccinations.

A multi model approach to the vaccine delivery including 'Have a jab give a jab', communication messages, social media usage, vaccine schedule plan, engaging with team

meetings and events such as induction, an electronic consent form and an enhanced use of digital technology.

The difficulties that can be encountered throughout the vaccine campaign and staff refusal around the vaccine to be considered and for the commitment from the Board and SMT throughout LCH to encourage and promote the vaccine in order for us to deliver safe effective care to the people we serve.

Recommendations

The board is recommended to note the contents of this report

Leeds Community Healthcare NHS Trust

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	Committed leadership (number in brackets relates to references listed below the table)	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	SMT will receive a weekly overview of the status of vaccine uptake during the campaign period, as well as a breakdown of uptake across business units. Staff will have opportunity to opt out of the vaccine programme, however they will need to complete an opt out form.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Vaccines have been ordered and we await delivery in the last week of September. We have purchased the Sanofi Pasteur Quadrivalent Influenza Vaccine (split virion, inactivated), suspension for injection in pre-filled syringe.
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	The IPC Annual Report provided a detailed evaluation of the campaign in addition to a standalone report for the 2018/2019 campaign.
A4	Agree on a board champion for flu campaign	Steph Lawrence, Executive Director of Nursing and AHP's
A5	All board members receive flu vaccination and publicise this	Board members to be vaccinated from 1st October 2019 as part of the launch and vaccines to be offered as part of the board meeting on the 4th October. Photographs to be taken and shared on social media as well as an article in Community Talk.
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	IPC lead on the flu campaign and planning meetings been held since June have included communications, class (e-rostering) and the business units.
A7	Flu team to meet regularly from September 2019	The IPC team have had planning meetings since May 2019, and an overview has been provided at our quarterly Infection Prevention Committee Group, where we have attendance from all business units. Going forward from mid-October there will be a monthly meeting including, communications, staff side and a representative from each business unit, to that we can appraise of the developments so far, and focus on where are attentions are required.
B	**Communications plan**	
B1	Rationale for the flu vaccination	An email will be sent to all staff from Thea Stein,

	programme and facts to be published – sponsored by senior clinical leaders and trades unions	highlighting the importance of the vaccine, facts and a copy of the schedule. This will have signatures from key leaders and staff side representing the unions.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Schedule available to staff members where they can drop in. staff can complete an electronic consent form to complete prior to the visit. The schedule is available on Elsie and is sent out to all members of staff via email. We have 500 printed which are sent out to business units.
B3	Board and senior managers having their vaccinations to be publicised	Photographs will be captured of the launch and board meeting, and they will be shared on social media and community talk.
B4	Flu vaccination programme and access to vaccination on induction programmes	A vaccinator will attend each monthly induction at Shine offering vaccinations.
B5	Programme to be publicised on screensavers, posters and social media	A screen saver profiling the campaign, posters have been designed in collaboration with LCC, IPC have a dedicated section to the intranet site and we profile the campaign on twitter and Facebook.
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Information will be made available on Elsie, as well as communications made with each business unit providing an overview of the number of staff vaccinated in each area.
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	In previous years we have offered this, but it can prove difficult due to not having vaccine fridges in all areas to store the vaccines. We will have peer vaccinators at the YOI.
C2	Schedule for easy access drop in clinics agreed	A vaccine schedule is made available that runs throughout the campaign from the 1st October till January/February. Drop in clinics rotate around the city at all bases. We attend team meetings, training programmes, and we advertise in CT that staff can contact the team should they require a vaccinator to attend a team meeting.
C3	Schedule for 24 hour mobile vaccinations to be	We have not made provision for a 24 hour mobile vaccines, but staff working twilight shifts will be offered vaccines at the start of their shifts periodically through the campaign. We also offer the flu vouchers to staff who work nights or out of area (i.e. custody staff).
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Incentives this year will be focused on have a jab give a jab.
D2	Success to be celebrated weekly	Weekly update available on front page of Elsie and an overview in Community Talk. Weekly overview to be sent to CEO and Director of Nursing on uptake percentages.

Completed by Liz Grogan 18th September 2019 Lead IPC Specialist and Deputy DIPC

THEA STEIN

Chief Executive,
Leeds Community Healthcare NHS Trust

NHS England and NHS Improvement

Pauline.Philip@nhs.net

17 September 2019

CC: Mr Neil Franklin

Chair,
Leeds Community Healthcare NHS Trust

Dear THEA,

Healthcare worker flu vaccination

The vaccination of healthcare workers against seasonal flu is a key action to help protect patients, staff and their families. Provider flu plans for 2018/19 saw a national uptake rate amongst front line staff of 70.3%, with some organisations vaccinating over 90% of staff. Our ambition is to improve on this through the actions outlined in this letter.

In March 2019, the Department of Health and Social Care (DHSC), NHS England and Improvement and Public Health England (PHE) wrote to all trusts setting out the appropriate vaccines for adults up to 64, the egg and cell-base Quadrivalent influenza vaccines (QIVe and QIVc) and for over 65s, the adjuvanted trivalent influence vaccine (aTIV) as well as QIVc.

Today, we are writing to ask you to tell us how you plan to ensure that all of your frontline staff are offered the vaccine and how your organisation will achieve the highest possible level of vaccine coverage this winter.

Background

Healthcare workers with direct patient contact need to be vaccinated because:

a) Flu contributes to unnecessary morbidity and mortality in vulnerable patients

b) Up to 50% of confirmed influenza infections are subclinical (i.e. asymptomatic). Unvaccinated, asymptomatic (but nevertheless infected) staff may pass on the virus to vulnerable patients and colleagues

c) Flu-related staff sickness affects service delivery, impacting on patients and on other staff – recently published evidence suggests a 10% increase in vaccination may be associated with as much as a 10% fall in sickness absence

d) Patients feel safer and are more likely to get vaccinated when they know NHS staff are vaccinated

Whilst overall uptake levels have increased every year since 2015/16, there is significant variation in the uptake rates achieved as some trusts have developed excellent flu programmes that deliver very high level of vaccination coverage, however others have not made the same progress.

An evaluation of last year's flu season showed that trusts that have developed a multicomponent approach have achieved higher uptake levels. Innovative methods to reach staff, going ward-to-ward, holding static and remote drop-in clinics and encouraging staff to contact vaccinators directly have been established. Trusts also used incentives to encourage staff, and even small incentives, such as badge stickers, worked to reinforce positive messages. Above all, board and ward leadership are critically important to promote vaccination to staff, providing visibility and transparency.

In order to ensure your organisation is doing everything possible as an employer to protect staff and patients from flu, we would strongly recommend working with your recognised professional organisations and trade unions to maximise uptake of the vaccine within your workforce. You can also access resources including National Institute for Health and Care Excellence (NICE) guidelines: https://www.nice.org.uk/guidance/ng103 and Public Health England's Campaign Resource Centre: https://campaignresources.phe.gov.uk/resources/campaigns/92-healthcare-workers-flu-immunisation-

We are now asking that you complete the best practice management checklist for healthcare worker vaccination [appendix 1] and publish a self-assessment against these measures in your trust board papers before the end of December 2019. Your regional lead will also work with you to share best practice approaches to help support an improvement in your uptake rates.

It is important that we can track trusts' overall progress towards the 100% ambition and all trusts will be expected to report uptake monthly during the vaccination season via 'ImmForm'.

As discussed, there is variation of uptake rates between trusts. Many trusts have made successful progress and have achieved near full participation, whilst other trusts are not increasing uptake rates quickly enough to protect staff and patients. It is important that improvements are made in those trusts. To support this, the healthcare worker flu vaccination CQUIN is in place again this year. New thresholds for payment have been set at 60% (minimum) and 80% (maximum).

We are also increasing requirements for trusts who have had low uptake rates. Each trust that was in the bottom quartile for vaccination uptake (at 61.7% or below) in the published data (Immform in 2018/19) will be required to buddy with a higher uptake trust. Working with them will provide an opportunity to learn how to prepare, implement and deliver a successful vaccination programme.

For trusts in this quartile progress will be reviewed weekly during the flu season by regional teams in addition to the monthly reporting that is provided to PHE via Immform.

In 2018/19, your trust achieved a frontline healthcare worker flu vaccination uptake rate of 76.9%. This does not put your trust in the lower quartile of trusts.

Organisations should use the Written Instruction for the administration of seasonal 'flu vaccination developed by The Specialist Pharmacy Service. NHS trusts vaccinating their own staff may consider that a PGD is more appropriate if it offers a benefit to service delivery e.g. provision by healthcare practitioners other than nurses, who may legally operate under a PGD. Health and social care workers should be offered either the egg or cell-based quadrivalent influenza vaccine. For the small number of healthcare workers aged 65 and over, if you are unable to offer the cell-based flu vaccine, these staff should ask their GP or pharmacy for an adjuvanted trivalent influenza vaccine (aTIV) which is preferable to the non-adjuvanted egg-based flu vaccine particularly if they are in an at risk group.

Finally, we are pleased to confirm that NHS England and Improvement this year is offering the vaccine to social care and hospice workers free of charge this year. Independent providers such as GPs, dental and optometry practices, and community pharmacists, should also offer vaccination to staff. There are two parallel letters to primary care and social care outlining these proposals in more detail.

Yours sincerely,

Pauline Philip
National Director of Emergency and Elective Care
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer
NHS England and NHS Improvement

Professor Stephen Powis
National Medical Director
NHS England and NHS Improvement

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	
A7	Flu team to meet regularly from September 2019	
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	
B3	Board and senior managers having their vaccinations to be publicised	
B4	Flu vaccination programme and access to vaccination on induction programmes	
B5	Programme to be publicised on screensavers, posters and social media	
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	
C2	Schedule for easy access drop in clinics agreed	
C3	Schedule for 24 hour mobile vaccinations to be agreed	
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (91)

Meeting: Trust Board 6 December 2019	**Category of paper** *(please tick)*	
Report title: Workforce Strategy update and Annual Equality and Diversity Report	**For approval**	√
Responsible director: Director of Workforce **Report author:** E&D Facilitator	**For assurance**	
Previously considered by: SMT 30th October 2019, Business Committee 27th November 2019	**For information**	

PURPOSE OF THE REPORT

The purpose of this report is to outline the Workforce E&D actions and progress made over the last 12 months, in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED), the NHS standard contract and on the delivery of the Workforce Strategy Diversity & Inclusion priority. This work supports the Trust's aspiration to be an inclusive employer and provider of services to every community in Leeds by being a truly inclusive place to work and receive treatment.

MAIN ISSUES FOR CONSIDERATION

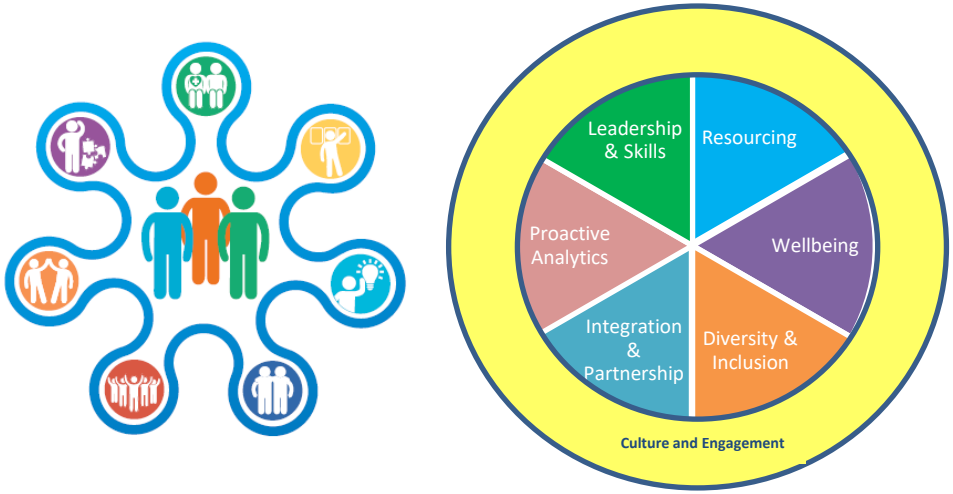
- Progress of the Trust equality objectives for 2018/19
- The Trust current NHS EDS2 grading
- The Trusts evidence of paying due regard to the Equality Act general duties by protected characteristic;
  - Race
  - Disability
  - Sexual Orientation
  - Gender
- Workforce Equality & Diversity Audit - TiAA (Internal auditors)
- The Trust is ranked 14th in the Top 50 Inclusive Companies award 2019
- Trust equality objectives for 2019/20
- WRES action plan – retiring of one achieved action and inclusion of three new actions.

RECOMMENDATIONS

The Trust Board is recommended to:

- Note the progress made over the last 12 months
- Agree the proposed equality objectives for 2019/20
- Support the proposed changes to the WRES action plan

Leeds Community Healthcare NHS Trust



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 meeting.

This report provides the Trust Board with an update on the progress made in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS standard contract during the period December 2018 – November 2019 and on the delivery of the Workforce Strategy Diversity & Inclusion priority.

2. Diversity and inclusion

Priority's Aim:

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

3. Progress: Diversity & Inclusion

Background

As a Trust we aspire to be an inclusive employer and provider of services to every community in Leeds, the content of this report lays out the activity, achievements and continuing challenges that the Trust faces to become a truly inclusive place to work and receive treatment.

To meet statutory and contractual reporting requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) to publicise our work, and comply with the NHS standard contract, the Trust Board receives an annual update on progress and future actions around equality and diversity.

Under the Equality Act 2010, organisations are required to have one or more Equality objective of between 1 and 4 years duration. Disability Confident employer and Workforce Disability Equality Standard (WDES) are the two Equality objectives previously agreed within the Trust.

Equality objectives

As the Trust is a public authority listed in Schedule 1 and 2 of the Equality Act 2010 (Specific Duties) Regulations 2011 (the specific duties) we must:

- Prepare and publish one or more objectives we think we should achieve to do any of the things mentioned in the aims of the general equality duty.

- Ensure that those objectives are specific and measurable.

- Publish those objectives in such a manner that they are accessible to the public.

The purpose of setting specific, measurable equality objectives is to help the Trust to better perform the general equality duty, focusing on the outcomes to be achieved. Equality objectives help focus attention on the priority equality issues within the Trust in order to deliver improvements in policy making, service delivery and employment, including resource allocation.

At the Trust Board meeting in December 2018 it was agreed that there would be two Trust equality objectives:

1. The implementation of the Workplace Disability Equality Standard (WDES)

2. The achievement of the Disability Confident Leaders accreditation.

The first objective has been completed. NHS England WDES reporting requirements were submitted and the Trust WDES action plan (Appendices A) was approved at the Trust Board meeting on the 2nd August 2019. The NHS England WDES reporting and action requirements have been met.

For the second objective, the Disability Confident leaders' accreditation actions to progress this equality objective have been included in the WDES action plan. It is proposed that this action, as an equality objective, is continued into the next reporting period.

NHS Equality Delivery Systems 2 (EDS2)

The EDS2 is a framework that helps NHS organisations improve the services they provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS. It is based on four goals, with 18 specific outcomes. The EDS goals are:

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

The Trusts current NHS EDS2 overall performance is "*Achieving*" the individual NHS EDS2 goal performance is illustrated in Appendices B.

Race

In the preceding 12 months, through extensive work with our BAME colleagues, there has been continued focus on Race equality within the Trust framed by the comprehensive Workforce Race Equality Standard (WRES) action plan. (Appendices C)

As part of the monthly organisational performance report, the Business Committee receives information around the WRES metric 1 - *Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce*.

The overall representation of BME staff in the preceding 12 months has remained at 10%, this is less than the mid-term population census estimate of 19% BME in the city of Leeds.

The inclusion of the WRES in the NHS 10 year plan provides a clear message that any increase in overall BME representation of the workforce will be a gradual one. BME representation will increase over a number of years, in parallel with the continued improvement of current BME staff's experience and equality of opportunity.

The representation of BME staff at Bands 8-9 has increased from 3.1% to 3.7%, a sustainable move in the right direction.

The *#RaceForEquality* event took place on the 20th March 2019; the event was well attended by LCH colleagues, regional NHS staff, voluntary sector partners and the NHS WRES team. As a result of the event there have been two further meetings of a number of delegates to "continue the conversation" and provide input to the review of the WRES action plan.

Services and individuals were inspired by the *#RaceForEquality* event:

"I had no idea of the feelings of the BAME workforce and the challenges they face every day - I always wrongly presumed everyone was treated equally. I am engaging with members of my team to address this" LCH Manager

"The WRES indicators and how targeting WRES improves the culture for all staff in an organisation. I didn't know that racism still existed to this extent in the workplace, and covertly - I assumed all employers were fully inclusive. It was really interesting to hear the experiences of BAME colleagues (positive and negative)" LCH *#RaceForEquality* delegate

OD and the BAME staff network are leading on the development of The BME talent management WRES action as part of the wider Trust talent management strategy, which will help improve access to non-statutory/mandatory training & development by BME colleagues.

Members of the BAME staff network have been integral in the recruitment and selection process for senior manager appointments, demonstrating the Trusts commitment to the WRES and transparency in the recruitment and selection process. This has resulted in growing confidence by BME staff that the Trust is committed to the WRES & BME staff through increased membership of the BAME network and positive verbal feedback from BME colleagues to the network Chair.

The Trust Reverse Mentoring initiative continues at a pace with 26 participants, there has been significant interest in this initiative from national NHS organisations and fellow NHS providers.

A review of the current two cohorts is scheduled for January & June 2020, as a result of a growing awareness of the benefits to personal growth there is a real appetite in LCH for a third cohort.

The current WRES performance submitted to NHS England on the 4th August 2019 is contained in Appendices D.

Disability

The Workplace Disability Equality Standard (WDES) action plan was approved by the Trust Board on the 2nd August 2019 (Appendices A).

Reasonable adjustment awareness for Managers session is delivered on a monthly basis at Shine and on request for service and team development to date 61 managers have attended a session

To raise awareness a number of disability awareness days have been identified throughout the year; these have and will continue to be promoted through internal communications and social media platforms.

A fledgling staff network has met on two occasions in Q3 and Q4 and will continue to meet exploring how a network can support LCH in realising an inclusive work environment.

The current LCH WDES metric data was submitted in August 2019 and is contained in Appendices E, it is anticipated that NHS England will publish all Trusts results in Q1 20/21 and share good practice.

Sexual orientation

The LCH NHS Rainbow badge initiative membership has grown since the launch during NHS Employers Equality, Diversity and Human Rights week in May 2019.

LCH has 617 staff Rainbow badge holders, showing that Leeds Community Healthcare believes that workplaces where all LGBT employees are accepted without exception and providing open, non-judgemental and inclusive care for all people, including children & young people accessing LCH who identify as LGBT+.

On 29th October 2019 there was a gathering of colleagues under the banner of the Rainbow Ambassadors to plan and support a number of actions. A second gathering is planned to be held in February 2020 to celebrate LGBT History month, plan LCH's involvement in Leeds Pride 20, review the Stonewall WEI results and receive a presentation from LYPFT Rainbow Network

LCH continues to demonstrate commitment to LGBT inclusion through membership of the Stonewall Diversity Champions programme. The Stonewall Logo is evident on the Trust and NHS Jobs websites clearly signalling the Trust commitment to be an inclusive employer.

Gender pay gap

LCH has met the Gender Pay Gap reporting requirements for 2018 data and narrative has been published on LCH's external website.

Workforce Equality & Diversity Audit - TIAA *(Internal auditors)*

The TIAA audit was carried out in May 2019 as part of the planned internal audit work for 2019/20 and focussed on Workforce Equality and Diversity and specifically on the following:

- The Strategy, Procedures and Guidance.
- Staff training requirements are identified, suitable training offered, and completion monitored.
- Equality and Diversity is promoted within the Trust and within the wider community.
- Business units can demonstrate, with the support of Workforce, how Equality and Diversity is embedded.
- A review of Equality and Diversity surveys.
- The adequacy of performance reporting and the completeness and timeliness of reporting to external agencies, including the WDES, WRES, EDS2 returns.
- That Equality and Diversity performance is included within the Trust's governance arrangements.

The current arrangement to mitigate risk provides the Trust with "***Reasonable assurance"***

Inclusive companies

The Inclusive Top 50 UK Inclusive Companies is a definitive list of UK based organisations that promote inclusion across all protected characteristics, through each level of employment within their organisation.

The Trust has been included in the Top 50 UK Inclusive Companies list for the second year running, improving our ranking from 49th in 2018, to 14th in 2019.

Next steps

Under the Equality Act 2010, the Trust is required to have one or more Equality objective of between 1 and 4 years duration, it is proposed that the following are/continue to be the organisations two equality objectives for the next 12 months:

- (Carried forward equality objective) Achieve and retain the Disability Confident Leaders accreditation
- (New objective) Increase the recording of staff members protected characteristics recorded on ESR. This will provide the Trust with data to make informed decisions linking with the Workforce Equality & Diversity Audit -TiAA (Section 3.6)

It is proposed that the WRES action 4, *Plan and deliver an equality event - #RaceForEquality*, is removed and actions 1-3, 5-8 remain in the WRES action plan 20/21;

It is proposed that the following new actions are included in the WRES action plan 20/21;

- Conduct analysis of the LCH WRES data at Business unit level to better share good practice, understand challenges and allocate resources.

- Conduct an equality analysis of the recruitment and selection process, specifically the application to shortlisting section of the process for BME applicants.

- Identify a process by which analysis of BME staff entering the informal staff disciplinary process can be conducted providing better understanding of BME staff experience.

- Take part in the 12 month NHS England (WRES team) led Workforce Race Equality Standard (WRES) cultural change pilot – details to be shared with Trusts at the launch in January 2020.

Recommendations:

The Trust Board is recommended to:

- Note the progress made over the last 12 months
- Agree the proposed equality objectives for 2019/20
- Support the proposed changes to the WRES action plan

Appendices A - LCH WDES action plan

#	Initiative/action	Lead	Desired outcome(s)	Delivery Date	Progress to date
1	Conduct analysis of the Trust WDES indicators	E&D Facilitator and EDI Project 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	The initial WDES action plan was created to address the initial finds of the first WDES data run. A review of the WDES action plan will take place in April 2020 following the staff survey results
2	Deliver monthly Reasonable Adjustment Awareness for Managers	EDI Project Officer	Ensuring Managers have sufficient disability equality awareness training	Start in Q2 19/20	Sessions have been delivered at Shine since June 2019, with an additional session delivered to the 0-19 Team
3	Design and implement a WDES Comms Plan	EDI Project Officer	Increase awareness of the WDES and its purpose. Highlighting key messages of the WDES. Engage with colleagues. Promote good practice and processes. Increase awareness of the EDI (Disability) Officer role	End of Q2 19/20	Implemented
4	Plan and deliver a disability focused event	EDI Project Officer	The target audience is aware of the good work that has already happened in the areas of Disability Raise supervisors/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	An options paper has been submitted to the DoW for decision

5	Engage with staff to test the appetite for a Disability Network	EDI Project Officer	Meet the requirements of the WDES	End of Q3 19/20	To date staff have met on 2 occasions to progress and have created a first draft TOR
6	Identify key stakeholders	E&D Facilitator	To share best practice and provide mutual support.	End of Q3 19/20	Relationships have been developed with - LCC Staff Disability and Wellbeing Network (DAWN), NHS Digital, LTHT, Leeds CCG, LYPFT, NHS Employers and Voluntary Action Leeds (VAL) *an umbrella organisation for all voluntary and community groups in Leeds*
7	Implement a Disability Talent Management Strategy	ODI Lead & Asst. Director of Workforce	An increase in disabled staff employed in Senior and Board level roles, Disable staff feel valued	End of Q4 19/20	No update available
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	Peer assessment by the Leeds City Council Disability and Well Being Network (DAWN) is being explored
9	Design and implement a Reverse mentoring programme for Board members and disabled staff	EDI Project Officer	Educate leaders about disability 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	This action will be developed in Q4 19/20 and delivered in Q1 20/21

Appendix B - Current LCH NHS EDS2 grades

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

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

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

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

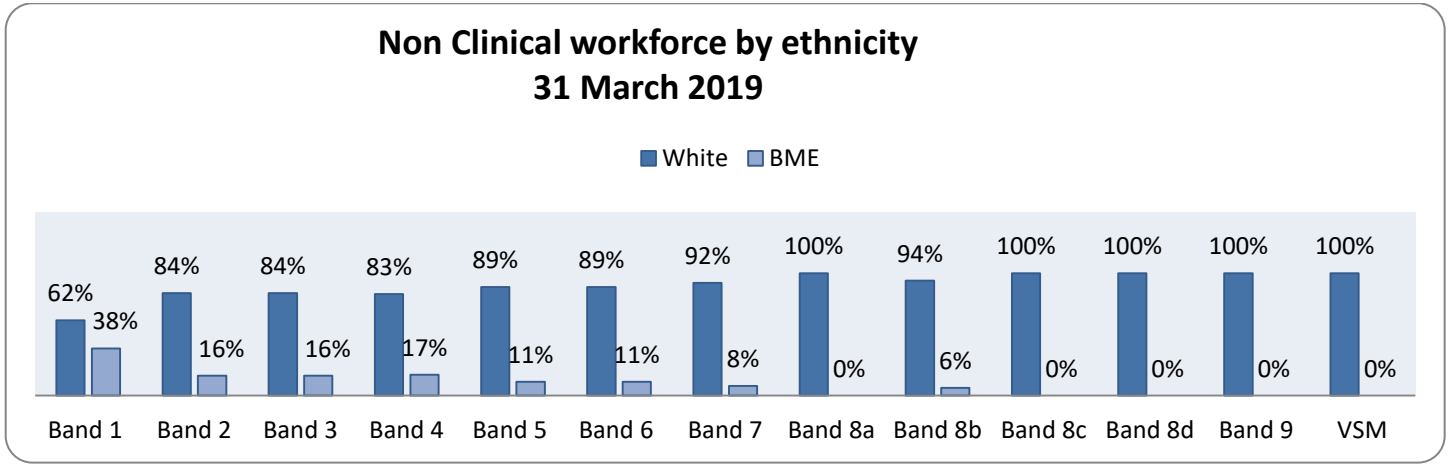
Appendices C - Current WRES action plan

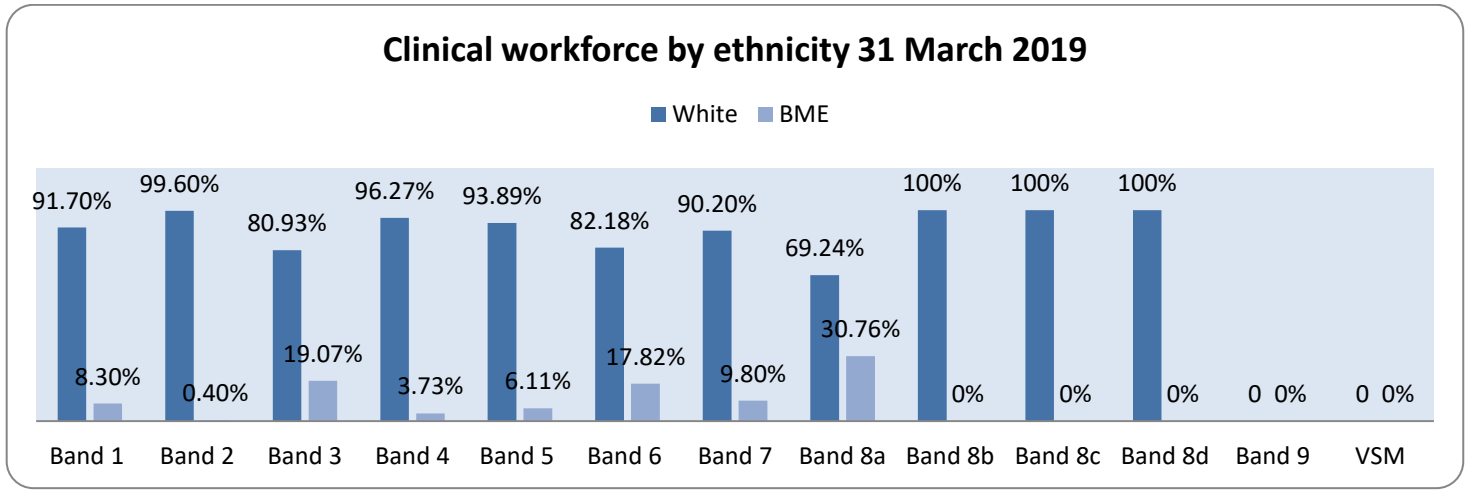
#	Initiative/Action	Lead	Desired Outcome	Delivery Date & progress
1	Design and implement a WRES Comms Plan	E&D Facilitator	Increase awareness of the WRES and its purpose	Ongoing
2	Design and implement a Reverse mentoring programme for Board members and BAME staff	BAME Project Officer	Educate leaders about Race issues, by exposing them to challenging dialogue, which they might otherwise never encounter.	The 1st *12 month cohort* began in January 19, the 2nd Cohort was launched June 19
3	Conduct analysis of the Trust WRES indicators data	E&D Facilitator	Understand the WRES data in order to identify actions to be included in the WRES action plan to create a level playing field where the treatment of staff is not unfairly affected by their ethnicity.	Analysis of the mid year WRES data conducted in October 19 has informed the proposed WRES actions for 19/20. Further analysis will be conducted in Q1 20/21
4	Plan and deliver an equality event - *#RaceForEquality*	Asst. Director of Workforce	Raise awareness of the inequality of experience by BAME staff compared to white staff seek a commitment to improve BME staff experience and equality of opportunity	Achieved - this was followed up with two further meetings with delegates to progress issues raised and review the current WRES action plan
5	BAME Talent Management	ODI Lead and Asst. Director of Workforce	An increase in BAME staff employed in Senior and Board level roles	The BAME staff network is working with OD, following involvement with BME staff; a first draft has been submitted by the BAME staff network Chair.

#	Initiative/Action	Lead	Desired Outcome	Delivery Date & progress
6	Create and implement a sustainable process to enable the Trust to hold recruitment & selection panels comprising of a diverse staff group	Resourcing Manager and Asst. Director of Workforce	The probability of BAME applicants being shortlisted and selected for posts is comparable to that of White applicants	Over the reporting period the focus has been Band 7 and above vacancies, BAME staff network members have been integral in the selection process of a number of senior posts in the Trust
7	Design and implement a management process to ensure that recording of staff applications for and outcomes of the application for non-mandatory training can be accessed through the ESR	ODI Lead and Asst. Director of Workforce	Provide robust data to inform the WRES action planning	No update available
8	Research and design a Cultural Competence (Race) awareness programme	ODI Lead & E&D Facilitator	Assist in equipping managers with a set of attitudes, behaviours and skills to enable success management of teams and individuals.	The Compassionate & Inclusive leadership session has been developed as part of the Leading LCH management training - further development of this action is planned to widen the audience beyond managers

Appendix D - LCH WRES metrics as at 31 March 2019

WRES Metric 1





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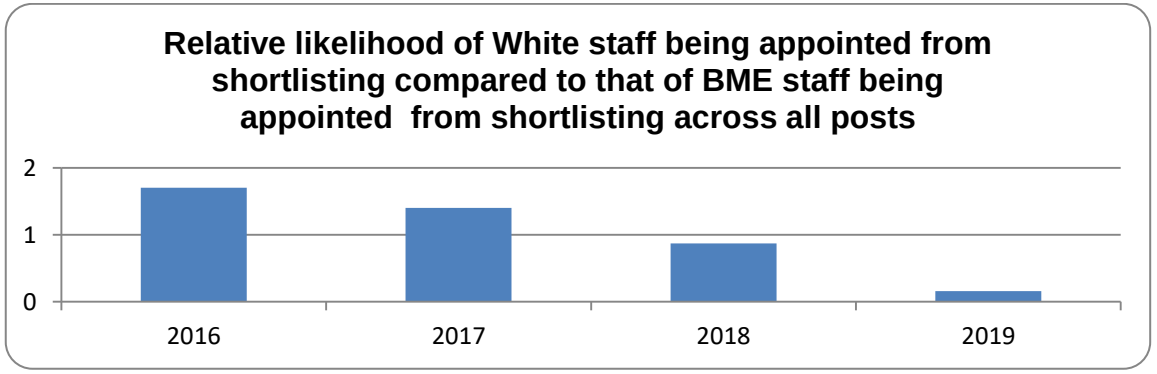

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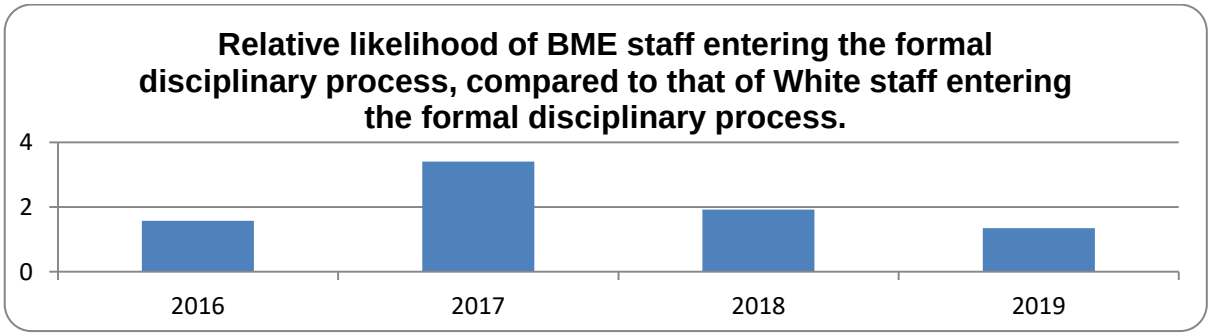
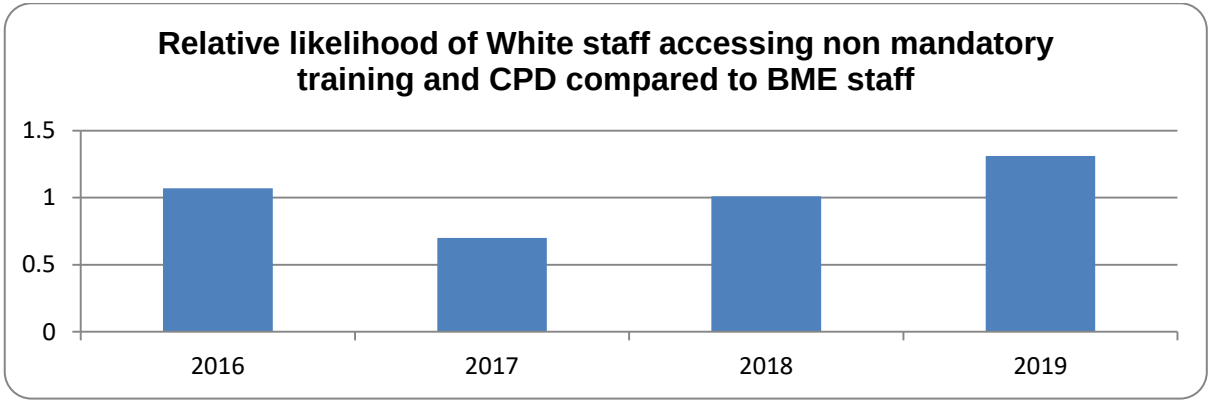
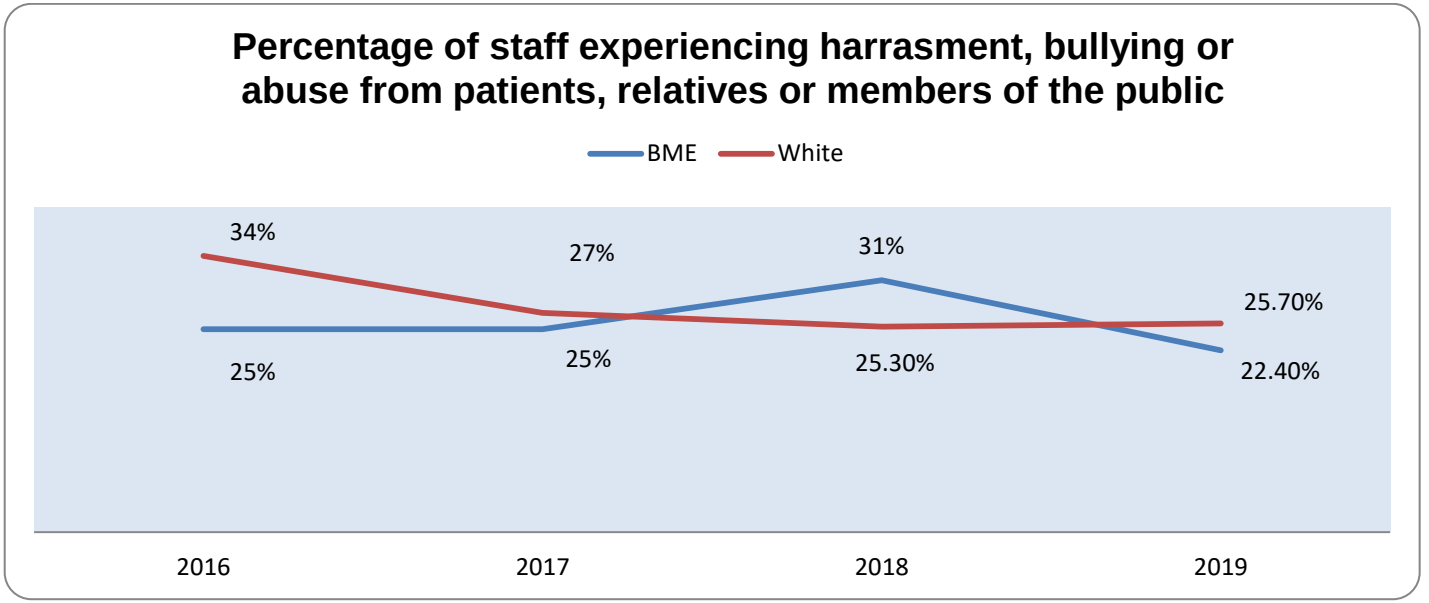


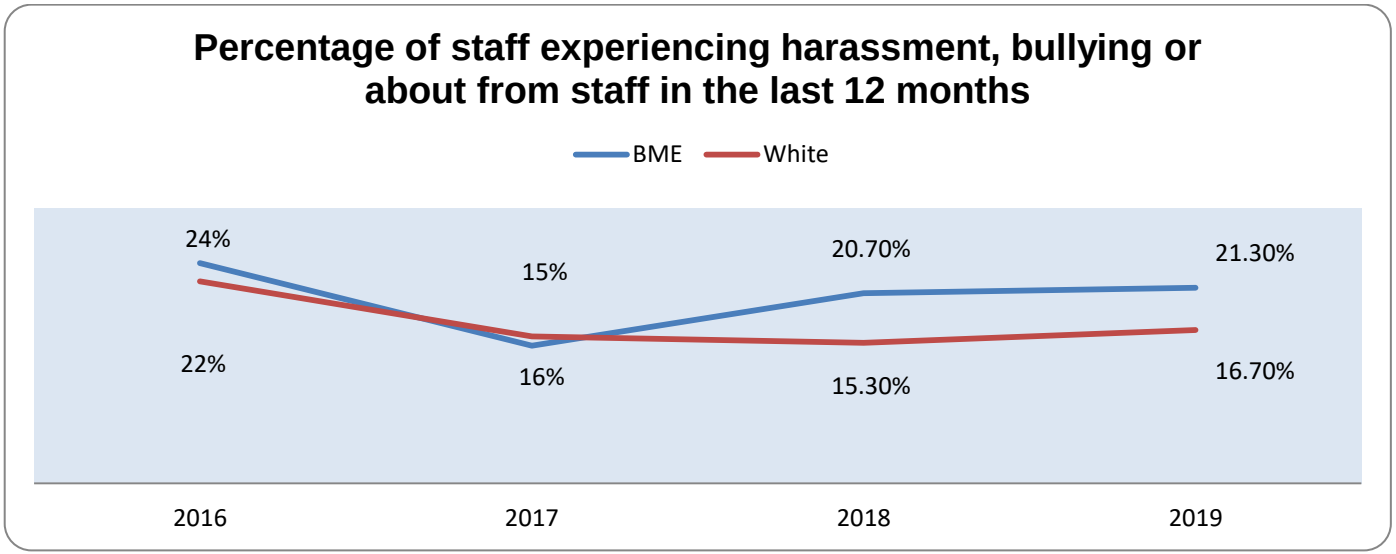
WRES Metric 4



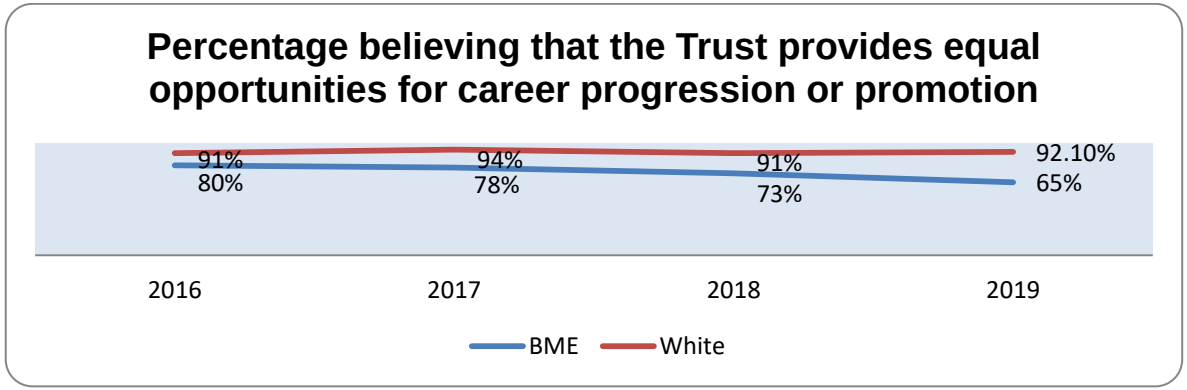
WRES Metric 5



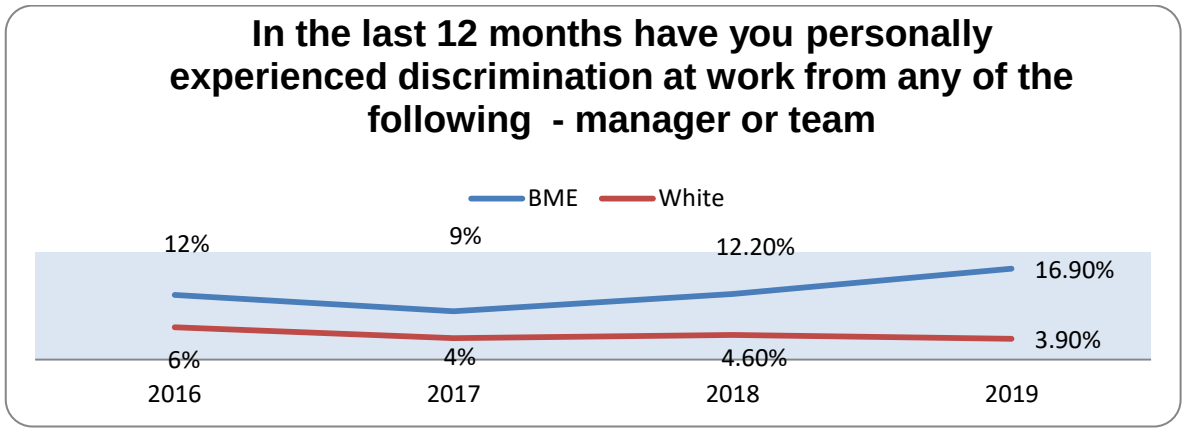
WRES Metric 6



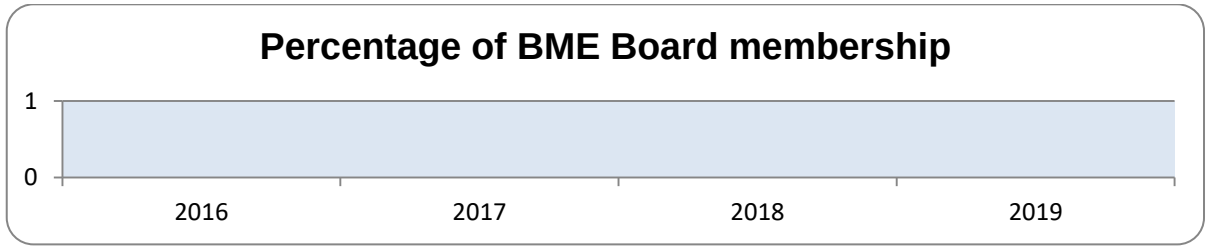
WRES Metric 7



WRES Metric 8

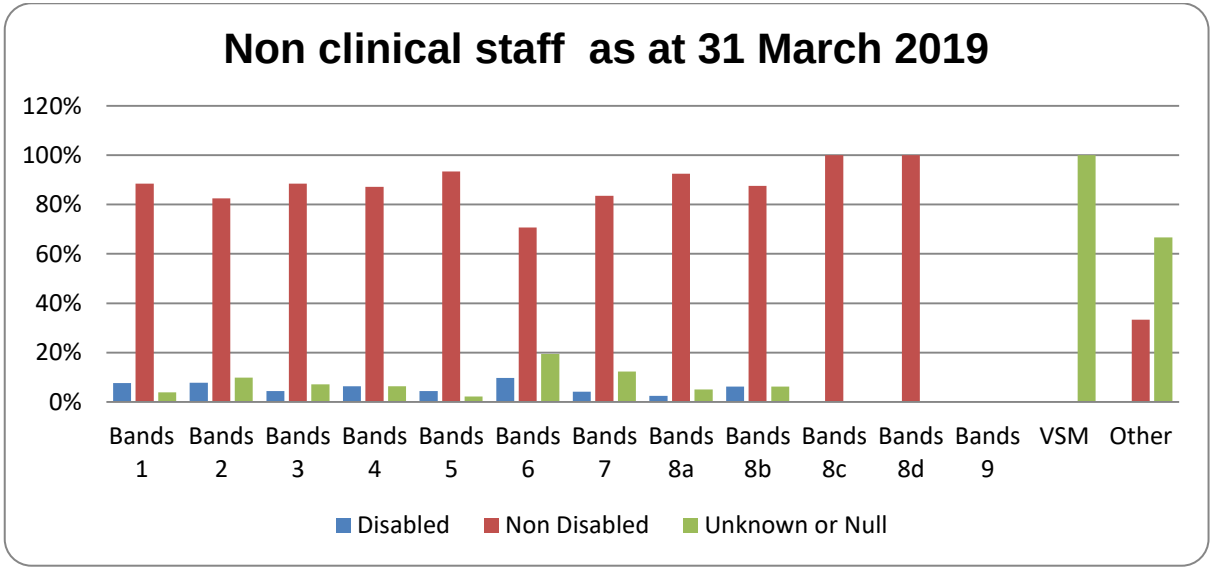


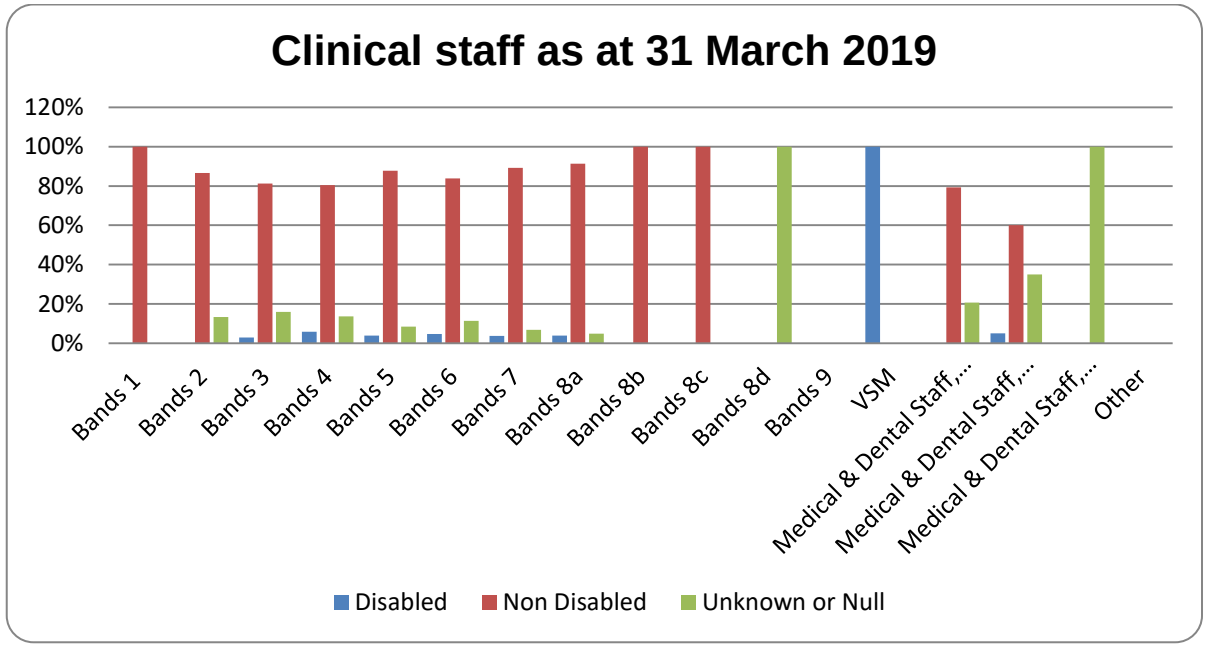
WRES Metric 9



Appendices E

LCH WDES metrics





2	Relative likelihood of Disabled staff being appointed from shortlisting compared to Non-Disabled staff	1.44	
3	Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	4.09	
		Disabled	Non-Disabled
4a	% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	34.2%	22.3%
4b	% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	56%	56%
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion.	83.9%	91.1%
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	29.7%	20.4%
7	% staff saying that they are satisfied with the extent to which their organisation values their work.	43.7%	51.3%
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	82.60%	
9a	The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation.	6.8	7.2
9b	Has the Trust taken action to facilitate the voices of Disabled Staff to be heard?	Yes - Ask Thea, Freedom to Speak Up, Health & Wellbeing Group, Disability & Wellbeing Network of Support	
10	% difference between the Board voting membership and its overall workforce, disaggregated; • By voting membership of the Board • By executive membership of the Board	0%	

Leeds Community Healthcare NHS Trust

Agenda Item 2019-20 (92i)

Meeting: Trust Board Meeting: 6 December 2019	**Category of paper** *(please tick)*	
Report title: Draft Digital Strategy 2020-2023	**For approval**	X
Responsible director: Executive Director of Finance and Resources **Report author:** Assistant Director of Business Intelligence, Clinical Systems and IT	**For assurance**	
Previously considered by: Business Committee 27th November 2019	**For information**	

Purpose of the report

The purpose of this paper is to present a Digital Strategy which demonstrates how the Trust will build on its previous strategy and adopt technologies, systems and processes that will best support the best possible of care for patients. At its meeting on 27 November 2019 the Business Committee agreed to recommend approval of the Strategy to the Board.

Main issues for consideration

The Digital Strategy identifies five key priorities:

- Supporting staff
- Supporting services
- Supporting patients and carers
- Supporting the path to digital transformation
- Ensuring our digital estate is compliant and well maintained.

Work will be necessary to build the detailed business plans required to deliver key components of the strategy which will fully identify the resource requirements, building on the outline costs provided within the document.

The progress of the delivery of this strategy will be reported through Business Committee via 6 monthly update reports.

Recommendation

The Board is recommended to approve the Digital Strategy.

Digital Strategy 2020-23

Contents:

Executive Summary

1. Foreword
2. Vision, values & behaviours
3. Context
4. Our organisational culture
5. Digital priorities
   - Supporting staff
   - Supporting services
   - Supporting patients and carers
   - Supporting the path to digital transformation
   - Ensuring our digital estate is compliant and well maintained
6. Delivering the strategy
7. Risks to delivery and resourcing
8. Conclusion

Appendices:

A. References / associated documents

B. Employee voices

C. Glossary

Executive Summary

The aim of the Digital Strategy is to support the Trust in its overall vision of providing the best possible care in every community we serve. Our direction of travel is towards increased integration with our health and care partners across primary care; across the city of Leeds and across our integrated care system. Beyond the integration agenda, this strategy seeks to identify how digital products and services can make our services more accessible to communities and patients and increase our effectiveness, efficiency and environmental sustainability.

Digital innovation is not discrete; essential to the successful delivery of the digital strategy is the need to link to the organisational development agenda.. It is part of the whole organisation environment that supports new and creative thinking.

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

1. **Supporting staff:** to support the development and enablement of staff to ensure that every individual has access to appropriate digital training, development and tools to empower them to deliver
2. **Supporting services:** to support services to ensure that they are enabled to deliver existing and new models of care in the most effective, efficient and environmentally sustainable ways using digital technology
3. **Supporting patients and carers:** to support patients and carers to ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology
4. **Supporting the path to digital transformation**: to support the Trust and its stakeholders on the path to digital transformation, enabling staff and patients to take advantage of new digital products and service to deliver care in more productive, effective and safer ways.
5. **Ensuring our digital estate is compliant and well maintained:** Using the Digital Maturity Index Assessments, to ensure that our digital estate is compliant and well maintained so that it is secure, effective and efficient

Whilst this Strategy identifies the need for leadership at Board level, all members of staff should feel that this is *their* strategy. We want to engender a digital culture across the whole organisation that helps us all provide the best possible care.

1. Foreword:

Welcome to the Leeds Community Healthcare (LCH) NHS Trust's Digital Strategy, 2020-23.

The aim of the Digital Strategy is to support the Trust in its overall vision of **providing the best possible care in every community we serve.** It is being introduced at a time when community and primary care services have been recognised as key to achieving better, more sustainable and more cost-effective outcomes for communities as set out in the NHS Long Term Plan in January 2019. It acknowledges that there are some new and important policy initiatives, such as Primary Care Networks (PCNs) and Local Health and Care Records (LHCRs), as well as significant technological developments and opportunities that may impact significantly on how and where Leeds Community Healthcare NHS Trust (LCH) delivers its services in the near future.

This strategy will be underpinned by and sets the direction for the Clinical Systems and IT directorate's business plans as well as aiming to both influence and respond to the plans from the business units operating within the Trust. It seeks to reflect other current and developing Trust strategies, particularly other enabling strategies for Estates and Workforce and our services' priorities.

This strategy succeeds the previous Digital Strategy which covered 2016-2020. We have brought forward the development of this strategy because of new digital priorities arising since those set out in the original strategy which was approved by the Trust Board in May 2017. In recognition of the growing importance of Business Intelligence a separate strategy will be developed to address this area.

Our direction of travel is towards increased integration with our health and care partners across primary care; across the city of Leeds and across our integrated care system, the West Yorkshire & Harrogate Health and Care Partnership. This strategy covers a 3 year period from 2020 to 2023 rather than a longer period, acknowledging the rapid pace of change and development in the digital world, in health and care structures and in national and local priorities. It does however look forward beyond 2023 to provide an indication of likely strategic direction.

Beyond the integration agenda, this strategy seeks to identify how digital products and services can make our services more accessible to communities and patients and increase our effectiveness, efficiency and environmental sustainability. The pace of the digital revolution affords the opportunity to transform the way we provide care and the types of employment opportunities we provide. We want to be ambitious, we want digital services and products to help transform our services, but we want to be realistic about what LCH can achieve over the next three years.

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

- **Supporting staff**
- **Supporting services**
- **Supporting patients and carers**
- **Supporting the path to digital transformation**
- **Ensuring our digital estate is compliant and well maintained**

Our vision for digital technologies is to:

“Harness digital opportunities which allow us to work safely and better together, promoting health and wellbeing and ensuring the best possible care is provided to all those we serve”

The strategy document will explore how this vision will be achieved through the delivery of specific projects, initiatives, products and services, but it will only be achieved through the successful combination of **people, process and technology working together**.

This strategy is the product of research, analysis and engagement with staff throughout the Trust. We particularly appreciate the input of our colleagues across the organisation, gained through face to face meetings, direct conversations and online surveys – these exchanges have helped us to shape our strategy and priorities in a more responsive way. This must be the start of an ongoing conversation with staff and stakeholders about our Digital Strategy to help and inspire innovation across the Trust.

2. Vision, Values & Behaviours:

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

We have used the **magnificent seven behaviours** icons in **Section 5** to indicate which behaviours support each priority's achievement.

3. Context:

This Digital Strategy is designed to support the Trust in **providing the best possible care in every community**. To develop the strategy, we have considered in detail the context within which LCH works now, and will work in the future recognising that the national, regional and local context in which the organisation operates converges to inform and shape digital priorities. This includes a large range of political, economic, social and technological factors.

3.1 National context:

> *"Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.*
>
> The NHS Long Term Plan. 2019

This Digital Strategy sits within a wider national context set out by the Five Year Forward View for the NHS (2014), Personalised Health and Care 2020 (2014), and the NHS Long Term Plan (2019). The Five Year Forward View and Personalised Health and Care 2020 describe the transformation needed across the health and care system to ensure it remains sustainable and high quality. The NHS Long Term Plan states that the NHS cannot fully embrace the opportunity offered by new technologies if many services remain largely paper-based. Specific reports on the role of digital technology on improving care in the NHS have been published to assess and address the challenges and opportunities of digital information technology, such as the Wachter Review (2016) and how it can be used to transform the outcomes of care for patients through patient-centred, personalised care. Most recently the Secretary of State for Health set out his vision for a more tech-driven NHS followed in June 2018 by the Department of Health and Social Care's policy paper on the vision for digital, data and technology in health and care (October 2018).

These and many other national publications and reports all emphasise the unique opportunity digital technology provides and the importance of embedding digital ways of working to transform and improve health and social care services in helping to meet demand whilst resources are limited. However, there are barriers. Some people's lack of skills in using digital technology, the lack of user-

friendliness of some technology and the often poor connectivity and interoperability of information technology across health and social care providers shows that there is still a long way to go to harness the benefits of digital technology for a wider population and across the health and social care system. Improvements have to be driven locally but learning from national best practice is vital .

> *“Ask what the user need is. Every service must be designed around user needs, whether the needs of the public, clinicians or other staff. Services designed around users and their needs:*
>
> - *are more likely to be used*
> - *help more people get the right outcome for them – and so achieve their intent*
> - *cost less to operate by reducing time and money spent on resolving problems*
>
> The future of healthcare: our vision for digital, data and technology in health and care. 2018

To drive digital maturity and transformation in the NHS, Global Digital Exemplars (GDEs) have been created and invested in as part of the national Provider Digitisation Programme. These are NHS trusts that are leading the transformation of healthcare technology in England and working towards becoming world-class examples of digitised health and care organisations. The blueprints they are developing will enable other trusts to follow in their footsteps as quickly and effectively as possible. They are a national resource which we will make use of by engaging directly with Exemplars where there is relevance to the services we provide.

A significant recent structural change at a national level which will impact throughout the healthcare system is the creation of NHSX in July 2019, a new organisation bringing together teams from the Department of Health and Social Care, NHS England and NHS Improvement to drive digital transformation and lead policy, implementation and change. NHSX aims to deliver the Health Secretary’s ‘Tech Vision’ as set out in ‘the future of healthcare: our vision for digital, data and technology in health and care’ (2018), building on the NHS Long Term Plan.’ LCH will therefore be directed by and respond to the digital agenda set by NHSX.

3.2 Regional context

Our Digital Strategy forms a part of a wider geographical digital agenda that spans the West Yorkshire and Harrogate Health and Care Partnership and enables the Trust to play its full part in supporting out of hospital care developments and in the provision of a Yorkshire and Humber Care Record.

3.3 Leeds context

A key priority in the Leeds Health and Wellbeing Strategy 2016-21 is to 'Maximise the benefits from information and technology', which includes objectives for patients to have access to their personal health records and to make better use of technological innovations in patient care, particularly for long term conditions management.

The Leeds-wide digital approach is designed to support this with developments such as "HELM", a patient held record which enables key information about a patient to be held in one place and crucially, allows patients to add pertinent information which they want to share to the record as well. The Digital Strategy supports this by delivering the right technology and governance mechanisms to staff to allow access patient held resources such as HELM.

> *"Leeds will focus on making services more person centred, integrated and preventative. All organisations need to work together to achieve this.* Leeds Health and Wellbeing Board, Leeds Health and Wellbeing Strategy 2016-21

The city's efforts to achieve this strategy is enabled through a joint governance structure and a collaborative approach at organisational level, allowing organisation to take advantage of unique citywide resources such as the Leeds Care Record to provide benefit for all.

The landscape is dynamic, with the creation of new organisations and partnerships such as the GP Confederation and Primary Care Networks, necessitating flexible, integrated systems and infrastructure allowing staff to move across organisational boundaries. This flexibility will be a key requirement both now and in the future as LCH pursues its strategy of integration and partnership and the strategy will deliver an infrastructure which is capable of responding to the continually changing organisations which make up the cities health and care setting.

3.4 Leeds Community Healthcare NHS Trust context

This Digital Strategy works alongside other key organisational strategies and plans, including the Trust's 4 strategic goals, its vision, values and behaviours as well as the other enabling strategies for Workforce, Organisation and Development and Estates.

The Trust's 4 strategic goals are:

- Ensure LCH's workforce is able to deliver the best possible care in all our communities
- Deliver outstanding care
- Work in partnership to deliver integrated care and care closer to home
- Use our resources wisely and efficiently

The future digital landscape needs to provide flexibility to accommodate commissioning changes, with services now commonly commissioned along pathways of care, with payment mechanisms based on outcomes rather quantity. This places a substantial strain on existing Electronic Patient Record systems and IT networks, which were designed to support services in very linear ways within clearly defined organisational boundaries.

Digital technology will be a key enabler in strengthening community services and supporting people in their community to achieve better health care outcomes following national guidance and supporting local digital roadmaps.

LCH spends £150m each year, employs 3000 staff across 58 services and operates from 120 sites across the city. Over 215,000 referrals are received and the services deliver around 2 million patient contacts every year. The breadth and geographical dispersal of services, provides challenges for developing common digital approaches but also greater opportunities to develop new ways of providing services to people in their communities.

> *"Patients need to be able to communicate with us about appointments and administrative issues in the way they run the rest of their lives – email, text messaging and apps are a much-needed evolution from the mountain of letters we post. No service should refuse to communicate electronically about these issues with a patient where they would previously have sent a letter*.
>
> The future of healthcare: our vision for digital, data and technology in health and care. 2018

Of the 19 separate elements from the implementation plan within the previous Digital Strategy, only one (Single Sign On) had been delayed, with a remaining 5 in progress, these outstanding items will flow through to the new Strategy where the business need continues.

LCH is seeking to develop new services and respond to new service commissioning requirements, often in partnership with other organisations. The Digital Strategy must respond to new pathways of care, potentially being delivered across organisational boundaries. There is likely to be increased used of LCH estate by 3rd parties which will need to be supported in terms of digital access and integration. The challenge will be how to join all of the "people-process-systems" together to achieve a common aim.

> *"Within 20 years 90% of all jobs in the NHS will require some element of digital skills. Staff will need to be able to navigate a data-rich healthcare environment. All staff will need digital and genomics literacy… We need to tackle differences in the digital literacy of the current workforce linked to age or place of work.* *Health Education England Topol Review 2019.*

The Trust continues on a trajectory towards a much greater level of integration with Primary Care. The Digital Strategy must support this by remaining focussed on supporting staff and direct patient care and not tying the digital infrastructure to the organisation itself. The provision of "industry standard solutions" rather than bespoke systems is a core piece of this strategy

In line with the Estates Strategy and as identified in the LCH Operational Plan 2019-20, we must aim to increase the environmental sustainability of the services we provide. The use of digital services can play a significant part in this objective, for example, through reduced paper consumption, reduced travel and better management of our buildings.

The most recent NHS digital maturity self-assessment exercises highlighted specific areas of strengths in the Trust such as Digitisation of Records, Assessments and Plans, Strategic Alignment and Resourcing. However, Medicines Optimisation and Electronic Transfers of Care are well below the levels seen at other NHS trust and form priorities which the Digital Strategy supports.

The Trust's digital transformation will be measured; ambitious for the benefits that can be realised but recognising the limit on resources for digital investment and organisational capacity for change. We will aim firstly to ensure any "tech debt" is made good in the early years of the strategy but then we will aspire to be outstanding in our use of digital services.

4. Our Organisational Culture:

Essential to the successful delivery of the digital strategy is the need to link to the organisational development agenda. Digital innovation is not discrete. It is part of the whole organisation environment that supports new and creative thinking; it cannot be enacted through a single strategy.

> *"Without innovation, public services costs tend to rise faster than the rest of the economy. Without innovation, the inevitable pressure to contain costs can only be met by forcing already stretched staff to work harder*
>
> Mulgan G & Albury D. Innovation in the public sector, Strategy Unity. 2008

Initial steps have been made to engage staff in developing a "digital conversation" through, for example the Chief Clinical Information Officers (CCIO) Group, via face to face digital strategy engagement sessions and through staff surveys to gather people's views on what is important to them. We will continue and extend this engagement. There will be firmer links to other strategies such as clinical, workforce and organisational development to establish and embed robust mechanisms to harvest ideas from within the organisation and to enable them to become a reality. We will develop a culture of "push and pull" where the Digital Subject Matter Experts (SME's) "push" new digital technologies or ideas out towards services for their consideration about how they fit in with or can replace current ways of work. However, just as importantly, there needs to be a "pull" from clinical and corporate services demanding digital solutions to perineal problems or to keep pace with evolution seen elsewhere. We aim to engender a digital culture across the whole organisation.

The results from staff engagement sessions and the online surveys are set out in Appendix B: Employee Voices.

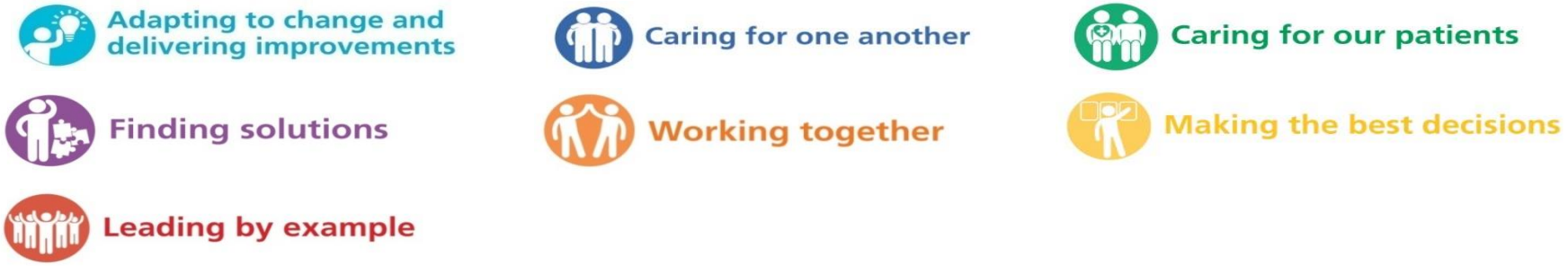
5. Digital Priorities:

This Digital Strategy has 5 key priorities that support Leeds Community Healthcare's vision and strategic goals.

1. **Supporting staff:** to support the development and enablement of staff to ensure that every individual has access to appropriate digital training, development and tools to empower them to deliver
2. **Supporting services:** to support services to ensure that they are enabled to deliver existing and new models of care in the most effective, efficient and environmentally sustainable ways using digital technology
3. **Supporting patients and carers:** to support patients and carers to ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology
4. **Supporting the path to digital transformation**: to support the Trust and its stakeholders on the path to digital transformation, enabling staff and patients to take advantage of new digital products and service to deliver care in more productive, effective and safer ways.
5. **Ensuring our digital estate is compliant and well maintained:** Using the Digital Maturity Index Assessments, to ensure that our digital estate is compliant and well maintained so that it is secure, effective and efficient

Each priority has an overarching aim (below) with underpinning objectives, initiatives and outcomes in the following tables. Against each objective, the year in which it will be achieved is identified. Where there is a known direct cost associated with the scheme an estimate has been provided. Further detailed costing work will be required in the production of specific business cases as the strategy moves into delivery.

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



5.1 Supporting Staff

	Priority's Aim:	To support the development and enablement of staff to ensure that every individual has access to appropriate digital training, development and tools to empower them to deliver

	What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Year	**Objectives**	**Initiatives**	**Outcomes**
1	Current digital skills gaps are identified and filled	Alignment of the Digital Strategy with the Workforce and Making Stuff Better Strategies Audit of digital capabilities in the workforce to identify gaps Explore new methods for effective training Agree what training is needed and solutions for delivery	Staff developed to the required level of digital literacy to deliver their clinical or corporate role to an outstanding level.
1	Staff have the digital tools that they need to communicate effectively and efficiently with colleagues and patients.	Evaluate "need" against available Apps Establish a build for new smart-phones and ensure these are controlled through a mobile device management system Evaluate new digital tools to support communication needs (instant messaging into EPR; image transfer, Pathology ordering) Continue Skype for Business roll out to staff	A suite of approved digital tools which staff can use to support communications with colleagues and with patients approved by SMT by December 2019 Mobile Device Management solution in place by November 2019 and controlling all new mobile phones purchased by the trust.

2	All staff are ready and able to successfully implement and manage change associated with a digital way of working	Using programmes derived from the Interim NHS People Plan: Deliver intensive training for boards and senior leaders to build tech and data awareness and capability. Ensure digital leaders can access the accreditation framework Support a digitally competent workforce, by linking to the developing library of education, learning, knowledge and best practice resources to support the current workforce in expanding their digital skills (generic and specialist technology). Training and development programmes which are based around the needs of the staff group	High quality supply of digital leaders A culture where digitally supported care is the norm across the workforce Attracting the best technologists, informaticians and data scientists
3	A clear path to a future where our workforce is fully competent, confident and capable in the use of digital technology in the workplace	Alignment with Workforce Strategy and Plans Assess how best to implement and utilise recommendations from HEE's 'Building a Digital Ready Workforce' programme, especially the Digital Literacy work stream and its capability framework	By 2022 there is a clear set of digital skills identified for each major role within the Trust Staff take responsibility for own continuous "digital" development

This priority aligns with the following organisational behaviours:

5.2 Supporting Services

	Priority's Aim:	To support services to ensure that they are enabled to deliver existing and new models of care in the most effective, efficient and environmentally sustainable ways using digital technology

	What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Year	**Objectives**	**Initiatives**	**Outcomes**
2	Services are able to bid for new contracts utilising digital technology to improve the value for money, staff and patient experiences propositions	Develop an assessment process with services to gauge digital requirements to support any new contract and to propose solutions with cost-estimates	Increase in the success rate of securing new contracts.
3	Services are able to make efficiency savings (time, money) through better use of digital technology	Complete e-rostering roll-out Project to implement single sign-on Work with services to identify opportunities to achieve efficiency savings through the use of digital technology (e.g. digital dictation, voice recognition, automation of processes, reducing duplication across processes, reducing travel time/costs)	Minimum of 2% increase in available patient facing time Minimum 1% reduction in time spent traveling
Resource consequence		**Single Sign On: £171k + £24.5k recurrent)** **Digital Dictation: £50k (recurrent trust wide estimate)**	

3	Services are able to improve their care through better use of digital technology	Incremental EPR development eg developing new forms, templates of questionnaires in SystmOne or enabling e-referrals through the national service. Develop a methodology for assessment of clinical systems to support improvement and replacement programmes Development of integration solutions (such Black Pear)	Realisation of efficiency and productivity gains (targets to be determined) Implementation of software integration solutions, to "tie together" disparate information system used in the provision of care Continued improvement in the use and development of the Leeds Care Record. Target is for 100% of services to have been provided with access
Resource consequence		**Integration Solution: £120k set up for one clinical pathway eg Diabetes and an additional £20k per clinical pathway using the "Black Pear model"**	
3+	Services can adapt to new models of care delivery, by adopting best of breed digital technologies which have been successfully deployed elsewhere or have been developed in-house	Through initiatives outlined in the Interim NHS People Plan	Services are able to take advantage of the advances in Artificial Intelligence or robotics (as examples), to enable patients to better access care or better self-manage their care working alongside clinicians Service delivery reduces its impact on the environment through digital products and services

This priority aligns with the following organisational behaviours

5.3 Supporting Patients and Carers

	Priority's Aim:	To support patients and carers to ensure that they benefit from improved, patient-centred, personalised care and experience through digital technology

	What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Year	**Objectives**	**Initiatives**	**Outcomes**
2	Patients and carers can benefit from self-care using digital technology where appropriate	Work with services to identify opportunities where digital technology can support self-care and support implementation Establish baseline of current usage of digital apps by staff By the introduction of new solutions, based on need	Supported self-care service offer for patients becomes part of a standard offer from the trust Ability to support a larger caseload with the same or fewer staff (metrics to be developed) One for one reduction in face to face contacts, replaced with a "digital" encounter
3	Patients and carers can communicate with us easily and efficiently using digital technology	Through a wider variety of instant messaging communication channels between trust and patient facilitated by digital applications or digital phone services Through improved scheduling / appointment opportunities via digital channels A broader set of contact options (eg web form, SMS messaging, SKYPE)	Easier for both staff and patients to have the "right" conversations improving staff / patient relationship Improved line of sight between clinician / service and patient leading to Reduction in DNA & improvement to waiting times.
Resource Consequence		**SKYPE: Provision to all Staff £30k (recurrent)** **Web form Development £10k (est. recurrent)**	

3	Patients and carers can access their electronic care record	NHS App – which will allow patients to check their symptoms, book or cancel appointments with the GP practice, order repeat prescriptions and view the GP medical record The “HELM” App which is the name employed to an “open source” project designed to improve decision-making by health professionals by giving patients access to their records so they can add information about their wellbeing	Patients regularly access and add to their HELM / NHS App record. Staff regularly checks the same.
3	Patients and carers are engaged with to ensure that their digital services are designed around their needs	Work with services and patient representative groups to design and test new digital initiatives aimed at patients (user research)	Thriving / two way conversation with patient groups to design digital services around their specific needs.

This priority aligns with the following organisational behaviours

5.4 Supporting the Path to Digital Transformation

	Priority's Aim:	To support the Trust and its stakeholders on the path to digital transformation, ensuring alignment with the wider health and care system and with a clear focus on benefit realisation and adding value

	What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Year	**Objectives**	**Initiatives**	**Outcomes**
1	The Trust is aligned with national, regional and local strategic and operational plans for digital transformation across the health and care system	Assess Global Digital Exemplar blueprints for potential utilisation in LCH Promote the use of the NHS App to the patients we serve	Any proposed major development or replacement of systems has firstly considered any nationally available GDE Blueprint
2	There is a clear and robust assessment and investment process to enable digital innovation to deliver benefits and add value	Develop an assessment process for digital ideas (focus on benefit realisation and resourcing for implementation) overseen by either an existing group eg the Change Board or through the creation of a Digital Board	A process exists to take a concept or idea through to a finished "product"
3	Our clinical systems are interoperable and support cross-organisational working and new models of care	Review current systems against national standards for interoperability and develop a set of recommended actions to meet these standards, exploring all options which are available to the market, building business cases for any subsequent implementation.	Our existing systems are developed to support the new multi organisation models of service being commissioned or we have transitioned to ones which can.

This priority aligns with the following organisational behaviours

5.5 Ensuring our digital estate is compliant and well maintained

	Priority's Aim:	To ensure that our digital estate is compliant and well maintained so that it secure, effective and efficient and that staff know their digital security and information governance responsibilities

	What do we plan to achieve?	How will we achieve it?	How will we know that we've achieved it?
Year	**Objectives**	**Initiatives**	**Outcomes**
1	Cyber security standards are met and the Trust is fully compliant	Maintain Cyber Essentials accreditation Cyber Essentials + accreditation	All systems are 100% compliant with NHS cyber security standards by June 2021 Full migration to Windows 10 by January 2021
Resource Estimate:		**Additional B6 IT Security Post: £40k recurrent**	
1	Effective and resilient networks that fully meets Trust needs,	Migrate to HSCN	Access to HSCN has been achieved by 31st December 2019
Resource Estimate:		**HSCN Implementation Charges of £15k (non-recurrent)**	
1	Improve the awareness and understanding of information governance responsibilities across all staff.	Engage with staff: information governance awareness, policies, training, and concerns to establish if there are unmet needs. Review current provision of training and awareness campaigns and recommend improvements	Maintenance of compliance with Data Security Awareness Training standard. Zero preventable Information Governance Incidents

1	Devices and software meet the needs of the Trust from a security and collaboration and the wider health and care systems	Upgrade to Office365 and Windows 10 to maintain standards and compatibility Review the potential of 5G devices Complete the national “Axe the Fax” campaign Introduction of “Single Sign On”	Migration to Windows 10 and Office 365 completed by Jan 2020 and June 2020 Axe the fax by March 2020 Simpler but secure processes for accessing the corporate network and major trust system by March 2020
Resource Estimate		**Office 365 - £392k recurrent** **Note: Guidance is awaited on any central funding deal for Office 365 licences.** **Windows 10 licences has been funded centrally**	
2	Improve the robustness, security and cost-efficiency of the Trust’s storage solutions	Move to cloud storage	Decommissioning of local file servers has been completed by December 2020
Resource Estimate		**£129k migration (Estimate - non-recurrent)** **Recurrent element TBC**	

This priority aligns with the following organisational behaviours

6. Delivering the Strategy:

Successful delivery of the priorities set out in **Section 5** will require the following to be in place:-

Leadership – the Trust Board will need to provide the “drive” for the organisation and embrace “digital” as the normal way of working. They will act as the role models where appropriate, to showcase the benefits which are attainable from the use of digital products and services. The Informatics Team will also have a significant part to play in leading the change and helping to identify “the art of the possible” for staff to help turn ideas into proof of concepts and where demonstrable benefits can be determined support the business cases and subsequent to their approval support into fully operational services.

The true benefits possible from digital technologies will require a much closer connection of Workforce / OD and Estates strategies, which traditionally have been developed and operated in isolation. To really take advantage of digital innovation, the technology needs to work in partnership with the workforce and in an estate which has been designed around the routine use of digital solutions such as appropriate areas to make and receive video call and collaborate digitally via SKYPE or similar.

The creation of a dedicated Digital Board led by an Executive Director or a refocus of existing groups e.g. Change Board to enable the “idea to be taken through to reality”. Many of the digital innovations will have major change consequences for the organisation and consideration will need to be given to ensure there is robustness to the governance mechanisms that critically assess and challenge the business cases behind each of the initiatives.

The priorities outlined in Section 5 need a supporting Business Plan with the detailed costings. These will be developed upon approval of the Strategy.

7. Risks to Delivery and Resourcing

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

Risk	Likelihood	Severity	Total	Mitigation
Untried or untested integration technologies (Black Pear example) may not work	3	3	9 (High)	Ensure specifications are precisely detailed and contracts for any new major digital investments protect the Trust from failure to deliver by a supplier.
Inflexibility or an inability to change working practices to adapt to digital ways of working means the benefits of digital transformation may not be fully realised.	2	3	6 (Moderate)	Senior Leadership acting as role models or change agents and giving staff groups the time and "space for change
Failure to link the digital strategy to other trust strategies making them non complimentary, wasting time, effort and resources	2	3	6 (Moderate)	Active engagement with the Workforce and Organisational Development teams to ensure that as each of the strategies develops and move into their implementation phase co-ordination between them is maintained
Expertise – lack of suitably qualified expertise will either slow down the pace of delivery or make the delivery and support of certain parts of the strategy impossible	2	3	6 (Moderate)	Promote access to "up to date" training and knowledge services such as College for Health Information Management Executives (CHIME) for staff Ensure detailed scrutiny of expertise takes place when recruiting to new positions Access the support mechanism and resources available from the likes of NHS Digital, NHS Providers, NHS England / Improvement or NHS X.

Risk	Likelihood	Severity	Total	Mitigation
Financial Resources – lack of capital and the inability to support the revenue consequences of investments in digital technologies may mean parts of the strategy are either delayed or remain unaffordable	2	3	6 (Moderate)	Ensure future cost pressure are fully recognised in the Trusts long term financial plans Detailed examination and challenge of business cases to ensure any productivity or efficiency gains identified can be actually realised.

To deliver this digital strategy there will be a need for new investment and each of the major schemes identified will need their own case for investment and implementation plan which will be created upon approval of the strategy by the Trust Board.

The Integrated Care System (ICS) has identified that in order to sustain digital maturity and advancements there is a need to reposition the underlying digital services to agree with industry standards which means that there should be IT budgets of 4-5% of revenue ongoing for digitally mature organisations. To put this into context for the Trust existing pay and non-pay operational budgets for the current “Digital” team are approximately £1.9m, excluding specific major project expenditure eg e-rostering. In order to sustain a digitally mature LCH, this figure would need to increase recurrently by between £1m-£2m.

A further consideration is that the models of funding required for major digital products and services are changing. Historically items such as Microsoft licences have been purchased and then used until the end of their life or funded centrally on behalf of the whole NHS, the same model has applied to devices such as file servers which may have been bought through capital monies and written down over a 5-7 year period. With the move to subscription services such as “Cloud storage” and Office 365 replacing the now unsupported Office 2010, finances will have to be remodelled, new revenue streams identified and account taken that items which were once funded as capital expenditure may no longer be in the future.

8. Conclusion

In conclusion, this strategy is designed around five key priorities which are linked to the Trust's values and behaviours. The immediate priorities are designed to ensure we get the basic infrastructure right with more innovative and complex products and services coming into place in later years.

Along with the need to get the right levels of resources to deliver and then sustain the digital transformation is the need to ensure this strategy is linked to the Workforce and Estates Strategies both now and in the future to ensure they work in harmony.

Staff engagement has played a major role in the development of this document and it has provided an important starting point for the conversation about digital needs and priorities as the strategy develops, a vital aspect will be to maintain that conversation.

Appendix A: References and Associated Documents

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Appendix B: Employee Voices

The voices and opinions of many LCH staff have inspired and contributed to the development of this Digital Strategy. Summaries and analysis of feedback from face-to-face engagement sessions and responses to online surveys on Digital Priorities and App Usage are given in this appendix. A selection of comments is also provided to give insight into the breadth, depth and value of the contributions.

C1. Face-to-face engagement sessions

Staff were asked for their thoughts on a variety of potential priority areas for actions.

Digital communications: This topic stimulated more engagement than any other. There is a strong demand for digital communication tools to use with patients, colleagues and external care providers, e.g. at LTHT, particularly to support clinical care but also for corporate use, e.g. email, mileage booking training. There was demand for smart phones for clinicians, with appropriate apps, quality camera function and service twitter accounts. Digital communications to support lone workers was also flagged.

Innovation: This topic provoked some immediate suggestions on areas which needed an innovative digital approach (devices/apps to support lone working and patient safety, need for a citywide approach) but chiefly discussion centred on cultural and process issues. There was agreement for a need for a methodology to decide which proposed innovation to invest resources in and implement. There was broad consensus that staff needed to be encouraged to come forward with ideas (induction was flagged as an opportunity and a ELSIE form was suggested) and that they needed to be given guidance on what factors will be used when cases for investment are considered. An innovation hub was suggested.

Patient centred solutions: This topic also generated a lot of discussion and ideas. A repeated theme was of patients leading the way with apps, suggesting new ones to clinicians. It was agreed that patients should have different options as to communication methods. Suggestions included: messaging to patients to advise that the clinician is en route with estimated time; opportunities to collect data prior to consultation or outcomes (SMS, web forms); SystmOne arrival screens for clinics; Interpreter app; service apps (sign posting, outcome measures; appointment booking.

Training and development: It was acknowledged that staff had a wide variety in digital skill levels and that there was a need for multiple routes into training and development. Another theme was that systems should be intuitive, with a stronger user design focus. Suggestions included: using tools like SKYPE to train / support each other; having a single way of doing things e.g. how to use NHS

Mail through a mobile phone; making better use of existing resources; creating shared material; exploring alternative methods such as video clips; digital training to train staff in other organisations, e.g. on line training for infusion pumps.

Integration and interoperability: The central theme for this topic was the distance between the demand (for clinicians to be able to access information across numerous systems in the NHS (but particularly LTHT and GPs), local authority, care homes, schools and voluntary sector) and the current reality of patchy integration and access. It was commented that there were organisational barriers to integration as well as technical ones, and that awareness of the Leeds Care Record was felt to be low.

Efficiency: This topic generated enthusiasm and some instant suggestions: use of bar code scanners to reduce manual input; better technology/systems for remote meetings e.g. skype, video calls, speech recognition to achieve more productivity, access to ESR and ELSIE via mobile/tablets or as apps.

Infrastructure: This topic drew less comment but it was expressed several times that there were staff without proper access to IT, having either limited access and/or limited time. Senior staff commented on the need for the ICT estate to be fully fit for purpose, e.g. up to date mobile phones.

Governance: There was some concern expressed as to whether staff were all confident in this area. Staff expressed the need for new guidelines/policies about apps, instant messaging, email etc for corporate and clinical use. It was suggested that the Clinical Governance group or a group directed by the Change Board should review the use of Apps.

Frustrations: Staff were given the opportunity to unload their particular frustrations with ICT. Broadly, this included issues with: hardware (poor battery life, passwords expiring too soon, clinicians in need of smart phones); software that was difficult to use, inaccurate, incomplete, faulty or out of date (ELSIE, ESR, SystmOne, PPM, Finance, BI v PIP); browsers (cookie blocking); email storage size; networks (Wi-Fi in SILCs); support for staff who experience dyslexia or similar issues; lack of citywide conversations; lack of a quick and effective way to turn ideas into reality.

Employee voices from face-to-face engagement sessions:

On digital communications…

“ *Demand for WhatsApp or similar for clinician to clinician*

“ *Smart phones for all clinical staff with good cameras*

“ *[We need] easier communication with LTHT Services*

On innovation…

“ *Staff need to know that their ideas are wanted*

“ *[You will need] to provide guidance on factors that will part of any methodology when considering whether to invest resources*

“ *Lack of a quick and effective way to turn ideas into reality*

On patient centred solutions…

“ *How do patients prefer to be communicated with? They should have options, e.g. text messaging as an alternative to current methods of communication*

“ *Opportunities to collect data prior to consultation*

“ *Patients/parents are suggesting apps to clinicians and taking the lead*

On training and development…

“ There is high variability in staff levels [of digital skills]

“ Use digital training to train staff in other organisations, for example to do, online training for infusion pumps

“ Re. alternative methods of training –can we equip services so that they can DIY video clips?

On integration and interoperability…

“ Clinicians potentially need access to everything…[such as the] Safeguarding alert….Leeds Care Record – is awareness low?

“ [Access is needed across LCH and] Local Authority (Mosaic), LTHT systems, care homes, voluntary sector, schools….

“ There are organisational barriers to integration.

On efficiency…

“ [We could] use bar code scanners to reduce manual input

“ [We need] better technology/systems for remote meetings e.g. skype, video calls

“ Speech recognition [would help us] to achieve more productivity

“ [How about] ELSIE as an app / access on personal phones / tablets / PCs for staff?

On infrastructure…

“ There are staff without access to IT (limited access and/or limited time)

“ The [ICT] estate needs to be fit for purpose

On governance…

“ Need new guidelines/policies about instant messaging/email etc – for corporate use AND for clinical use

On their frustrations…

“ Passwords are expiring constantly on laptops

“ [Poor] battery life in phones / laptops (options for portable chargers)

“ Email storage being exceeded

“ [We need] software that is intuitive to use - unlike SystmOne, ESR or Finance!

“ On PPM – Social Care and Ward notes missing – but acknowledged as a really useful resource

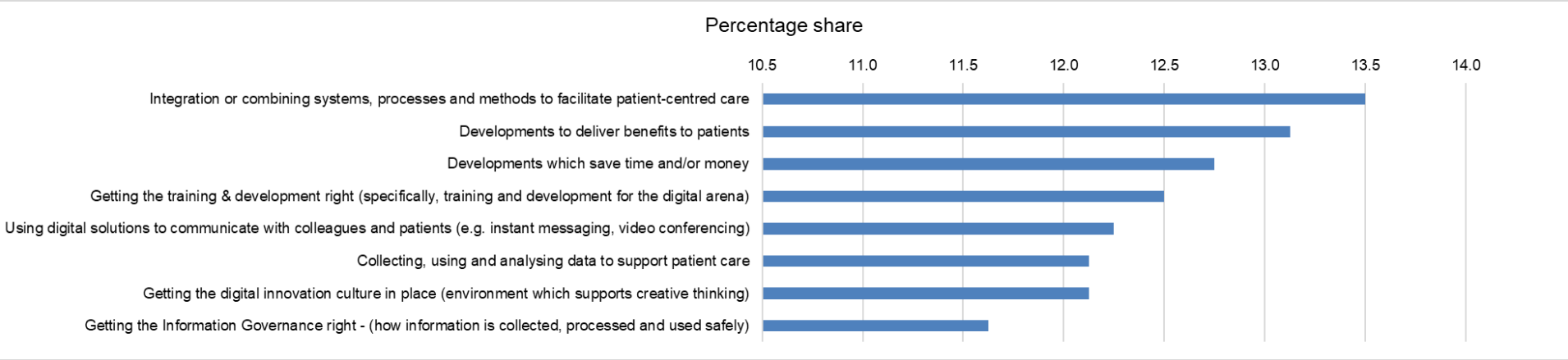
“ The lack of citywide conversations

“ ELSIE…poor content management - lots of historic data [and it needs to have] service information i.e. neighbourhood teams – empty

Employee voices from online survey on Digital Priorities. 2019

C2. Online survey on digital priorities

Staff were asked to rate the importance of a list of digital priorities for action in an online survey, an analysis of which is shown below. Although all priorities were rated highly a weak ranking did emerge. However the results should be treated with caution as the response rate was very low (23).



When asked how the felt about the digital future at the Trust (where 1 was very negative and 5 was very positive) the average response was 3.3 for clinical staff and 3.5 for non-clinical staff.

Staff raised issues about the need for digital communications (with patients and with internal/external colleagues), linking these communications to the EPR, more training, single sign-on, integrated/interoperable systems across organisations, improved network speed and calls for investment in kit and innovation. A selection of comments is shown overleaf.

Employee voices from the online survey on digital priorities:

> *In children's, we often need to share things like [questionnaires] with education, and not having shared systems is a real barrier - we can't even email schools securely*

> *One consistent approach for digital communication, that everyone uses*

> *I would like to be able to add short video clips to a patient record…we currently have no secure IG approved way to store video and therefore are unable to use this as an effective outcome measure.*

> *I feel my job would be so much easier if all GPs [and us] used the same system*

> *Use of digital apps for patients should be a high priority in terms of getting them the right information that they can access easily*

> *[We need] better funding for trials. Things sometimes have to be tried and be prepared to stop and rethink and redo if necessary*

> *[We need] better staff confidence in using the technologies we do have. Far too many paper forms still in existence...*

> *Our IT can barely support what we have, and need investment if we are to grow digitally*

> *All digital developments should be working towards patient care, to do this staff must be equipped and trained with the most appropriate resources…there is no development for anyone who would like to learn and develop their skills*

> *We seem to be behind the acute trust in communicating with our patients e.g. they have a form online to cancel appointments*

> *Let's make some bold commitments to innovation and be prepared to fund them*

Employee voices from online survey on Digital Priorities. 2019

Appendix C: Glossary

Acronym / Abbreviation	Meaning
CCIO	Chief Clinical Information Officer: The Chief Clinical Information Officer (CCIO) is a position that exists within the healthcare industry, that combines the expertise of a long-practicing medical clinician with the IT knowledge of a CIO role
EPR	Electronic Patient Record: comprises a series of software applications which bring together key clinical and administrative data in one place
GDE	Global Digital Exemplar. An internationally recognised NHS provider delivering improvements in the quality of care, through the world-class use of digital technologies and information.
HEE	Health Education England
LCH	Leeds Community Healthcare NHS Trust
LHCR(E)	Local Health and Care Record (Exemplar)
LTHT	Leeds Teaching Hospitals NHS Foundation Trust
PCN	Primary Care Network

Leeds Community Healthcare NHS Trust

Agenda item
2019-20
(93)

Version 7: 5 November 2019

Topic	Frequency	Lead officer	4 October 2019	6 December 2019	7 February 2020	27 March 2020	27 May 2020	7 August 2020
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	EDN&AHPS	X	X	X	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X
Perfomance Brief: annual report	Annual	EDFR					X	
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X
Care Quality Commission inspection reports	as required	EMD						
Quality account	annual	EDN&AHPS					X	
Mortality report	annual	EMD			X			
Staff survey	annual	DW				X		
Safe staffing report	2 x year	EDN&AHPS			X			X
Seasonal resilience	annual	EDO	X CE's report					
Serious incidents report	4 x year	EDN&AHPS		X	X		X	X
Patient experience: complaints and incidents report	2 x year (six monthly Dec annual August)	EDN&AHPS		X Six monthly report				X Annual report
Freedom to speak up report	2 x year	CE		X				X Annual report
Guardian for safe working hours report	4 x year	EMD		X	X		X Annual report	X
Strategy and planning								
Organisational priorities position paper	3 x year	EDFR	X			X 2020-21	x 2019-20 End of year report	
Service strategy	as required	EDFR	X Patient engagement strategy					
Engagement Strategy	2 x year (Mar &Oct from 2020)	EDN&AHPS				X		
Quality Strategy	annual	EDN&AHPS			X			
Workforce Strategy	every meeting from May 2019	DW	X Wellbeing	X Diversity and inclusion	X Integration and Partnership	X Proactive Analytics	X	X Resourcing
Research and development strategy	annual	EMD	Deferred to December	Deferred to February 2020	X			X
Governance								
Medical Director's report: doctors' revalidation	annual	EMD					X b/f prev August	X
Nurse and AHP revalidation	annual	EDN&AHPS						X
Well-led framework	as required	CS						
Annual report	annual	EDFR					X	
Annual accounts	annual	EDFR					X	
Letter of representation (ISA 260)	annual	EDFR					X	
Audit opinion	annual	EDFR					X	
Audit Committee annual report (part of corporate governance report)	annual	CS					X	
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS					X	
Annual governance statement (part of corporate governance report)	annual	CS					X	
Going concern statement (part of corporate governance report)	annual	EDFR				X		
NHS provider licence compliance	annual	CS					X	
Committee terms of reference review	annual	CS					X	
Board and sub-committee effectiveness	annual	CS					X	
Register of sealings	annual	CS					X	
Declarations of interest/fit and proper persons test (part of corporate governance report)	annual	CS				X		
Corporate governance update	as required	CS						
Reports								
Equality and diversity - annual report	annual	DW					X	
Health and safety report	2 x year	EDFR		X -in the performance brief			X	
Infection prevention control annual report	annual	EDN&AHPS	X					
Additional items								
West Yorkshire Mental Health Services Collaborative	as required	CE		X				
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 - New Care Models	as required	EDFR		X				
West Yorkshire and Harrogate Health and Care Partnership (Formerly STP)	as required	CE						

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
EMD	**Executive Medical Director**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (95a)

Audit Committee

Boardroom, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Thursday 1 August 2019
9.00am–11.30am

Present:	Jane Madeley (JM)	Chair, Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	Clare Partridge	External Audit Partner (KPMG)
	Tim Norris	Internal Audit Manager (TiAA Limited)
	Beric Dawson	Counter Fraud Specialist (TiAA Limited)
	Dominic Mullen	Local Security Management Specialist (for Item 26b)
Apologies:	Professor Ian Lewis	Non-Executive Director
	Peter Harrison	Head of Internal Audit (TiAA Limited)
	Matthew Moore	External Audit Manager (KPMG)
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2019-20 (23)	**Welcome, introductions and preliminary business** The Chair welcomed members and attendees.	
2019-20 (23a)	**Apologies** Apologies were noted from Non-Executive Director, Professor Ian Lewis, Peter Harrison and Matthew Moore.	
2019-20 (23b)	**Declarations of interest** There were no declarations of interest made in relation to any items on the agenda.	
2019-20 (23c)	**Minutes of the previous meeting 22 May 2019** The minutes of the meeting held on 22 May 2019 were reviewed and agreed as an accurate record subject to the following amendment: *Members present: Richard Gladman ~~Associate~~ Non-Executive Director*	
2018-19 (23d)	**Actions' log** The Chair asked that verbal updates be given on the actions agreed at the previous meeting: • *Well Led Framework audit report:* the Company Secretary confirmed that the report had been circulated by e-mail. • *Well Led Framework audit report- Board workplan:* the Company Secretary confirmed that the Board Workplan had been updated. There were no other matters arising from the minutes.	

2019-20 (24a)	**Internal audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that three audits had been completed: Risk Management, IAPT Data Quality and Equality and Diversity. The Committee discussed the executive summaries and management actions included in the report. *Risk Management* This audit had been determined as reasonable assurance with three important recommendations, relating to the risk management processes and the inclusion of SMART performance information in the Risk Register. The Committee discussed the recommendation that subcommittees of the Board and other groups should consider how issues raised in their meetings were risk assessed and if appropriate escalated onto the risk register. Non-Executive Director (RG) observed that the minutes of the various subcommittee meetings should reflect the discussion around risks including an assessment of whether new issues should be added to the risk register. *IAPT- Data Quality* The audit had been determined as reasonable assurance with one important recommendation related to implementing measures to improve data quality and three routine recommendations related to the development of more automated reporting and improving the quality of data input. The Committee discussed the relevance of the management comments about embedding a change of behaviour/culture in relation to improving data quality entry. The Chair of the Committee observed that if this was specific to ownership of the data and allowing teams to scrutinise and improve their own data then she would hope that this could be embedded over a shorter timescale than the 12-18 months proposed. The Executive Director of Finance and Resources agreed to seek more clarity on the rationale behind the proposed implementation timetable. **Action: The Executive Director of Finance and Resources to seek more clarity on the rationale behind the proposed implementation timetable for embedding a change in culture in relation to improve data quality on entry from the Executive Director of Operations.** *Equality and Diversity* The audit had been determined as reasonable assurance with four important recommendations relating to updating the Trust's Intranet page, the inclusion of periodic refresher training for all staff, formal monitoring of the protected status of job applicants and the rates of training completed by staff declaring a protected characteristic. The Committee discussed the management comments and implementation timetable for each recommendation. The Chair of the Committee was again concerned about the extended timescales for implementing some recommendations which she would like to be achieved more quickly than the six to nine months proposed and she asked for the rationale behind the timetables to be clarified.	**Executive Director of Finance and Resources**

	Action: The Executive Director of Finance and Resources to discuss the rationale for the timescales with the Director of Workforce, Organisational Development and System Development.	**Executive Director of Finance and Resources**
	The Committee reviewed progress against the Annual Plan for 2019/20. The Chair of the Committee was pleased to see that a significant number of audits were on schedule for completion in quarter 3 and she asked the Internal Audit Manager to ensure that as many reports as possible were presented to the Committee at its meetings in October and December 2019 to avoid a backlog in spring 2020. **Outcome:** The Committee noted the contents of the summary internal controls assurance report, including the conclusion of three audits.	
2019-20 (24b)	**Internal audit recommendations update** The Executive Director of Finance and Resources introduced the report and the Committee discussed the ten recommendations not completed by their due dates and the proposed revised dates for completion. Three overdue recommendations related to the 2017/18 Data Quality 2 audit – waiting lists and loaned IT devices and had proposed revised dates for completion of 30 September 2019. The Executive Director of Finance and Resources explained that the revised dates for completion were linked to the Trust's new contract with O2 which included the provision of a Mobile Device Management System. The Committee also discussed the two overdue recommendations and management comments relating to the audit of complaints management completed in 2018/19 which both had an original due date of 31 March 2019 and proposed new deadlines of 31 August 2019. The Chair of the Committee asked that responsible directors were reminded again about the importance of implementing all internal audit recommendations by their agreed due date and especially by revised deadlines where these had been proposed and agreed. **Action: Executive Director of Finance and Resources to remind responsible directors about the importance of implementing all internal audit recommendations by their agreed due date.** **Outcome:** The Committee noted the status report.	**Executive Director of Finance and Resources**
2019-20 (25a)	**External audit** **Annual audit letter** The External Audit Partner introduced the report which reflected the information included in the ISA 260 audit memorandum which had been reviewed by the Audit Committee at the meeting on 22 May 2019. **Outcome:** The Committee noted the annual audit letter 2018-19.	
2019-20 (25b)	**External audit technical update** The External Audit Partner introduced the monthly health sector update for information. Referring to the KPMG report on 'Creating a culture of excellence in healthcare' the external Audit Partner agreed to circulate a copy of the report to Committee	

	members. **Action:** External Audit Partner to distribute a copy of the KPMG report on 'Creating a culture of excellence in healthcare' to Committee members. **Outcome:** The Committee noted the technical update.	**External Audit Partner**
2019-20 (26a)	**Counter fraud and security management** **Counter fraud annual report 2018/19** The Counter Fraud Specialist presented the annual report which summarised counter fraud activity undertaken across the organisation in 2018/19. Section 2 of the report contained a copy of the Self Review Toolkit which had been submitted to the NHS Counter Fraud Authority on 30 April 2019 with an overall assessment of green. The Committee discussed the commentary contained in Section 6 of the report: 'Hold to Account', which related to some clinical staff employed by the Trust providing cosmetic treatments in a private capacity outside their contracted hours. The Counter Fraud specialist explained that staff were not breaching their Trust contracts as the services were being offered as part of secondary employment alongside their substantive contract. The Committee discussed the potential reputational risks to the Trust if any treatments went wrong but agreed that no further action could be taken other than checking that the correct processes for declaring secondary employment had been followed by the staff concerned. The Chair of the Committee thanked the Counter Fraud Specialist and added that the Committee was reassured by the report. **Outcome:** The Committee noted the Counter Fraud Annual Report 2018/19	
2019-20 (26b)	**Security management annual report 2018/2019** The Local Security Management Specialist (LSMS) attended the meeting and presented the security management annual report for 2018/19 and an overview of the main aspects of his work during the year. The Committee discussed the data on security incidents, the trends in incidents over the last three years and noted that the figures for 2018/19 no longer included incidents related to damaged IT equipment and safeguarding issues as these were no longer considered to be security issues. Overall the year on year comparison showed that the number of incidents in 2018/19 (197) was roughly midway between 2016/17 and 2017/18 levels. The LSMS reported that he saw no significant underlying trends in either total numbers of incidents or categorisation of incidents to draw to the attention of the Committee. The Committee asked the LSMS to consider whether future data on incidents could illustrate the balance between the proactive advice he had provided and re-active responses to incidents. The Executive Director of Finance and Resources complimented the LSMS on his work and said that the Senior Management Team (SMT) continued to place significant value on the work he undertook across the Trust and the value that staff	

	in the Trust place on his approachability, his visibility and his support with incidents and risks both perceived and real. He particularly highlighted the work the LSMS had carried out on the Zero Tolerance Campaign in collaboration with other trusts in Leeds. The Chair of the Committee thanked the LSMS for his thorough report and commented on his professionalism, thorough approach and the breadth of work he undertook and expressed appreciation. **Outcome:** The Committee received and noted the report.	
2019-20 (27i) **2019-20** (27ii) **2019-20** (27iii) **2019-20** (27iv)	**Covering paper: Leeds Community Healthcare Charitable Funds and Related Charities draft annual report and accounts 2018/19** The Committee noted the position outlined in the covering paper. The Committee received the annual report and accounts for the Trust's charity. The independent examination had been carried out by Sedulo (accountants). There were no concerns and the accountants had come across no other matters in connection with the examination to draw to the Trust's attention. The Chair of the Committee asked for an explanation of the difference in spend over the past two years on Patients Welfare and amenities in note 6.1 of the Charitable Fund Accounts. **Action: The Executive Director of Finance and Resources to provide the Chair with an explanation of the difference in spend over the past two years on Patients Welfare and amenities in note 6.1 of the Charitable Fund Accounts by e-mail.** **Letter of Comment** The Committee noted the letter of comment received from Sedulo who had carried out an independent examination of the charitable funds accounts. There were no areas of concern to note. **Letter of Representation** The Committee noted the letter of representation from Leeds Community Healthcare NHS Trust to Sedulo Leeds Limited. **Outcome:** • The Committee noted the annual report and accounts 2018/19 and associated documentation • The Committee recommended the adoption of the annual accounts by the Charitable Funds Committee at its next meeting on 20 September 2019 subject to receipt of the explanation requested in relation to spend on patients welfare and amenities referred to at Item 27ii of these minutes.	**Executive Director of Finance and Resources**
2019-20 (28a)	**Governance** **Board assurance framework report 2019/20** The Company Secretary introduced the Board Assurance Framework (BAF) 2019/20 report. The revised BAF summary of agreed strategic risks was last presented to Audit Committee on 26 April 2019 following approval by the Board on 29 March 2019 (as part of the operational planning process for 2019/20). The Board Assurance Framework (BAF) has been reviewed by individual directors and then collectively by SMT. The Chairs of the Audit, Business and Quality Committees jointly reviewed	

	the BAF risk descriptions, scores and controls on 8 July 2019. A revised draft BAF would be presented at each sub-Committee for agreement prior to being received at Trust Board in summary in October 2019. The Committee considered the sources of assurance against each of the 18 current BAF risks to establish if they were adequate to offer the Board sufficient assurance. The Chair of the Committee suggested that in the absence of Non-Executive Director (IL), the sources of assurance for risks assigned to the Quality Committee (1.1, 1.2, 1.3 and 1.4) were deferred for a separate discussion. **Action: The Company Secretary to arrange a meeting with Non-Executive Director (IL) to discuss the risks assigned to the Quality Committee.** The Committee reviewed the remaining risks and provided comments against each risk for consideration by individual executives and the committees as follows: • Risk 2.1: The Committee discussed the sources of assurance referenced in the BAF and agreed that the reporting processes quoted appeared to be out of date and asked that the Business Committee review and re-fresh as soon as possible. • Risk 2.2: Non-Executive Director (RG) observed that the reporting cycles to Business Committee had now changed and were not reflected in the BAF. Business Committee review and re-fresh as soon as possible. • Risk 2.3: Non-Executive Director (RG) observed that new sources of assurance were being embedded and these were not reflected in the BAF. Business Committee review and re-fresh as soon as possible. • Risk 2.4: It was suggested that the minutes of the Contract Management Board should be included as a source of assurance. • Risk 2.5: The Committee agreed that overall this risk was underpinned by a balanced set of assurance measures. • Risk 2.6: The Committee agreed that the prevalence of attacks was increasing but the number of robust key controls and sources of assurance had also significantly increased. These were reflected in the sources of assurance. The Committee asked if statistics which illustrated the number of attacks which had been prevented by the mitigations put in place by the Trust could provide further sources of assurance. The Committee reviewed and agreed the suggested revised risk score. • Risk 3.1: The Committee agreed that overall the sources of assurance appeared to be adequate but suggested that more narrative could be included about links to the Trust's Workforce Strategy. Business Committee to review and consider. • Risk 3.2: The Committee felt that the sources of assurance required a thorough review and asked that the Business Committee take this forward. • Risk 3.3: The Committee felt that the key controls and sources of assurance did not reflect recent developments on the Workforce Strategy. Business Committee to review and refresh. • Risk 4.1: The Committee discussed whether the minutes of meetings provided an adequate source of assurance and overall felt that this should be considered and reviewed by the Business Committee. • Risk 4.2: This risk was the responsibility of the Trust Board. The Committee felt that a more in depth review was required perhaps as part of a Board Workshop or a discussion at a private meeting of the Board. • Risk 4.3 and 4.4: Both these risks related to work in partnership to deliver integrated care closer to home. The Committee felt that more reference should be made to the new partnership governance framework and asked the Business Committee	**Company Secretary**

	Outcome: The Committee: • considered all the sources of assurance to establish whether these were sufficient and made suggestions for review by executives and other committees • reviewed and agreed the suggested revised risk score for BAF risk 2.6	
2019-20 (28b)	**Risk Management update** The Company Secretary presented the report which provided the Committee with an update on the ongoing development of the Trust's risk management processes, particularly focussing on actions completed since the last report to the Committee in December 2018. The Committee discussed the monitoring of risk assessments across the Trust and asked for a proposal for a more robust mechanism to the brought to the next Committee meeting. **Action: The Company Secretary to consider whether a more robust mechanism for the monitoring of risk assessments is required for the Trust.** The Committee approved the risk appetite statement which had been reviewed by relevant directors with no changes suggested. **Outcome:** The Committee: • noted the actions undertaken since the previous report to the Committee in December 2018 • Noted planned improvement actions • Approved the risk appetite statement	**Company Secretary**
2019-20 (28c)	**Information governance – Information Governance Group: updated terms of reference** The Executive Director of Finance and Resources presented the updated terms of reference for the Information Governance Group. The main changes were highlighted and noted by the Committee. **Outcome:** The Committee received and approved the updated terms of reference for the Information Governance Group as presented without amendment.	
2019-20 (29a) **2019-20** (29b)	**Financial controls** **Tenders and quotations waiver report** The Executive Director of Finance and Resources introduced the report which presented an extract from the 2019/20 register and showed that a total of eight waivers had been completed in this financial year to date. **Outcome:** The Committee noted the report. **Losses and special payments report** The Executive Director of Finance and Resources introduced the report which covered payments made between April and June 2019. The Chair of the Committee noted that the total value of losses for the reporting period was £8,291 primarily relating to a settlement through NHS Resolution. **Outcome:** The Committee noted the report.	

2019-20 (29c)	**Register of gifts, hospitality and sponsorship** The Company Secretary introduced the report and the gifts, hospitality and sponsorship register for 2019/20 which was appended. **Outcome:** • The Committee noted the gifts and hospitality register.	
2019-20 (30)	**Minutes of noting** **Information Governance Group: 15 February 2019 & 18 April 2019** The minutes were noted and no questions raised.	
2019-20 (31)	**Committee's Workplan** There were no items removed or changes made to the workplan.	
2018-19 (32)	**Matters for the Board and other committees** The Chair noted the following items to be referred to Board colleagues: • Progress on internal audit • Charitable Funds annual report and accounts • Security management annual report • Board Assurance Framework • Risk management update report	
2018-19 (33)	**Any other business** No matters of any other business were raised.	
	Date and time of next meeting Friday 18 October 2019 9.00 am – 11.30 am Friday 10 January 2020 9.00-11.30 am Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	

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NHS Trust

AGENDA ITEM 2019-20 (95bi)

Quality Committee
Monday 23 September 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Committee Chair
	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Helen Thomson	Non-Executive Director
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
In attendance	Sam Prince	Executive Director of Operations
	Diane Allison	Company Secretary
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Caroline McNamara	Clinical Lead for Adult Services
	Elaine Goodwin	Clinical Lead for Specialist Services
	Helen Rowland	Clinical Lead for Children's Services
	Suzanne Slater	Clinical Governance Manager
	Sarah McDermott	Clinical Service Manager for Night Service and Palliative Care
	Jaginder Sandhu	Clinical Pathway Lead for Meanwood and Wetherby Neighbourhood Teams
	Sam Austin	Palliative Care Clinical Lead
	Liz Allen	Head of Research and Development
Minutes	Rebecca Hill	Clinical Governance Officer (Audit and Effectiveness)
Observing	Heather Thrippleton	Patient Experience and Engagement Lead
	Emma Sutcliffe	Team Manager, Little Woodhouse Hall
	Stuart Murdoch	Deputy Medical Director
	Margaret Duke	Aspiring Non-Executive Director
Apologies	Carolyn Nelson	Head of Medicines Management

Item no	Discussion item	Actions
Welcome and introductions		
2019-20 (40a)	**Welcome and Apologies** The Committee Chair welcomed members and attendees.	
2019-20 (40b)	**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 Chair asked if there were any additional interests. There were no additional declarations of interest received.	
2019-20 (40c)	**Minutes of meeting held on 22 July 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	

2019-20 (40d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. <u>Action 2018-19 (87c) – Research and Development Strategy update</u> To be discussed under agenda item 2019-20 (44b). The action was completed. <u>Action 2019-20 (25c) (i) - Matters arising and review of action log: Outcome Measures update.</u> The Executive Medical Director updated that all Outcome Measures posts had been recruited into and the Outcomes Programme Manager had been in post for 6 weeks. The Outcome Measures posts within the Business Intelligence Team would be linked to individual Business Units. The Executive Medical Director updated that the next Clinical Effectiveness Group (CEG) meeting would be a Deep Dive workshop on Outcome Measures. It was noted there would be a report on Outcome Measures at Quality Committee in November 2019. The action was completed. <u>Action 2019-20 (26) – Performance brief and domain reports</u> To be discussed under agenda item 2019-20 (42c). The action was completed. <u>Action 2019-20 (31a) – Service spotlight review</u> To be discussed under agenda item 2019-20 (41b). The action was completed. <u>Action 2019-20 (32a) – Serious Incident update report</u> To be discussed under agenda item 2019-20 (40d) (i). The action was completed. <u>Action 2019-20 (32b) (i) – Pressure Ulcers Investigation Update</u> To be discussed under agenda item 2019-20 (42b). The action was completed. <u>Action 2019-20 (33a) – Performance brief and domain reports</u> To be discussed under agenda item 2019-20 (43a). The action was completed. <u>Action 2019-20 (33f) – Quality Challenge+</u> The Clinical Governance Manager updated that the quarterly schedule of Quality Challenge+ Walks was currently being prepared and would be shared with the Non-Executive Directors once it had been finalised.	
2019-20 (40d) (i)	**Serious Incident Transitions Update** The Executive Director of Nursing and Allied Health Professionals (AHPs) advised the Committee that there would be further information about the NHSI Transitions Collaborative at the next Committee meeting. The Executive Director of Nursing and AHPs also noted that the Clinical Commissioning Group (CCG) in association with LYPFT and LCH would be monitoring the implementation of the action plan which is shared with Leeds and York Partnership NHS Foundation Trust. Following discussion, it was agreed the actions were completed but further work was needed to provide the Committee with assurance that the actions and changes to practice had been embedded. The Executive Director of Nursing and AHPs agreed an updated action plan inclusive of evidence of assurance would	

	be returned to Committee in Jan 2020. It was noted that Leeds CCG would meet with the young person's mother and that the CCG's assurance report that LCH actions have been embedded would be provided to Quality Committee **Action: Serious Incident Transitions action plan update required by Committee January 2020** The Committee agreed that limited assurance had been provided whilst awaiting evidence of actions being embedded in practice.	**The Executive Director of Nursing and AHPs**
Quality Spotlight		
2019-20 (41a)	**End of Life care** The Clinical Service Manager for Night Service and Palliative Care, the Clinical Pathway Lead for Meanwood and Wetherby Neighbourhood Teams, and the Palliative Care Clinical Lead joined the meeting. The Clinical Lead for Adult Services expressed thanks for the opportunity to share the story of palliative care across Leeds. Two patient stories were presented; the Clinical Lead for Children's Services discussed the end of life care provided to a child by the Children's Community Nursing Service and the Clinical Lead for Adult Services discussed the feedback received from an experienced nurse whose mother received end of life care in October 2018. The Trust Chair noted that it was useful that an experienced nurse was able to provide structured feedback on the end of life care her mother received but questioned what assurance we had in relation to the consistency of end of life care across the city. The Clinical Lead for Adult Services explained the mortality review process confirming that all deaths are monitored and reviewed. This had identified consistent themes emerging and therefore the focus of improvement work. The Trust Chair remarked that the lack of oversight from senior clinicians in the Adult Business Unit patient story was a significant issue. The Committee discussed that the patient had deteriorated quickly upon referral to the Neighbourhood Team which may explain the lack of senior clinical oversight. The Trust Chair noted that an individual's condition at End of Life is never stable so the Committee required assurance that any patient who suddenly deteriorated would receive the appropriate clinical care. It was discussed that the clinical pathway work around the deteriorating patient policy and use of NEWS (National Early Warning Score) and the development of a Virtual Frailty Ward would provide this assurance. The Executive Medical Director remarked that some issues had arisen from the GP surgery in the adult patient story and she enquired whether the teams felt they had appropriate forums to raise and discuss such issues in Primary Care. The Committee discussed that Gold Standard Framework Meetings were a regular opportunity to discuss end of life provision. Additionally, it was noted that the Palliative Care Network had hosted workshops and training at GP TARGET events around end of life care which had been attended by GPs and Advanced Nurse Practitioners. The Chief Executive queried how we ensure we serve all communities when delivering end of life care. It was explained that this issue would be explored	

	later in the year once new guidance from Public Health England had been published. The Clinical Lead for Children's Services also noted that the Trust would be involved in a research study commencing at Martin House which would be looking at everyone receiving end of life care regardless of their demographic. The findings of this would help identify the focus of further work. A Non-Executive Director (NED) queried what happened to young people who were receiving end of life care and transitioning to adult services concurrently. The Clinical Lead for Children's Services noted that has not happened previously but is an issue that needed to be explored. The Committee agreed that this Quality Spotlight should be repeated after the Bereavement Survey had been completed. The Clinical Service Manager for Night Service and Palliative Care, the Clinical Pathway Lead for Meanwood and Wetherby Neighbourhood Teams, and the Palliative Care Clinical Lead were thanked for their contribution and left the meeting.	
2019-20 (41b)	**Quality Spotlight Programme** The Executive Director of Nursing and AHPs described that she had reviewed the Quality Spotlight programme with a Non-Executive Director (HT). They had agreed that there should be no fixed long-term plan of Quality Spotlights as they should be responsive to emerging issues. It was discussed that services should be given some notice ahead of Quality Spotlight presentation so it was suggested that the November 2019 Quality Spotlight would focus on the 0-19 Public Health Integrated Nursing Service (PHINS). The two subsequent Quality Spotlights should explore the Quality Improvement work at Children's Community Nursing Service, and the deep dive comparisons in Neighbourhood Teams. The Committee agreed this proposal.	
Key Issues		
2019-20 (42a)	**Matters to Escalate from Subgroups** Most of the information escalated from Committee subgroups was for information only. The Company Secretary remarked that minutes from Committee subgroup meetings require improvement and it was agreed the Company Secretary would address this outside of the meeting with the Executive Medical Director and Executive Director of Nursing and AHPs. **Action: Company Secretary to highlight the subgroup minutes requiring improvement to the Executive Medical Director and Executive Director of Nursing and AHPs.**	**Company Secretary**
2019-20 (42b)	**Pressure Ulcer Improvement Plan** The Executive Director of Nursing and AHPs described that an overarching pressure ulcer improvement plan had been developed to supersede various individual improvement plans. The Trust Chair queried whether aiming to eliminate pressure ulcers was unachievable. Following discussion, the Committee agreed that there were improvements to be made and learning to be embedded within the Trust. If,	

	once the improvement plan had been implemented and embedded, pressure ulcer performance remained stable, this may demonstrate that the Trust could not improve further and alternative discussions would be required. The Committee Chair remarked that a number of reported pressure ulcers were not attributable to LCH care but LCH were required to investigate them. Following discussion, it was agreed that the purpose of the LCH investigation was to examine any acts or omissions in LCH provided care and there was discussion around a suite of outcome measures that could be considered including Pressure Ulcer healing rates as alternatives. Future chair of the LCH pressure ulcer group will be the Assistant Director of Nursing who will also be involved in the citywide pressure ulcer group and review the direction of travel. It was noted that the Pressure Ulcer improvement plan would be monitored by the Patient Safety, Experience, and Governance Group (PSEGG) and would return to Quality Committee in January 2020. **Action: Pressure Ulcer improvement plan to be returned to Quality Committee January 2020**	**Executive Director of Nursing and AHPs**
2019-20 (42c)	**Duty of Candour update** The Executive Director of Nursing and AHPs fed back that the Care Quality Commission (CQC) had highlighted some concerns around the Trust's Duty of Candour process during their visit in June 2019 and that the report explains what action had been taken in response to this. A Non-Executive Director (HT) remarked that it's useful to view the action plan but queried how the Committee received assurance that those actions were implemented and embedded. Following discussion, it was agreed that the Executive Director of Nursing and AHPs would add an "assurance" column to the action plan. It was also acknowledged that this ongoing assurance of compliance would be provided through the performance brief The Committee agreed that limited assurance had been provided. **Action: Executive Director of Nursing and AHPs to revise the Duty of Candour action plan to include an assurance section**	**Executive Director of Nursing and AHPs**
2019-20 (42d)	**CAMHS Inpatient Unit: NHS England Quality Monitoring Visit Action Plan** It was described that following an NHS England visit to the CAMHS Inpatient Unit in July 2019, an action plan had been developed. The Committee agreed that the action plan should be amended to include an "assurance" column. The Clinical Lead for Children's Services remarked that the service has been spot-checked and it was agreed this could be added to the "assurance" column. The Executive Director of Operations expressed that measures within the action plan needed to be more meaningful. For example "new doorbell to be ordered" should be replaced with "new doorbell to be in place and in use". It was agreed that the Clinical Lead for Children's Services and the Executive Director of Nursing and AHPs would update the action plan and it would return to Quality Committee in January 2020 as many of the actions weren't due for completion until the end of 2019.	

	Action: CAMHS Inpatient Unit NHSE action plan to be revised to include SMART actions and assurance.	**Clinical Lead for Children's Services**
Quality Governance and Safety		
2019-20 (43a)	**Performance Brief and domain reports** The Committee discussed the *'Concerns at Armley Neighbourhood Team'* section of the report. It was discussed that there were daily capacity and demand reviews in the Neighbourhood Teams and resource is shared across all Neighbourhood Teams to ensure all essential visits are completed. Following discussion, the Committee agreed that the *'Concerns at Armley Neighbourhood Team'* section of the report should be removed before the report is discussed at the Trust Board. Clinical Lead to bring comparison across Neighbourhood Teams to March 2020 Quality Spotlight. The Committee discussed that there were a number of patient safety incidents that were not attributable to LCH care and queried why these incidents were investigated locally. The Executive Director of Nursing and AHPs reported that at Cambridgeshire Community Services NHS Trust, such incidents are 'passed back' to the organisation where the incident originated to be investigated. The Director of Nursing and AHPs confirmed this is being explored with LTHT as incidents originating in LTHT account for approximately 30% of LCH reported incidents The Committee agreed that reasonable assurance had been provided.	
2019-20 (43b)	**Clinical Governance Report** The Executive Director of Nursing and AHPs highlighted that the Clinical Governance Manager and Assistant Director of Nursing and Clinical Governance were working on plans in relation to embedding the new Patient Safety Strategy in LCH systems and processes. A change to the existing serious incident framework will be piloted by the CCG in LTHT prior to further roll out across Leeds. The Clinical Lead for Adult Services highlighted that the Adult Business Unit (ABU) was currently involved in a Population Health Management Programme which would have an impact on the capacity of the ABU leadership team though there were plans in place to mitigate this. It was also highlighted that the 3Ds Framework (Dementia, Depression and Delirium) had been completed and was a useful resource for all Business Units and Primary Care. Additionally, it was highlighted that the Virtual Frailty Ward would be launched in October 2019. Following discussion, it was explained that the concerns at Armley Neighbourhood Team had not been included in this report as it would be a repetition of the Performance Brief (agenda item 2019-20 43a). The Clinical Lead for Specialist Services highlighted that the Virtual Respiratory Ward had been discussed at the Citywide Steering Group and it had been agreed that the development of the Virtual Respiratory Ward should be aligned with the development of the Virtual Frailty Ward to ensure patient-centred care. The risk is that the two virtual wards would have different referral routes and it was acknowledged that this needed to be addressed. The Clinical Lead for Children's Services highlighted that the Watch It service commenced their new service specification on 1st September 2019 and it is now part of the 0-19 PHINS service. It was also highlighted that the Young People's	

	Board had started to look at projects to get involved with, including Chat Health and clinic environments. The Young People's Board would discuss at their meeting the following day to consider inviting Non-Executive Directors to meetings.	
2019-20 (43c)	**Risk Register** The Company Secretary described that 2 clinical risks had been added to the Risk Register; increased admissions to Specialist Inclusive Learning Centres (SILCs) (risk 982) and lack of dietetic cover at Little Woodhouse Hall (risk 983). The Clinical Lead for Children's Services updated that risk 983 should be closed as the service had agency cover and a substantive member of staff commenced on 1st October 2019. The Committee Chair queried why the risk rating for risk 982 had been reduced. The Clinical Lead for Children's Services explained this was due to a significant amount of work taking place with the SILCs to put interventions in place. It was also noted that the CCG were aware of this risk. The Committee Chair queried why there were 4 risks scored as 9 but controls in place were marked as 'adequate'. The Company Secretary explained this was because the controls in place mitigate the immediate risk but more controls are needed to reduce the risk permanently.	
2019-20 (43d)	**Mid-year proposed revisions to the Board Assurance Framework** The Company Secretary described that following a meeting of Committee Chairs in July 2019, the Board Assurance Framework (BAF) had been updated. The Company Secretary provided a summary of the changes that had been made. Following discussion, the Committee agreed it would recommend that the Trust Board approved the changes.	
2019-20 (43e)	**Draft Standards of Partnership Governance** The Company Secretary explained the purpose of the report and provided a summary of the proposed standards. The Executive Director of Operations remarked that this was a welcome piece of work that had been well-received by SMT. It had also received positive feedback from Tim Morris from Internal Audit. The Committee agreed that the proposed standards would address previous issues that had emerged, by being explicitly clear about the roles and responsibilities for all parties. Following discussion, the Committee agreed it would recommend that the Trust Board approves the proposed standards of partnership governance.	
2019-20 (43f)	**Winter Planning – quality implications** The Executive Director of Nursing and AHPs explained that the report provides an overview of the Trust's current position and that there were no current issues to highlight. However, it was acknowledged that winter planning is not always possible to predict so would be monitored closely. It was noted that winter pressures and EU exit could occur concurrently and would have a more significant impact. Following discussion, the Committee agreed that reasonable assurance had been provided as the Trust was learning from the previous year.	

2019-20 (43g)	**Mortality Report** The Executive Medical Director presented the report and highlighted ongoing work with the Business Intelligence Team to validate data. The Committee Chair remarked that the lack of senior clinician oversight discussed under agenda item 2019-20 (41a) was not addressed in the report. The Clinical Lead for Adult Services explained that the ABU review 150 – 200 deaths per month and it is unusual that patients don't have appropriate case management. A Non-Executive Director (HT) remarked that the condolence cards (described under 3.7.9) were a positive change. The Chief Executive discussed that patients with mental illness and/or learning disabilities were underrepresented in these figures. It was discussed that the Trust does not code patients' mental health issues and/or learning disabilities and it is data that is retrieved from other systems. It was acknowledged that this may begin to improve as understanding of learning disabilities and mental health issues continues to improve. The Chief Executive also remarked that she was working with the Executive Director of Nursing and AHPs to consider the role of Learning Disability champions within the Trust. The Committee agreed that reasonable assurance had been provided.	
2019-20 (43h)	**Quality Strategy implementation plan quarterly update** The Executive Director of Nursing and AHPs provided an overview of the report and described that there were no significant issues to note. The Committee agreed that progress was on schedule.	
2019-20 (43i)	**Quality Priorities quarterly position** The Executive Director of Nursing and AHPs reported that good progress had been made and there had been little change since quarter once. It was also described that there were no concerns to be escalated. The Committee agreed that reasonable assurance had been provided.	
2019-20 (44j)	**Board members' service visits** The Committee was provided with reports from three recent visits: • Multi-disciplinary Respiratory Rehabilitation Team at Leeds Teaching Hospitals NHS Trust (St James's University Hospital) - Neil Franklin, 24 July 2019 • Morley Neighbourhood Team – Brodie Clark, 29 July 2019 • Police Custody Suites – Neil Franklin, 30 July 2019 The Trust Chair had visited a Multi-Disciplinary Team (MDT) meeting for the Respiratory Rehab service in July 2019. He reported that the visit had been very informative and that the response to patients' mental health issues was interesting. The Trust Chair also remarked that the LTHT consultant's questioning of LCH nursing staff was very good. The Trust Chair had visited Shepcote Police Custody Suite (PCS). He reflected to the Committee that there was a potential for PCS staff to become isolated,	

	particularly in Doncaster where there was only one embedded member of staff. The Trust Chair conveyed that this needed to be addressed from a management and leadership perspective.	
Clinical effectiveness		
2019-20 (44a)	**Patient group directions (PGDs)** The Committee was asked to ratify four PGDs. It was confirmed that the PGDs had been through the correct processes and there were no concerns to highlight. The Committee ratified the four approved PGDs. The Chief Executive left the meeting.	
2019-20 (44b)	**Research and Development Strategy** The Head of Research and Development (R&D) joined the meeting and introduced herself. The Head of R&D described the changes that had been made to the draft of the R&D strategy since it was previously discussed at Quality Committee. The Head of R&D reported that the strategy would be discussed at the Patient Involvement Group the following day to ensure the strategy was readable and accessible for the public. The Chief Executive and the Trust Chair remarked that it would be unachievable to develop a strategy that everyone will understand and suggested a summary document was developed and shared with the public. The Committee Chair remarked that the strategy should emphasise the financial commitment needed to establish LCH as a research organisation. The Executive Medical Director remarked that previously the Clinical Research Network had focussed on recruitment so LCH had prioritised this rather than ensuring patients were accessing high quality research. Following discussion, the Committee Chair requested that all comments on the draft R&D strategy should be returned to the Head of R&D via e-mail. The Head of R&D was thanked for her work on the R&D strategy and left the meeting.	
Patient Experience		
2019-20 (45a)	**Engagement Strategy** The Executive Director of Nursing and AHPs explained that the Engagement Strategy had been well received at the Senior Management Team meeting in the preceding week and was scheduled to be presented to the Trust Board for approval in October 2019. A Non-Executive Director (HT) queried the use of 'engagement' and remarked that it caused confusion between patient voices and statutory regulations. The Trust Chair suggested stating in the strategy that it "does not purport to cover the statutory responsibilities covered elsewhere". The Committee Chair asked how the strategy could be successfully demonstrated in the work of the Committee. The Executive Director of Nursing and Allied Health Professionals expressed that she would like patient representatives to attend the Committee meetings in future.	

	The Committee thanked the Patient Experience and Engagement Lead for her work on the Engagement Strategy.	
Policies and reports for approval or noting		
2019-20 (46a)	**Safeguarding annual report** The Executive Director of Nursing and AHPs advised the Committee that the report had been written using the standard template and had been scrutinised in depth at PSEGG. The Committee agreed that the report was comprehensive and approved the report. A Non-Executive Director (HT) queried whether this report would be uploaded to the LCH website and the Committee were in agreement that it should be uploaded to the external website, once it is approved by the Board in October 2019.	
2019-20 (46b)	**Infection prevention and control (IPC) annual report** The Executive Director of Nursing and AHPs advised the Committee that the report had been written using the standard template and had been scrutinised in depth at PSEGG. The Executive Director of Nursing and AHPs highlighted that there had been fewer care home closures as a result of infection outbreaks in 2018/19. The Committee discussed that the flu jab campaign would be launched the following week and that 'jab-for-jabs' had been arranged via the Charitable Funds route so that for every LCH colleague who received a flu jab, a flu jab would be given to a child in a developing country. This was following colleague suggestions. The Committee discussed the internal hand hygiene audits completed on a monthly basis. It was noted that any emerging concerns would be escalated via Clinical Lead reports. A Non-Executive Director (HT) queried whether this report would be uploaded to the LCH website and the Committee were in agreement that it should be uploaded to the external website once it is approved by the Board in October 2019.	
Sub group minutes for noting		
2019-20 (47a)	**Clinical Effectiveness Group (CEG) meeting (24 July 2019) and workshop (29 August 2019)** Noted for information.	
2019-20 (47b)	**Safeguarding Committee meeting (22 August 2019)** Noted for information.	
2019-20 (47c)	**Patient Safety, Experience and Governance Group (PSEGG) meeting (30 July 2019)** Noted for information.	
2019-20 (47d)	**Mortality Surveillance Group meeting (13 August 2019)** Noted for information.	

2019-20 (47e)	**Mental Health Act Governance meeting (21 June 2019)** Noted for information.	
Quality Committee Work Plan		
2019-20 (48a)	**Work Plan** The next Quality Committee would be a workshop followed by a one hour formal meeting. There had been no significant changes to the work plan to note.	
Matters for the Board and other Committees (including assurance levels)		
2019-20 (49)	It was agreed the following topics should be escalated to the Trust Board: • The End of Life presentation • Research and Development Strategy and Patient Engagement Strategy • Serious Incident and Transitions update • Duty of Candour update • Assurance levels	
Reflections on Committee meeting		
2019-20 (50)	**Reflections on Committee meeting** The Trust Chair reflected on the volume of papers and length of time required to prepare for the meeting. The Committee discussed that reducing the volume of papers would need to be balanced with ensuring all mandatory topics were covered in the required depth. However, it was acknowledged that there had already been improvements as there were less repetitive discussions and it was felt that reducing the number of meetings had supported this. Two suggestions were made; increasing the use of annexes and ensuring reports were clear about what the key issues were.	
Any other business		
2019-20 (51)	**Any other business** The Executive Director of Operations fed back on behalf of the Chief Executive that the Business Committee was overseeing the EU Exit but there were no issues relating to quality that needed to be escalated to Quality Committee.	
	Dates and times of next meetings Monday 21 October | 09.30am-12.30pm | Boardroom, Stockdale House Monday 25 November | 09.30am-12.30pm | Boardroom, Stockdale House	

NHS
Leeds Community Healthcare
NHS Trust

Quality Committee
Monday 21 October 2019
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Agenda item 2019-20 (95bii)

Present	Professor Ian Lewis	Committee Chair
	Neil Franklin	Trust Chair
	Helen Thomson	Non-Executive Director (Items 52-53)
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Dr Ruth Burnett	Executive Medical Director
In Attendance	Sam Prince	Executive Director of Operations
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Elaine Goodwin	Clinical Lead for Specialist Services
	Helen Rowlands	Clinical Lead for Children's Services
	Carolyn Nelson	Head of Medicines Management
	Rachel Lee	Quality Lead, Adult Business Unit (deputising for Caroline McNamara)
	Suzanne Slater	Clinical Governance Manager
	Dr Stuart Murdoch	Deputy Medical Director
	Andrea North	General Manager Specialist Business Unit (Item 53)
	Liz Ward	Head of Service (clinical) - Leeds Contraception and Sexual Health (Item 53)
	Adele Archer	Head of Service (operational) - Leeds Contraception and Sexual Health (Item 53)
	Jo Firth	Lead Nurse - Leeds Contraception and Sexual Health (Item 53)
	Gillian Meakin	Project Manager – Leeds Stroke Pathway (Item 53)
	Helen Knight	Clinical Head of Service for Neurology and SLT (Item 53)
	Becky Goodwin-Vickers	Therapy Lead LTHT – Leeds Stroke Pathway (Item 53)
	Heather Thrippleton	(Item 54)
	Kezia Prince	(Item 54)
	Helen Williams	HR Advisor (Item 54)
	Diane Allison	Company Secretary – Items 56a-59
Minutes	Bridget Lockwood	Business Support Manager (CEO & Chair's Office)
Apologies	Thea Stein	Chief Executive
	Caroline McNamara	Clinical Lead, Adult Services

Item no	Discussion item	Actions
Welcome and introductions		
2019-20 (52a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed attendees. The group introduced themselves. Apologies were received from the Chief Executive and the Clinical Lead for the Adult Business Unit.	

Business Unit focus:		
2019-20 (53)	**SBU workshop** The Clinical Lead for Specialist Services introduced two services who outlined their experiences of working in partnership to deliver integrated care and care closer to home, including what the teams had learnt, barriers they had faced and/or overcome, and the outcomes for patients. **Integrated pathway Sexual Health** Liz Ward (Head of Service – Clinical), Adele Archer (Head of Service – Operational) and Jo Firth (Lead Nurse) delivered a presentation. The Committee noted that the service had been established in 2015, in partnership with Leeds Teaching Hospitals NHS Trust (LTHT) and Yorkshire MESMAC. Leeds Community Healthcare NHS Trust held the contract and was the lead provider on clinical governance. The team outlined the service's journey since the outcome of an inspection by the Care Quality Commission (CQC) in January 2017. Following a rating of 'Requires Improvement' for the Responsive and Safety domains, the service re-focussed its efforts, with greater emphasis on the quality, procedural and leadership agendas. This included managing waiting times, tackling the high DNA rates and the number of complaints received, reviewing the leadership structure, how the Trust and LTHT worked in partnership, and a review of procedures and policies. Work was also undertaken to address issues around child protection training and supervision. The service's Lead Nurse outlined the review that had been undertaken on appointments, which had led to service users now being seen within 40 minutes of arrival, more service users being seen in clinics, clinicians feeling more in control of the flow of clinics, reception staff managing waiting arrangements better, and less complaints being received. The Head of Service (operational) explained how listening to staff ideas and engaging with service users had assisted in reducing complaints and increasing staff and service user satisfaction. The Committee noted that CQC inspectors had advised the service during their inspection in May this year to showcase the changes and their approach nationally. The Executive Medical Director asked how the service had managed to achieve a huge change in culture within the service. The Lead Nurse responded that all staff attended away days where they were encouraged to put forward ideas on how the service might be improved. All ideas submitted in an ideas box had been responded to (320 in total). An example was shared which had led to the lead nurses being situated behind reception to allow then to support reception staff around clinical judgements. The General Manager for Specialist Services added that the change in the role of the Head of Service, to split the operational and clinical components of the role had also made a huge difference. The Head of Service (Clinical) also highlighted that the delivery of the service from five sites in the city allowed changes to be trialled at one site and rolled out across the sites if successful. A Non-Executive Director (HT) asked how the service would handle an increase in demand. The Head of Service (Clinical) responded that demand was constantly increasing and it was not possible to see as many service users as the service would like. The service was now in a position to signpost service users elsewhere if necessary. The Lead Nurse added that the service endeavoured to see all service users who were exhibiting symptoms as a priority.	

The Executive Director of Nursing and Allied Health Professionals asked how the team engaged with service users on an ongoing basis. The Head of Service (Clinical) responded that the team had reviewed the areas service users had raised in complaints and concentrated on these areas. The team were now looking to be more proactive in this work, working alongside the Patient Engagement Team. The Head of Service (Operational) added that service users had also been surveyed regarding the project work undertaken the previous year.

The Trust Chair asked if it was challenging to make the service offer known in the harder to reach communities. The Lead Nurse responded that the service bases included some of these areas of the city, including Burmantofts, Beeston, Chapeltown and Armley, and, in conjunction with MESMAC, there was a very good outreach team undertaking this work. In addition, two clinical slots were allocated to sex workers in clinics.

The Committee Chair asked if the service was able to evidence that the changes made had led to an improvement in the achievement of KPIs, and against national outcomes. The General Manager responded that initially the service had been required to report against 164 KPIs. More recently commissioners had worked with the service to ensure meaningful KPIs were in place, and had nominated the service for an excellence in partnership award. The Executive Director of Operations added that the service was achieving higher than the national average on a number of Public Heath performance measures, and it was noted that Leeds was the first city to highlight incidences of antibiotic resistant Gonorrhoea.

The Deputy Medical Director asked if the service had considered clinics on a Saturday afternoon and Sunday. The Lead Nurse responded that the service had originally been open until 3pm on a Saturday but service users preferred to attend in the morning. The Head of Service (Clinical) added that extending the hours may lead to service users that do not require a Level 3 service attending. It was noted that the service was commissioned to see 60k contacts per year and was seeing seven per cent more than this number already this year.

The Executive Director of Operations reflected on the work of an incredible team that had achieved significant improvements, with no additional investment. The Committee noted that the service would be negotiating a contract extension and it was therefore essential that additional funding be secured in recognition of the increase in footfall.

The Committee Chair thanked the team for the presentation and asked what learning they would wish to share with other services within the Trust seeking to make improvements. The team responded that communication at all levels was vital, listen to service users, capitalise on the experience within the team of staff, and not to be reactive.

Integrated Stroke pathway

Gillian Meakin (Project Manager), Helen Knight (Clinical Head of Service for Neurology and SLT) and Becky Goodwin-Vickers (Therapy Lead at LTHT) attended the meeting to outline the pathway and work undertaken since its inception in 2018.

The Project Manager described stroke pathways in the city prior to integration,

	including high length of stays, a high number of outliers, frustration from community and acute staff regarding flow not working well, and the limited criteria in place for service users to access the community service. In 2018 Newton Europe had identified, as part of a review of flow within the city, that the length of stay for Stroke service users was 30 days compared with a national average of 21 days. The Stroke pathways were therefore identified as one of five key areas for review within the system. In addition to the focus and governance structure this provided, a new commissioner assisted in driving the workstream forward. This gave staff and service managers permission to make improvements across organisational boundaries, all of which were patient focussed. Changes to the criteria for the pathway were outlined, such as, service users were seen for 12 weeks rather than six weeks, the community team provision had changed, including the removal of the 12 week limit to access rehabilitation in the community. Funding had been combined across Leeds Community Healthcare NHS Trust and LTHT to allow allocation of service and staff according to need. A secondment arrangement had been agreed between the organisations which allowed more flexible arrangements, and engendered a culture of learning, partnership and communication, with monthly team meetings to encourage improvement, training and learning from case reviews. In addition, a team had been created to focus on outliers in the acute trust to ensure that patients not on the Stroke ward were able to access the same quality of rehabilitation. The Project Manager highlighted the improved outcomes as a result of the pathway integration, with a better flow of patients, an increase in the number of referrals to the community team, a reduction in outliers in LTHT (down to 9 in 2018-19 from 18 for the period April to September 2018), a reduction in average inpatient stays from 31 days to 15 days, and excellent feedback from patients. The team were now working on e-referrals, a community care bed pathway, Neighbourhood Team and Stroke Team discharge pathways, work to progress Stroke Association involvement across the whole pathway, and further joint patient engagement. The Executive Director of Operations congratulated the team on their achievements and asked if support was required from senior colleagues to support the treatment of patients on outlying wards. The Therapy Lead, LTHT felt that this was not necessary as a dedicated Occupational Therapist and Physiotherapist in the outlier team, linked with nursing team, were seeing these patients, often on the neurological wards. The Project Manager confirmed that a better understanding of data had also enabled the team to predict fluctuations more effectively. The General Manager asked that senior colleagues assist in spreading the positive messages about the joint pathway to other colleagues in the city. They added that the change in commissioner, which had promoted a freedom to act, could make huge differences across other pathways if the same approach were replicated. The Trust Chair congratulated the team on a brilliant achievement and asked the team what obstacles they faced in seeing the right patients at the right time and how these obstacles might be removed. The Project Manager responded that the changes to the criteria for the community team had led to a waiting list being created which members of the team were uncomfortable with. However, the change had confirmed that it was appropriate for some patients to wait for	

	rehabilitation by convalescing at home, therefore an element of trust and understanding within the staff group needed to be built through ongoing communication and an improved culture to support this. Further investment by commissioners would also support and enable a review of the position to take place. The ambition of the team was to see patients that needed input within 48 hours, rather than the current wait of approximately a week. The team at LTHT were undertaking more outreach work for patients at the end of their recovery journey which enabled the community team to focus on cases where community intervention was most appropriate. The Committee Chair was pleased to hear that patients did not recognise their care was being delivered by two separate Trusts. The Committee Chair asked if we are now contributing to the six month assessment element of the national Stroke audit. The Project Manager responded that a CQUIN had now been introduced to assess our compliance with this measure of effectiveness. The Committee noted that half of those admitted to LTHT following a stroke recently had then been referred to the community team. The General Manager added that there had been a shift away from viewing the work stream as a clinical review to being a patient engagement exercise. The Clinical Lead for Specialist Services reflected that preparing for the presentations to Business Committee had been helpful in identifying the key drivers for the services in their integration journeys, and learning that was now being shared across the Specialist Business Unit and across the Trust. The Committee Chair reflected that it had been helpful to hear the journeys people had been on and thanked both teams for their time, and their hard work and commitment to date.	
2019-20 (54)	**National Patient Safety Strategy** The Assistant Director of Nursing and Clinical Governance introduced the team who were undertaking work on the Just Culture and Staff Safety elements of the National Patient Safety Strategy. The Quality Committee workshop formed part of a wider engagement exercise which would assist in forming the Trust's approach to implementing the Strategy. The Committee noted that the Strategy had been published in July 2019 and had a two year implementation period. The main focus of the Strategy was to enable continuous improvements in patient safety by building a culture of patient safety, with three strategic aims – Insight, Involvement and Improvement. Also in attendance and presenting were the Head of Clinical Governance, a HR Advisor, the Patient Experience and Engagement Lead and the Incident and Assurance Manager. The Patient Experience and Engagement Lead provided national context around the approach to patient involvement in the Trust's investigation processes, and a co-produced patient engagement approach to service pathway reviews. The HR Advisor outlined a 'people before process' approach to support staff in the complaints and investigation processes, with a focus on a culture of learning rather than blame. The Committee noted that the Senior Management Team had already agreed a revision to the disciplinary process within the Trust. The Incident and Assurance Manager outlined a good reporting culture within	

	the Trust. The Committee noted that the majority of incidents reported were no harm or minimal harm incidents, and three new categories had been introduced earlier in the year. An in-depth review of Duty of Candour processes and 72 hour review of potential serious incidents was underway with the support of the Assistant Director of Nursing and Clinical Governance. Committee members were asked to undertake discussions in groups on what implementation of the patient and staff involvement elements of the Strategy might look like: • What does the future of staff involvement look like in investigations, and what are the challenges and solutions? • What does the future of patient involvement look like in investigations, and what are the challenges and solutions? • What are the potential outcome measures relating to staff and service users? The group discussions determined that the relationship between the clinician and patient was vital in assisting with positive conversations in the event of a patient safety incident or complaints investigation. It was also agreed that the first conversation often determined whether the process would be positive for staff or patients (or the patient's family). The Chair felt that there needed to be as little process as possible, but added that any process in place needed to be well thought out and effective in supporting individuals. The Assistant Director of Nursing and Clinical Governance confirmed the outcomes of the workshop would be incorporated into consultation feedback gained from staff, drop-in meetings and the Patient Safety and Experience Group workshop to be held later in the month. The Committee Chair thanked the team for their time and requested that the Quality Committee be updated on the next iteration of the process being developed. It was agreed that timescales would be determined and agreed at the next meeting of the Committee. **Action: Timescales regarding the Trust's process National Patient Safety Strategy to be determined and fed back to the next meeting of the Quality Committee, including a proposal on when the Committee would consider the next iteration of the process**	Assistant Director of Nursing
2019-20 (55a)	**Declarations of Interest** None recorded.	
2019-20 (55b)	**Minutes of meeting held on 23 September 2019** The minutes were reviewed for accuracy and agreed as a true record of the meeting, pending the following changes: • Item 46b – Infection Prevention and Control Annual Report – third paragraph to be updated as follows: "…the flu jab campaign would be launched the following week and that 'jab-for-jabs' had been arranged via the Charitable Funds route so that, for every LCH colleague who received a flu jab, a **tetanus** jab would be given to a child in a developing country." • Items 46a and 46b – The Committee Chair requested that the minutes be amended to further highlight that both the Safeguarding Annual Report and the Infection Prevention and Control Annual Report had been excellent reports.	

2019-20 (55c)	**Matters arising and review of action log** <u>Item 43b – Clinical Governance Report</u> The Committee Chair enquired when the Committee would receive feedback from the Young People's Board. The Clinical Lead for Children's Services responded that the group were ready to meet with Committee members. It was agreed that an update on the Young People's Board would form part of the Clinical Governance Report in November 2019 **Action: Clinical Governance Report (Children's Clinical Lead section) in November 2019 to include feedback from the Young People's Board** It was agreed that all completed actions would be removed from the action log.	
2019/20 (55d)	**Key issues** **CQC update** The Executive Director of Nursing and Allied Health Professionals updated the Committee that the inspection report was likely to be published the following week. **Unwarranted variation** The Executive Director of Nursing and Allied Health Professionals confirmed that this work was being taken forward and a further update would be provided to the Committee in due course.	
Quality governance and safety		
2019-20 (56a)	**Performance brief and domain reports** The Committee acknowledged that an updated version of the Performance Brief would be presented to the Board. *Safe domain* The safety brief identified an increase in overall incidents, with a decrease reported as Patient Safety Incidents. The Committee noted that improvements had been made to the Duty of Candour process, including inclusion of the letter templates on Datix, at the request of clinicians. Five safety notifiable incidents had been closed in month, all identified no acts or omissions in care and therefore had been determined to be unavoidable to the Trust. The Committee Chair queried the ratio of low and no harm incidents in the previous year compared with this year. The Clinical Governance Manager responded that the increase this financial year was due to new categories added on Datix which had led to an increase in reporting. It was reported most of the incidents reported were associated with skin damage. The Clinical Lead for Specialist Services asked if the change in reporting accounted for the increase in reported incidents by one third. The Clinical Governance Manager confirmed that the new categories, combined with the inclusion of staff incidents, had led to the increase reported. It was agreed that an explanation in the narrative of the report would be helpful. It was further noted that the level of incident reporting was expected to come back into normal variation, therefore the forecast for the indicator should move from amber to green. *Caring domain* The Executive Director of Nursing and Allied Health Professionals highlighted	

	that the decrease in the percentage of respondents recommending inpatient care was due to the response by one patient in the Community Neurology Rehabilitation Service. It was noted that the Trust was mandated nationally to report this data, however, it was felt that comments received from service users would be more pertinent in assessing the quality of this service. *Effective domain* The Committee noted that a delay in staff coming into post to support the outcomes workstream had led to a delay in achieving the outcomes activity that had been forecast. The Clinical Lead for Specialist Services confirmed that services were collecting this data. The Committee were pleased to note that only two clinical and corporate policies were now overdue for review. The Committee Chair queried the number of clinical audits undertaken in Quarter 2 and it was clarified that the number reported were those that had begun, rather than completed and it was not always linear across the quarter. The Committee Chair commented that the NICE guidance data quoted in the report was explicable. The Head of Medicines Management updated the Committee that the position had also improved since the report had been drafted. The Committee Chair noted the low number of Quality Challenge+ walks completed in 2019/20. The Clinical Governance Manager responded that the position had improved on the previous year and added that the number of 'Quality Walkers' had recently increased. Once inducted, the number of scheduled walks would also increase in line with the trajectory. The Clinical Lead for Specialist Services queried the outcomes achieved from the research work undertaken. The Executive Medical Director responded that further work was being undertaken to ensure that learning and outcomes from research activity was communicated more effectively, supported by a new Research Strategy in January 2020. *Responsive domain* The Trust Chair queried the reduction in the percentage of people referred to the IAPT service who received treatment within six weeks of referral. The Executive Director of Operations responded that a commissioner led initiative to concentrate on the access target had impacted on the ability of the service to see people within six weeks. The Executive Director of Operations was confident that the new LMWS service would address issues of demand, although the Clinical Lead for Specialist Services cautioned that this would not happen immediately. *Well–led domain* The Committee Chair commented on the good position reported overall in this domain. *Finance domain* The Committee Chair reflected that the report indicated that the current financial position was not having an impact on the quality of services provided by the Trust. The Executive Director of Operations confirmed that there were currently no financial constraints on operational services.	
Quality Committee work plan		

2019-20 (57a)	**Work plan and format of meetings:** The Company Secretary informed the Committee that the Patient Engagement implementation plan would be considered in January 2020. An update on progress against the Patient Engagement Strategy would be considered in March 2020.	
2019-20 (58a)	**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 subjects: • Details from each of two workshops • Performance brief: Numbers of patient safety incidents; First Always event; Quality Challenge + walks; enhancing feedback from research and development and IAPT response times	
2019-20 (58b)	**Reflections on meeting** The Committee Chair reflected on two very interesting presentations from the Sexual Health and Stroke integrated pathways and asked that the Committee be kept up to date on the learning and sharing of the positive progress made on the work streams. The Trust Chair reflected on the need to build relationships and trust when working in integrated services/teams and added that leadership was key in progressing a mutual desire to improve and work in partnership. The Executive Medical Director and the Trust Chair recognised the role and support of the Clinical Commissioning Group as fundamental to the progress made with the Stroke integrated pathway. The Committee Chair highlighted that a discussion had taken place at Audit Committee on the paper drafted by the Company Secretary on partnership, and had requested that further work be carried out on the clinical accountability relating to partnerships. The Executive Medical Director highlighted that a meeting of the Clinical Senate will be used to discuss barriers to integration in the city, and how the system might get to a position where clinical risk was accepted more readily than it was now. It had been agreed to take forward a programme of leadership development and a meeting be arranged to establish common problems and barriers which the Executive Medical Director and Dr Phil Wood were reflecting on further. The Committee Chair reflected on the strong focus on quality that had been discusses and concluded the meeting.	
2019-20 (59)	**Any other business** There was no further business.	
	Dates and times of future meetings (09:30 – 12:30) 25 November 2019 27 January 2020 24 February 2020 23 March 2020 27 April 2020 18 May 2020 22 June 2020 27 July 2020 21 September 2020	

	26 October 2020 23 November 2020	

Leeds Community Healthcare NHS Trust

Agenda item 2019-20 (95ci)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 25 September 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:	Laura Smith	Director of Workforce
	Diane Allison	Company Secretary
	Katie Smith	Project Manager, Virtual Frailty Ward (for item 36c)
Apologies:	Helen Thomson	Non-Executive Director (HT)
Observer:	Margaret Duke	Aspiring Non-Executive Director
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2019/20 **(35)**	**Welcome and introductions** The Committee Chair welcomed the Aspiring Non-Executive Director to the meeting. **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 minutes of the meeting dated 24 July 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 following updates were noted. *Item 30a – Performance Brief (reporting of staff incidents)* The Executive Director of Finance & Resources reported that the health and safety data did not support the linkage of incidents to sickness levels. The reporting of staff incidents would continue through Performance Brief. The two data sets when compared did not correlate the link. **Action:** The Executive Director of Finance & Resources and the Director of Workforce (LS) were to work together to review the correlation of the data systems.	**BM / LS**

	Item 30a – Quarterly finance report The Committee Chair thanked the Executive Director of Finance & Resources for circulating a copy of the Care Quality Commission assessment framework for the Use of Resources. The Executive Director of Finance & Resources and the Non-Executive Director (HT) were meeting to discuss the reporting process within the performance pack. (Meeting dated 30.9.19) **Action closed.** *Item 30e – Risk register* It was noted that risk 979 (0-19 service recruitment issues) had been updated by the Director of Workforce. **Action closed.**	
2019/20 **(36)**	**Key issues** **a) European Union (EU) exit risk assessment** The Committee discussed the risk assessment which was under regular review by the Executive Director of Operations. The assessment of risk remained "low" across all areas. As part of the planning the Executive Director of Operations had considered a fuel shortage scenario and advised the Committee that the Trust had experience of managing this type of situation, and assured the Committee that she would continue to look at the different scenarios. The Committee Chair requested a further conversation with the Executive Director of Operations together with the Non-Executive Directors closer to the EU exit date in terms of providing additional assurance and support. **Outcome:** The Committee discussed the EU exit risk-assessment. **b) Implications of Amin Abdullah review** The purpose of the report was to provide the Business Committee and the Trust Board with the findings of an independent inquiry and NHS England and NHS Improvement (NHSE&I) Task and Finish Advisory Group, into an event that occurred at a London NHS Trust. Amin Abdullah was the subject of an investigation and disciplinary procedure, and was summarily dismissed on the grounds of gross misconduct. Shortly before an appeal hearing Amin took his own life. The report concluded that in addition to serious procedural errors throughout the process, Amin was treated very poorly, to the extent that his mental health was severely impacted. NHSE&I had now formally written to all NHS Trusts asking that HR teams and the boards reviewed the guidance and recommendations and assess against their current procedures and processes, and importantly, make adjustments where required, to bring the organisation in line with best practice. The Director of Workforce (LS) asked the Committee to review and consider the RAG rated self-assessment against the recommendations and agree whether this was an accurate position for the organisation. A timescale had been set to ensure the necessary recommendations to adjustment the policy and ways of working were implemented. The Director of Workforce (LS) said that the current position of the Trust was fully compliant with three recommendations, partially compliant with four and there was a further three the Trust was not compliant with. The Director of Workforce (LS) said that whilst the report focused purely on disciplinary	**SP**

process in an organisation it actually splices well with the overall cultural direction of travel in the Trust.

The Director of Workforce (LS) said that there was an opportunity to use these recommendations, not just for disciplinary hearing but also during investigations to support and develop managers around compassion, people before process and handling of challenging circumstances.

The Committee was asked to comment on the proposals, note the self-assessment and findings of the Abdullah's report and to consider the proposed next steps.

In response to a question from a Non-Executive Director (RG), the Director of Workforce (LS) advised the Committee that a task and finish group had been convened to determine the action plan.

It was noted that the new policy would be in place by 20 December 2019 subject to approval. There were no time scales set nationally for development of the training. The Trust was likely to be fully compliant with all the required improvements and delivery of training by 2020/21once the new policy was in place.

The Executive Director of Operations welcomed the training and suggested an additional training element is added 'how to run a successful investigation and expectations' and perhaps link the first cohort of people to some kind of mentorship or buddying up. She said her second point was about releasing people from their day jobs to do the critical work. The Executive Director of Finance & Resources said that this had been explored in the senior management team meeting and outside resource was being considered as it was a huge commitment in order to comply with this in a timely way.

The Director of Workforce (LS) added that nationally there had been no time scale set but this was a priority for the organisation. The Chief Executive agreed outsourcing whilst training in-house staff. The Committee Chair requested updates to be included in workforce strategy report.

The Committee Chair said he was content with the policy in place by 20 December 2019 and that the training aimed to be completed sometimes during 2021. In the meantime other processes were being put in place as necessary to ensure staff were qualified with the skill set required for taking it forward.

Outcome:
The Committee noted the key points from the implications of Amin Abdullah's review and commented on the RAG rating of self-assessment and associated timescales for the next steps.

c) Virtual frailty ward business case (VFW)
The Committee Chair welcomed the Project Manager for VFW to the meeting.

The Executive Director of Finance & Resources introduced the paper and explained that governance required the development of a new service to be approved by Business Committee. The VFW service was in its pilot and development phase, as the business case was being clarified and refined.

The Project Manager said that VFW was a working title. The service was about supporting people who were severely and moderately frail and poorly for conditions managed safely at home but not poorly enough to need emergency admission.

	The Project Manager said that at the moment the testing phase was for people age 70 years and above, and would go live in early November 2019. The aim was to keep people at home rather than hospital admission. The people benefiting from the service would only be attending hospital for outpatient appointments. Phase one was avoiding people attending hospitals and phase two principally avoiding people being admitted. The majority of staffing was from Leeds Community Healthcare NHS Trust as the primary provider. Other provider colleagues were from the hospital, the Trust and possible support from Age UK with regards to patient transport options. A Non-Executive Director (RG) asked about commissioning involvement within specification and budget. The Project Manager said that partner organisations both at development group level and steering group included commissioners. She said it was an emerging model being tested out with a view to routinely becoming a commissioned service. The Executive Director of Finance & Resources said that the additional cost to the Trust was being made available through time-limited transformation funding. The Project Manager said that she was aware of the workforce challenges and that one of the biggest risk to the Trust was relating to the recruitment of staff. Discussions were underway to decide how to fulfil these roles for a short time and whether these posts could be absorbed into other roles within the system. The Chief Executive was concerned that there was no mention of work linking to primary care or Primary Care Networks. The Project Manager said that the revised paper will describe on-going discussions with primary care, third sector and others about what their contribution model would be. She said discussion with primary care Directors about the initial testing was underway with GPs involvement in the multidisciplinary teams. The Trust Board was to be notified of the development of the service through the Chief Executives report to Board on 4 October 2019. **Action:** An update on business case was to be provided to the Business Committee in six months' time (March 2020). **Outcome:** The Committee noted the recommendations and accepted a low level of financial risk associated with staffing requirements.	**BM**
2019/20 **(37)**	**Strategies** **a) Estate strategy** The Executive Director of Finance & Resources introduced the revised estate strategy which had been previously considered as a draft estate strategy at its meeting in July 2019. As a result of the Committee's deliberations and a follow up meeting with the Chair of the Committee the strategy had been substantially rewritten. The Business Committee was asked to comment on the revised draft, any comments received would be taken into account in a final draft before approval by the Committee in October 2019. The revised draft strategy listed fewer priorities and was more ambitious in the	

	utilisation of estate. The strategy was well received with the Committee recognising that this was an enabling strategy, which opened up possibilities for different ways of working. The Committee suggested some minor changes and recommended that the Board should review the draft strategy at its meeting in October 2019 meeting. The Committee Chair suggested tiding up the propositions around hubs and mobile delivery sites, being more specific, and scaling the outcome benefits. **Outcome:** The Committee reviewed the revised estate strategy and agreed to reflect its discussions at the Trust Board meeting on 4 October 2019. **b) Workforce strategy priority update: health & wellbeing** The Committee was provided with an update on the delivery of the Workforce Strategy, focussing on the Health and Wellbeing priority, progress and delivery. The key message was that the rate of staff sickness absence had been below 5% for three months since April 2019. The Director of Workforce (LS) said that this could be attributed to a number of factors including leadership and engagement programme. She said there had been media interest in the Trust's innovative approach to staff health and wellbeing. The Committee also discussed the findings of the Amin Abdullah review and agreed that the learning from this would be incorporated into the Workforce Strategy and were keen to see a rigorous and early delivery of the promised improvements. Two key risks to the health and wellbeing work stream were set out in a table in the paper, together with mitigating actions. The Committee considered that the RAG rating columns within the risk table were not accurate and were to be removed. **Outcome:** The Committee noted the progress made on health and wellbeing since April 2019 and endorsed the approach identified for work during 2019/20. **c) Update on digital strategy** An earlier draft digital strategy had been reviewed outside the meeting by the Committee Chair who had suggested that further work was undertaken before presented to the Committee. The Executive Director of Finance & Resources said that the conversation about the estate strategy had been helpful for the digital strategy. He said one of the key recommendations was to set up a forum to include what is happening nationally and locally and understanding how digital can help the organisation to improve patient care. The Committee Chair queried if there was anything in the market to help organisations in terms of developing strategies and how to present, perhaps a workshop or spending time with experts who produce strategies. The Executive Directors agreed to consider external support to strategy development outside the meeting. **Outcome:** The Committee noted the progress of the digital strategy, which would be revised and presented to Committee in October 2019.	**BM**

2019/20 **(38)**	**Business and commercial** **a) Operational plan update** The Committee received a report in July 2019 on the delivery of the Trust priorities at the end of quarter one. This report now presented the position at the end of month five, rather than the end of quarter two to enable the Trust Board to receive a timely position report in October 2019. The Executive Director of Finance & Resources said that the Trust was continuing to make good progress in delivering the agreed priorities. At the end of month five the changes to note were in the RAG ratings of two priorities as follows: • Priority 12 related to progressing with the CAMHS Tier 4 build and service model to the agreed time-frame; changed from red to amber. • Priority 15 related to implementing the digital and estates strategies; the year to date position had changed from green to amber reflecting slight delay in bringing the digital strategy to Business Committee and then Board for approval. **Outcome:** The Committee received the report and noted areas of achievement and those still to progress. **b) Draft Standards of Partnership Governance** The Committee reviewed the draft Standards of Partnership Governance and welcomed the proposed approach for management of partnership arrangements. The Committee was assured of its effectiveness as the standards had been reviewed and tested out by business managers and the internal auditor, all of whom had provided positive feedback. The Company Secretary was amending the draft version based on feedback received. The Standards of Partnership Governance would be presented to Audit Committee in October 2019 and then to the Trust Board in December 2019. A template of Memorandum of Understanding was being developed to guide people when applying the standards. **Outcome:** The Committee reviewed the draft process proposed and agreed if applied that it would provide the Trust Board with assurance that its partnerships are being governed effectively.	
2019/20 **(39)**	**Project management** **a) Projects report update (Change Board)** The Committee was provided with an update on the Trust's key projects, including a flash report indicating key milestones achieved or expected to be delayed since the last update in July 2019. The Committee was advised that the administration review project had identified some legacy issues concerning a misalignment of roles and bandings. The extent of the issue was being investigated and resolution to this was anticipated to be complicated, which meant that the project would be potentially delayed.	

	The Committee recognised the importance of ensuring these legacy issues were resolved effectively. The financial risk associated with this would be added to the Trust's risk register. There were no issues of concern raised with the other projects. The Committee noted that the e-rostering project was achieving its timescales in line with the project plan and there had been good progress in recruiting to the project team. **Action:** • A projects update report to the Committee in November 2019 was to include the scale of the problem dictated by the findings. • Adding administration cost risk to risk register. **Outcome:** The Committee Chair noted uncertainty around the timescales and financial implications for the administration review project. **b) CAMHS Tier 4 business case update** The Executive Director of Finance & Resources said that work was progressing well and a draft business case would be presented to the next Business Committee meeting in October 2019. He said working through finances to understand the revenue consequences of the capital costs and critically evaluating the initial staffing structures had allowed an affordable case. The Executive Director of Finance & Resources said that when the new unit opens it should be the best Child and Adolescent Mental Health Service (CAMHS) unit in the country, meeting all relevant standards, in a high quality, but affordable building. The business case was also considering 'do nothing or do minimum' options and what the financial consequences of that would be. The 'do minimum' option required closure of Little Woodhouse Hall. The planning permission had not yet been granted with some concern that tree planting issues may cause a delay. In the meantime the enabling works would continue in parallel to the approval process. The Executive Director of Finance & Resources said that if the site plan is not approved the work would not be wasted as there would then be a greenfield site to sell for alterative development. The target opening date for the CAMHS Tier 4 was noted as September 2021. **Outcome:** The Committee noted the update, taking into account a number of issues that had been shared. **c) E-rostering update** The Director of Workforce (LS) introduced the e-rostering paper. The paper provided an update on the project progress since it was last seen by the Committee in March 2019. She said regular updates were also included in the Change Board paper. The paper had targeted an item specifically responding to a Non-Executive Director's (RG) query from the last Business Committee meeting in July 2019 about the status of e-rostering project. In terms of the project itself the Committee was advised that the project was continuing to achieve its time scale within the project plan. The Director of Workforce (LS) said that the project had secured resource from	**SP** **SP**

	Leeds Clinical Commissioning Group to implement e-rostering at scale to meet the mandated deadline of March 2021 set by NHS Improvement for the implementation of e-rostering across provider organisations. Due to the nature of the project there was a risk that there would be insufficient resources available from the business units to implement the e-rostering system at the required pace. Another risk to note was through pilot implementation about reporting systems and maximising the value, a need for aligning finance with ESR and e-rostering to ensure the interface across the systems worked efficiently. The Director of Workforce (LS) said that work was underway to carefully phase it, not causing any problems to the roll out timescale. **Action:** The Committee queried whether paragraph 4.2 referred to a bank module or the bank service. The Director of Workforce (LS) to clarify this. **Outcome:** The Committee noted progress of the project and its achievement within the time scales. Funding had been identified to ensure ongoing implementation.	**LS**
2019/20 **(40)**	**Performance management** **a) Performance brief and domain reports** The Committee reviewed the August 2019 performance data. The Chief Executive provided an update from discussions held at the Quality Committee meeting on 23 September 2019 regarding other provider incidents reported on the Trust's incident system and about receiving an in-depth operational report within Armley Neighbourhood team. The Quality Committee welcomed the continued experimentation and the experience of the senior team in Armley but felt that this level of detail should be removed before the submission of the report to the Trust Board. The Quality Committee had also reviewed the safe, caring and effective domains. There were no particular issues to raise or escalate. The Committee Chair noted that there were not many changes in the Performance Brief; most of the indicators were consistent with previous months, particularly in terms of responsive and well-led. **FINANCE** In the Finance section of the Performance Brief, the Committee was apprised of the risk concerning the interaction between the new care model, CAMHS Tier 4 and the Trust's core budgets. The forecast overspend on the new care models (NCM) budget was being addressed through a renewed focus on the length of stay of inpatients. The national system, CAMHS database, would suggest that the NCM budget was overspending significantly after four months. The Executive Director of Finance & Resources said if the NCM position did not significantly recover, the development costs of the new unit may have to be met from the Trust's own core revenue budgets. He said that this had been set out in terms of modelling and a proposal of inter-relationships between the three separate financial flows. The Executive Director of Finance and Resources drew Committee's attention to the concerns raised by the West Yorkshire and Harrogate Health and Care	

Partnership regarding the overall income and expenditure position, for which the Trust had a small share of the risk. The overall West Yorkshire and Harrogate position was causing concern.

The Executive Director of Finance & Resources said that his overall conclusion was that the Trust would still hit the control total.

Outcome:

- The Committee expressed concerns about the current financial position but the finance targets were forecast to be achieved for the year end.
- The Committee recognised the risk to the Trust regarding West Yorkshire and Harrogate Health and Care Partnership revenue concerns.

b) Neighbourhood report and quality, staffing and finance: triangulation report

The Committee received the quarterly update on quality, staffing and finance, triangulated into one report. It was advised that in future the Quality Committee would also receive this report.

The Committee recognised that the overall position was stable, and there had been important improvements on the previous year. There were variations, with some teams under pressure, and resource was being used flexibly to manage these. There was a concern about losing staff within the first year; however, the Committee was advised that the Trust is in a similar position to the national picture.

A Non-Executive Director (RG) said that in terms of overall staffing levels and vacancies the Trust was in a stronger position than this time last year, but some of the graphs did not reflect this. The Committee Chair said that the commentary had been helpful in terms of all the different graphs and charts when considered together form an overall picture of stability

Outcome:

The Committee received the report and noted the overall position.

c) Productivity group update

The Committee expressed its disappointment that the Productivity Group had not met recently and that this matter was not progressing some months after its inception.

d) EPRR 2019/20 assurance submission

(Please see private minutes)

e) Operational and non-clinical risks register

The Committee considered changes to the non-clinical risks on the risk register as follows:

- One non-clinical risks scoring 8 or above
- Two non-clinical risks had been deescalated
- One non-clinical risk had been closed

The Company Secretary said that Risk Management was rated as having 'reasonable assurance' in a recent internal audit review.

Outcome:

The Committee noted the recent revisions made to the risk register.

	f) Board Assurance Framework (BAF) draft amendments The Company Secretary introduced the BAF report. The paper advises Business Committee of the suggested changes to the BAF risks assigned to Business Committee to consider and recommend to the Trust Board. The content of the BAF had been reviewed by the Chairs of the Audit, Business and Quality Committees at a meeting on 8 July 2019, which was also attended by the Executive Director of Finance and Resources and the Company Secretary. Some changes had been proposed to the descriptions and risk scores for some strategic risks. Individual directors had also reviewed the risks they hold responsibility for and have suggested additional description changes. SMT had reviewed this report and agreed with the suggested changes. **Outcome:** The Committee was content with the proposed changes and agreed to recommend them to the Trust Board. **g) Internal audit reports:** The reports covered the completed audits from the 2019/20 plan and the audit opinion related to the following review: • IAPT Data Quality • Workforce Equality and Diversity • Review of Budgetary Control and Cost Improvement Programmes. In each case the audit concluded a reasonable assurance opinion. **Outcome:** The Committee noted the completed audits and recommendations.	
2019/20 **(41)**	**Minutes to note:** **Health and Safety Group minutes (29/08/2019)** The Committee received the Health and Safety group minutes from the meeting dated 29 August 2019. It was noted that in future a highlight report will be provided for the Committee to focus on areas for consideration.	
2019/20 **(42)**	**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 **(43)**	**Matters for the Board and other Committees** • EU Exit • Virtual Frailty Board business case • Estate strategy • Workforce strategy • Partnership governance • Projects management report • CAMHS Tier 4 update • E-rostering update • Performance brief • Neighbourhood report / quarterly report	
2019/20 **(44)**	**Any other business** None discussed.	

Leeds Community Healthcare NHS Trust

Agenda item 2019/20 (95cii)

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 23 October 2019 (9.00 am to 12.00 noon)

Present:	Richard Gladman (Chair)	Non-Executive Director (RG)
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Helen Thomson	Non-Executive Director (HT)
Attendance:	Jenny Allen	Director of Workforce
	Diane Allison	Company Secretary
	Richard Slough	Assistant Director of Business Intelligence (for item 47a)
	Gareth Burns	Programme Manager (for item 46a)
	Emma Gregory	Clinical Pathway Lead for the Adult Business Unit (item 46a)
Apologies:	Brodie Clark	Non-Executive Director (BC)
	Thea Stein	Chief Executive
Observer:	Claire Staveley	Head of HR Operations
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2019/20 **(45)**	**Welcome and introductions** The Committee Chair welcomed everyone to the meeting. **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 25 September 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 following update was noted. *Item 39(c) – E-rostering* The Director of Workforce confirmed that the 'bank staff module' for processing time sheets for all staff registered with clinical and support service (CLASS) in-house staff bank was being used. **Action closed**.	

2019/20 **(46)**	**Project management** **a) Electronic Patient record (EPR) update (presentation)** The EPR project team presented an overview of the benefits realisation approach for the EPR project including: quality, patient safety and clinical excellence and reducing non-value added data. The team described the importance of data quality and of clinicians being able to access the same clinical record per patient. The Committee was advised that whilst data collection was still in its infancy, it was already proving useful to services and was being welcomed by clinicians and managers. Examples were provided of how data was being used to good effect including identifying where patients risk assessments had not been completed, managing un-outcomed visits, understanding capacity and demand for better use of resources, provision of targeted training and support. The Committee Chair noted some quality benefits being realised relating to financial business and moving into clinical, quality and safety. The Executive Director of Operations said that there was learning in terms of getting the base line right at the beginning of projects and able to quantify the benefits financially. In response to a question from the Committee Chair about tangible benefits and changes in cost benefits the Clinical Pathway Lead said that the greatest benefit was about having accessibility information for making better clinical decisions for safer care. The Committee was advised that to get people to use the information for their daily work, the EPR team was working closely with the data quality team. Data quality training was in place for all new starters to understand the importance of data being used correctly at different levels. The Executive Director of Finance & Resources said that there was a danger of not following on the biggest improvement opportunities. The Clinical Pathway Lead said that a workshop was being organised to focus on analysing data collectively and to develop a database for safe use of data. The Committee Chair thanked the EPR team for their presentation. The Executive Director of Operations asked whether the Committee was assured sufficiently on the benefits realisation of the project and if the report on benefits realisation in the neighbourhood team could now be discontinued. The Committee agreed to this request. The Committee was reasonably assured of the benefits being realised by this project. It recommended that the focus should now be on exploring the data to establish where the largest improvement gains could be made. The Committee also recommended that the presentation should be shared with the Quality Committee. **b) Child and Adolescent Mental Health Service (CAMHS) Tier 4 Draft full business case** The Executive Director of Finance and Resources provided the Committee members with copies of the draft full business case for their consideration to review outside of the meeting. The Committee was advised that a similar governance process and timescale was being adopted by Leeds and York Partnership NHS Foundation Trust	

	(LYPFT) to ensure that its Board governance structure had an opportunity to scrutinise the same document. The Executive Director of Finance & Resources said that the key issues considered in the business case were revenue and capital affordability and value for money. He said work was continuing over the next four weeks before submission to Boards for final approval. The guaranteed maximum price (GMP) was still being finalised by Interserve Ltd. The value engineering process so far had identified £400k reduction to the capital cost. The project team was in discussion with staff at Little Woodhouse Hall to assess the clinical implications of the next layer of value engineering process. The Executive Director of Finance & Resources tabled a paper to provide an overview of finances for the CAMHS new build. This paper had been the basis of a presentation he had made to the NED/Governor event of the Mental Health Provider Collaborative on 22 October 2019. A breakdown of cost was provided to the Committee. The capital cost of the scheme was £19.5m of which £13m was being funded by public dividend capital and the balance covered by LYPFT, LCH with scheme development costs assumed to be met by the CAMHS new care model (NCM). The Executive Director of Finance & Resources said that the current modelled bed day rate for the business case was high compared to current average rate. He said that because it was assumed that in the first two years of operation of the new service the commissioning would be under Provider Collaborative arrangements NHS England had asked for letters of support from the CAMHS provider collaborative Trusts. The Executive Director of Finance & Resources explained that there was a risk in terms of scheme development costs due to the New Care Models budget not underspending as planned. Therefore, there is a £900k financial risk pressure to the Trust of over spend against its control total and a plan to mitigate that was in development. The Executive Director of Finance & Resources referred to the tabled paper that provided details of how the business case demonstrated its affordability. He said that the NCM budget will become the Provider Collaborative budget of circa £9.5m which will include learning disability patients who are currently not part of the NCM. The financial risk was that the provider collaborative commissioning budget delegated to three providers in West Yorkshire would not be sufficient to afford £6.2m cost annually for the new unit. The Committee Chair said he would brief the Quality Committee Chair following discussions today. The Executive Director of Operations asked if the Scrutiny Board was sighted on the plans for the new unit. The Executive Director of Finance & Resources said he would speak to the secretary to the Scrutiny Board **Action:** • A joint meeting to be arranged between Leeds Community Healthcare NHS Trust and Leeds & York Partnership Foundation NHS Trust to discuss the business case. • The Executive Director of Finance & Resources to speak to the Chair of the Scrutiny Board about receiving the business case.	**BM** **BM**

	Outcome: the next steps were for Committee members to provide comments before the business case was presented at a joint meeting between LCH and LYPFT in November 2019 prior to being received at December 2019 Trust Board for approval.	
2019/20 **(47)**	**Strategies** **a) Digital strategy update** The Assistant Director of Business Intelligence presented the revised draft digital strategy and asked the Committee if the digital strategy captured the aspirations of the Trust in terms of its digital ambitions and working in ever more integrated health and care system with other provider's data. He emphasised Cyber security will continue to be very important thread in the future to make sure that Trust requirements are adequately described in it. The Committee was advised that the draft strategy had been further developed taking into consideration the context in which the Trust now works, and will work in the future and had been aligned with the workforce and estate strategies. Staff had been actively consulted to ensure challenges with existing systems were captured. The Committee suggested that it should also link with 'Making Stuff Better' strategy for quality improvement, and should establish new arrangements to capture service improvement ideas utilising new digital models and to ensure the work plan for 2020/21 onwards had the full support of the Executive Directors and CCIO. The Director of Workforce (JA) asked if the strategy was ambitious enough and whether there was an opportunity to use technology where there were workforce pressures. The Committee Chair said that he recognised the drive, an opportunity to take advantage of innovative technology in the future. He said it was good to have the foundations right and having an ambitious target of those things in the future as and when they become available. The Committee suggested that the Trust should establish new arrangements to capture service improvement ideas utilising new Digital Models and ensure the work plan for 2020/21 onwards had the full support of the Executive Directors and CCIO. The Executive Director of Operations said that there was a huge demand for business intelligence and systems development and she thought that the strategy did not quite capture that. She was also concerned about getting everybody digitally literate and getting people fully competent with computers. The Committee Chair summarised the discussion and said that for the level of ambition there was still further foundation work to undertake around governance, an aspiration to be as good as can be in terms of community provider and technology. He continued to say that there was something about being service led, allowing delivery of better care in order to meet service transformation aspirations and improve care. A Non-Executive Director (HT) suggested that the strategy should also be provided in a condensed form for staff to see and recognise. The Committee Chair said he was content with the update and the way the strategy was coming together. He recommended that the draft strategy should be revised taking account of the Committee's recommended changes; having more emphasis on service led, patient led and not just IT replacement. He said	

	he was happy to work with the Executive Director of Finance & Resources with an aim to get it to the Board in December 2019. **Outcome:** The Committee agreed that with minor changes the Board should receive the draft strategy at its December 2019 meeting for approval. **b) Business development strategy update** The Committee was advised of two key highlights as below. • Leeds Childhood Flu Immunisations tender was now out and due to close on 25 October 2019. This was to provide childhood flu immunisations to the children of Leeds. The Executive Director of Operations said that the contract was lost to Harrogate three years ago, and the Trust was bidding to bring it back to integrated schools immunisation programme. The bid put together met the requirement of the specification for a contract value of £500k. This required the Committee's approval to go ahead with the submission. • The Executive Director of Operations said that this was the last update of the existing strategy. It was suggested that at the next Business Committee meeting in November 2019 discussions will be held to review the successes and challenges of the current strategy. A Board workshop in January 2020 will focus on the new strategy's development. In response to a question from the Committee Chair about colocation, the Executive Director of Operations explained about the mobilisation project for Leeds 0-19 Public Health Integrated Nursing Services (PHINs). She said that the requirement in the specification was that the service should be co-located within children's centres; however this had not been possible. Hub sites were being set up in Trust buildings and connections with children's services were being made in different ways. **Action:** • Leeds Childhood Flu Immunisations bid submission to be presented to the Committee in November 2019. • Future strategy development discussions are to be held at the next meeting in November 2019 prior to Board workshop in January 2019. **Outcome:** The Business Committee noted the progress against the business development strategy priorities.	**SP** **SP**
2019/20 **(48)**	**Business and commercial** a) **NHSE/I new financial architecture** The Executive Director of Finance and Resources described the new arrangements that would replace control totals, and that the Trust's suggested surplus target for the coming year was £780k. As the Trust's surplus is linked in with the aggregate target for the Integrated Care System (ICS), if the Trust did not agree to the suggested target, it could adversely affect the financial position of other Trusts in the ICS. The Executive Director of Finance and Resources advised that he had accepted the target and explained that the latest planning document was due to be submitted by noon that day describing how the Trust would meet the suggested surplus target.	

	Outcome: The Business Committee noted the agreed surplus target and the Executive Director of Finance and Resources confirmed that he would apprise the Board at the November 2019 workshop. **b) Community dental services reconfiguration (CDS)** The Executive Director of Operations presented a paper that outlined the case for reducing the Community Dental Service's delivery sites and provided details of the public consultation that had taken place. The Committee was advised that the new community dental service contract awarded to LCH in October 2018 had posed some challenges and the proposed solution was to reduce the number of sites from five to three, in order to provide the enhanced service required within the cost envelope. The specification required new elements of the service including domiciliary care and intravenous sedation with clear quality improvements. Public engagement had now ended following the Scrutiny Board's request to keep the engagement open for 12 week. The proposal is to transfer CDS services currently provided at Beeston Hill Health Centre and Armley Moor Health Centre to Middleton Heath Centre, Reginald Centre and Yeadon Health Centre with effect from 1 January 2020. The Committee considered the options appraisal and the level of public engagement. It also enquired about engagement with staff who may be affected by the proposed changes and the plan for the redundant estate. The Executive Director of Operations said that the Scrutiny Board had agreed in principle to reduce the service to the three sites to deliver the requirement of the specification and recognised the Trust's compromised position. Letters will go out to each patient to notify them of their next appointment at the new venue. A Non-Executive Director (HT) asked whether a quality impact assessment had been completed and this was confirmed. **Outcome:** The Committee agreed to recommend to Trust Board that it should approve the proposal to reduce to three delivery sites.	
2019/20 **(49)**	**Performance management** **a) Performance brief and domain reports** The Committee reviewed the September 2019 performance data, in particular the responsive, well-led and finance section. The Committee Chair queried the friends and family test calculations. The Executive Director of Finance & Resources said that this was also being reviewed by the senior management team. The Committee agreed there was more work to be done to drive up the appraisal rate by improving data quality and continuing a targeted campaign. The Committee discussed sickness absence rates, in particular long term sickness and how these cases were being managed. The Committee Chair asked for further information to be provided on the number of cases of sickness absence connected with staff involved in disciplinary procedures.	

	Effective The organisation was generally performing well against the measures in this domain. The measures relating to outcome measures, audit and research were behind schedule and the Quality Committee was monitoring this. *Responsive* Performance in this domain remained good with the majority of targets met. Improving Access to Psychological Therapies (IAPT) performance remained a concern with actions in place to address the waiting list backlog whilst the service mobilised to the new service model. It was noted that there had been further breaches of the six week wait for diagnostic tests in the audiology service this month. *Well-led* Overall well-led performance indicators remained good with turnover and sickness absence trends being fairly stable. Turnover for staff with less than twelve months service had also reduced from last month and at the end of month six, sickness absence was below 5% as compared with previous year. Work continued on increasing appraisal rates with targeted support within hotspot areas being undertaken as well as training on appraisals themselves. The Director of Workforce (JA) provided an update on the appraisal target proposal. She said that the current appraisal rate was around 85% and requiring improvement. She said reviewing information on a weekly basis and identifying hot spots and providing training guidance on appraisals and use of electronic staff record system was having an impact. The Director of Workforce (JA) said that a number of months ago she had asked whether the target could be lowered and adjustment made appropriately. It was noted that work was still continuing to improve the compliance rate. The action referred to meeting dated April 2019 regarding appraisal target proposal was now closed. The Committee Chair said that in terms of long term sickness he would expect that staff are constantly being reviewed to understand their circumstances. With that focus and a view on how to target those people, he expected more people coming off long term sickness than going onto it. The Director of Workforce (JA) responded to say that the percentage had come down between quarter one and two, but once somebody is on long term sickness it is much harder for a return to work. **Action:** Committee to receive sickness absence figures of staff involved in disciplinary procedures in January 2020. **FINANCE** The Executive Director of Finance & Resources introduced the finance section of the performance report. He said the year to date financial position was consistent with previous months and overall the surplus continued to be £0.1m more than planned. The Trust continued to forecast delivery of the control total at the end of March 2020, dependant on successful mitigations to the CAMHS scheme development costs not being met by an underspend on the New Care Models. All other finance targets were forecast to be achieved for the year.	**JA**

The Executive Director of Finance & Resources remained 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 was monitored closely and it should be noted that the Trust had no funds available for unplanned, ad-hoc expenditure.

Outcome:
The Committee received an overview of the current financial situation, and noted that the risks to the achievement of control total would be achieved.

b) Quarterly finance report
The financial position had been discussed as noted above.

c) Estates assurance and activity report
The Committee received the estates assurance and activity report, period between 1 June to 31 August 2019, covering the work of the estates team, including the processes in place to provide assurance on the safety and compliance of the estate.

The Trust had a partnering services agreement with Community Ventures Leeds Ltd (CVL) to provide a fully resourced Estates Department, including an agreed resource for the implementation of the Strategic Estate Strategy.

There were no estates related health and safety issues reported on Datix in the period. A risk relating to information provision and communication for Little Woodhouse Hall had been placed on the Trust risk register.

The Executive Director of Finance & Resources felt that this was more like a quarterly estate report managing the estate rather than providing assurance. He said that over time it should describe safe systems of working and use national premises assurance model for assurance reporting.

Outcome:
The report provided the Business Committee with information about the arrangements for the safe management of the estate.

d) Productivity Group update
The Committee received a paper informing it of the Productivity Group's assessment of its purpose and how it intended to improve progress against its objectives and agreeing the aims set out in priority 14 of the corporate priorities on unnecessary variation and reducing waste of resources.

The paper described the Group's agreed priority work areas which included taking the lead on the 'Getting it Right First Time' programme of work, and focussing the programme around seven Trust services. This will involve leading on the assessment of information for the Model Community Services Programme, continuing its involvement with the ICS in understanding variation across the wider region, and receiving and sharing learning from a number of existing work streams within the Trust and its productivity.

The Productivity Group will consider the information provided in the corporate benchmarking report and annual reference cost data with a view to identifying improvement opportunities.

A Non-Executive Director (HT) suggested the Group's work would link to the number of 'did not attend' waiting times and patients missing out on care. The

	Committee Chair agreed that it should be about improving patient care and that it should not just be a corporate responsibility, services should be involved too. The Executive Director of Finance & Resources said that this was to support services to identify and reduce waste of resource priority. He said that the waste reduction was a terminology embraced at the Leeds Teaching Hospitals Trusts successfully. It was identified that the Trust had not done as well as it had expected because of other priorities had prevented progress. The Productivity Group recognised those barriers and agreed to work on the priority work areas at its next session. The Executive Director of Finance & Resources said that the challenge now was to re-focus on some key areas of work and generate the opportunities around productivity and capture and reflect on that before bringing it back to the Committee in January 2020. **Action:** The Committee requested a further report on tangible progress at its meeting in January 2020. **Outcome:** The Committee noted the renewed focus being taken by the Productivity Group. **e) Corporate benchmarking** The Committee was provided with the corporate benchmarking report produced by NHS Improvement, which included the Trust's corporate data for comparison. From the report it was clear that clinical governance and corporate governance were areas identified through the benchmarking exercise which the Trust should focus its attention and had the greatest potential for cost reduction. The report presented to the Committee cautioned against a conclusion that this would be possible or desirable. The recommendation was that further exploration of cost reduction opportunities should be undertaken by the Productivity Group. Concern was raised about the quality and reliability of the benchmarking data. Overall, the Trusts corporate services costs were below the sector median but there were significant differences function by function. The Executive Director of Finance & Resources said that further exploration of the cost reduction opportunities identified within the Corporate Benchmarking report for 2018/19 would be undertaken. Regular reports will be provided to the Productivity Group with an update on the outcome from the analysis to Business Committee in January 2020. **Action:** • The Executive Director of Finance and Resources was asked to establish if the definitions of roles to be included in the benchmarking data were being accurately applied to the Trust's data submission. It was agreed that a further update would be provided to the Committee in January 2020. • The Committee to receive an update in January 2020 on the analysis of cost reduction opportunities. **f) Quarterly workforce report** The quarter two workforce report provided the Business Committee with an update on progress made on the delivery of the six priorities of the Workforce	**BM** **BM**

	Strategy 2019-21. The key highlights were noted as follows: • The recruitment service continued to stabilise during quarter two. • The average sickness absence rate had come down to below 5%. • Electronic staff record plan for the organisation was progressing well • Appraisals rates had shown slow but steady improvement • Good progress had been made with employment offer to Primary Care Networks. The Committee Chair asked if the recruitment service had stabilised and this was confirmed. A Non-Executive Director (HT) asked about retention levels in the nursing associate role and it was confirmed that levels were good. **Outcome:** The Committee agreed it was a comprehensive report. **g) Operational and non-clinical risks register** The Committee considered changes to the non-clinical risks on the risk register as follows: • *Two new risks:* Deprivation of Liberty for 16 and 17 year olds Transporting compressed oxygen cylinders by the Respiratory and Dental Services • *One risk had an increased score:* Increase in demand for the adult speech and language therapy service. There was an increase in demand for the service provided in partnership with Leeds Teaching Hospitals NHS Trust. A service review was underway by the Commissioners. The controls were documented on the risk register. **Outcome:** The Committee noted the recent revisions made to the risk register. **h) Internal audit report: Review of Conflicts of Interest** The report covered the completed audit from the 2019/20 plan and the audit opinion related to the review of conflicts of interest: to ensure that senior managers across the Trust feature and cascade Conflicts of Interest requirements at meetings in their business units to increase staff awareness. The Company Secretary referred to the recommendation about the sponsorship within the Trust. Having a clear set of sponsorship principles developed and aligned with the Conflicts of Interest requirements. The Executive Director of Finance and Resources was tasked to produce an extended set of principles and a procedure for communicating across the Trust and subsequently being monitored. The audit concluded a reasonable assurance opinion. **Outcome:** The Committee noted the completed audit and recommendations.	
2019/20	**Business Committee work plan**	

(50)	The work plan was reviewed by the Committee members and no changes were requested. **Outcome:** The Committee agreed the work plan.	
2019/20 **(51)**	**Matters for the Board and Committees** • EPR benefits update (reasonable assurance) • CAMHS Tier 4 draft Business Case • Digital strategy (reasonable assurance) • Community dental service reconfiguration • New financial architecture • Performance brief and domain reports • Productivity group update • Corporate benchmarking	
2019/20 **(52)**	**Any other business** None discussed.	

Agenda item 2019-20 (95d)

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:	3 October 2019
Name of meeting reporting to:	<Board of Directors>

Key discussion points and matters to be escalated:

This paper provides an update from the WYMHSC C-In-C held Tuesday 3 October of which members of the four trusts were present. The programme update paper and full action notes are attached with the key decisions and actions highlighted below:

- The minutes of these meetings are being taken through public boards with the exception of private items.
- A programme update was received including the process underway to enable reporting of the programme and wider performance metrics in quantifiable measures. A draft programme reporting dashboard will be presented at the next meeting.
- A risk management framework to support consistent recording of programme risks was approved by members. The new metrics will be implemented going forward.
- An update on the new Child and Adolescent Mental Health Service (CAMHS) unit was received with valid reasons given for the 15 months delay of the original plans; the new opening date will be September 2021. A CAMHS update will be provided at a future meeting in line with progress.
- A brief progress update on steady state commissioning was received. Ensuring the capacity to deliver was raised as a vital element. A draft version of New Care Model (NCM) / steady state commissioning key milestones will be presented at the next C-in-C. A meeting with the Chief Operating Officers and Sean Rayner, SWYPFT will be established to discuss immediate operational pressures.
- The programmes 5-year strategy and programme structure were discussed and will undergo further development and incorporate feedback from this meeting. The final strategy will be in place in November and will be linked to the overarching ICS strategy which will be published in December.
- The overall focus for the WYMHSC Joint Governor and Non-Executive Director's (NED) event on 22 October, Cloth Hall Court, Leeds was agreed. Feedback from the previous event was taken into consideration ensuring a balance of programme progress and interactive discussions. Discussions will be centred around the programmes 5-year strategy and seek how NED's and Governors can further support collaborative working.

Report completed by:	Name of Chair and date:

Minutes of the

West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C)

held Thursday 3 October 2019, 10.00-12.00 in

Training room 4, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP

Present:

Angela Monaghan (Chair) (AM) – Chair, South West Yorkshire Partnership NHS Foundation Trust
Brent Kilmurray (BK) – Chief Executive Officer, Bradford District Care NHS Foundation Trust
Cathy Elliot (CE) – Chair, Bradford District Care NHS Foundation Trust
Rob Webster (RW) – Chief Executive Officer, South West Yorkshire Partnership NHS Foundation Trust
Sara Munro (SM) – Chief Executive Officer, Leeds & York Partnership NHS Foundation Trust
Sue Proctor (SP) – Chair, Leeds & York Partnership NHS Foundation Trust
Thea Stein (TS) – Chief Executive Officer, Leeds Community Healthcare NHS Trust

In attendance:

Keir Shillaker (KS) – Programme Director, West Yorkshire and Harrogate Health and Care Partnership
Andy Weir (AW) – Deputy Chief Operating Officer, Leeds & York Partnership NHS Foundation Trust
Tom Jackson (TJ) – Clinical lead and Head of Learning Disability Services, South West Yorkshire Partnership NHS Foundation Trust
Lucy Quirk (notes) (LQ) – Programme Support Officer, West Yorkshire and Harrogate Health and Care Partnership

Apologies:

Neil Franklin – Chair, Leeds Community Healthcare NHS Trust

Glossary of acronyms in this document can be found on page 6.

Item	Discussion / Actions	By whom
1	**Introductions:** A Monaghan (AM) welcomed the group and noted apologies as above.	
2	**Declaration of Interests Matrix / Conflict of Interest:** The declaration of interests was reviewed: **ACTION1/10**: L Quirk (LQ) to update Cathy Elliott (CW) and Rob Webster's (RW) declaration of interests.	**LQ**
3a	**Review of Previous Minutes:** **ACTION 2/10**: Private and public minutes to be circulated to the group for future meetings. With the above noted, the notes from the previous meeting held 28 June were accepted as an accurate record.	**LQ**
3b	**Actions log and matters arising:** The actions log had been updated to reflect progress with members discussing the actions below: Action 2/7: The communications plan is in progress and will include the benefits of collaborative working. The finalised strategy will feed into the communications plan. Action 5/3: RW speaking to Claire Murdoch regarding the NHSE investment standard.	
4	**West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) Mental Health, Learning Disabilities and Autism (MHLD&A) Programme update:** K Shillaker (KS) introduced the programme update noting the process underway to report the programme and wider performance metrics in quantifiable measures: • Core system performance supported by Carrie Rae, NHSE to be presented at October's programme board • Development of the programme dashboard with high level indicators linked to the strategy; underpinned by the workstream key indicator metrics identified by the workstream leads. **ACTION 3/10**: Draft programme reporting dashboard to be presented at the next meeting.	**KS**

Item	Discussion / Actions	By whom
	An up to date risk register is now in place, however on the back of feedback from the Collaborative Executive Group a revised quantifiable risk rating to support consistency was presented to the committee for comment and approval. Members supported the proposed risk rating. **ACTION 4/10**: The risk register to be presented at the next meeting. Linked to the risks, members discussed <u>steady state commissioning</u>: • Positive that the 3 new care model (NCM) bids are going ahead however need to ensure the capacity to deliver including the right support from NHSE. • Creation of a virtual team of those with NCM expertise. • NHSE guidance being developed from which key milestones can then be established. • A meeting with Chief Operating Officers and Sean Rayner will be established to look at immediate operational pressures. **ACTION 5/10**: Draft version of NCM/steady state commissioning milestones to be presented at the next meeting. T Stein (TS) gave a brief update on the development of the new Child and Adolescent Mental Health Services (CAMHS) tier 4 unit, noting that planning should go through very soon. • Clinical work taking place involving a wide group of clinicians looking at the model. • Everyone working together incredibly hard, but the business case is challenging. Will go through the treasury process and must be green book compliant. • Papers submitted to LCH and LYPFT boards last month approved enabling work before the business case is signed off. This was agreed due to the low financial risk and to shorten the construction process where possible. • A lot of processes to undertake but the official opening day is 1st September 2021; 15 months behind schedule predominately due to ensuring the clinical model is the right one for West Yorkshire. • Many benefits of partnership working, noting that working collaboratively does take time. **ACTION 6/10**: TS to provide a CAMHS update to a future C-in-C; timing in line with progress and if appropriate include a service user story. **ACTION 7/10**: L Quirk (LQ) to enquire if Woodhouse Hall is available for the next meeting. Members thanked TS for the informative update. KS provided an update on the Out of Area Placement workshop held 19 September which had concluded that a strategic approach will be taken, moving the group's focus from operational issues. Members acknowledged and thanked Jo Butterfield and all those involved in gaining the Community Mental Health funding through a truly collaborative approach and voice.	**KS** **KS** **TS** **LQ**
5	**Business & Strategy: Mental Health, Learning Disabilities & Autism (MHLDA) Programme Strategy** Members had received the excerpt from the Integrated Care System (ICS) partnership strategy and the detailed MHLDA strategy that sits behind that. KS presented at this stage as a sense check to ensure the approach taken is the right one. KS asked members to feedback on areas that required adapting or adding in particular. • The MHLDA strategy will be published but is not a public facing document. However, it should still be a clear read and acronym/jargon free, including a version in easy read. • After feedback from the partnership board a shorter version of the ICS strategy is being created by the core team. **ACTION 9/10**: KS to incorporate the below feedback into the next version of the strategy. • Edit bullet point in box on first page; intend to eliminate people to go outside WY • A clearer sense of what the most important priorities and key principles are. • Mention of primary care networks but could be stronger – integrated care. • Consistency required on what sits in this programme, other programmes and at place.	**KS**

Item	Discussion / Actions	By whom
	• Ambition of having a local service framework to set expectations and standards regarding autism. • Apply principles to three categories of sharing, standardisation and reconfiguration; what are the expected practical changes. • Insert in the strategy re meaningful and sustainable investment being needed. • Use of NHSE analytical staffing tool will help to plan recruitment/ required workforce expansion. • Strong VCS and wider partner voice in the collaborative; celebrate third sector – what we are doing and what our ambitions are. How do we make it easier to know who we can support e.g. police, VCS. • New housing link via the programme board with Sarah Roxby who has already completed great work on mental health and housing. • A better connection between the narrative around children and young people's mental health, self-harm and suicide prevention. Sits separately and could be connected better. • Add a statement on how as a partnership we are really engaging with safeguarding of adults; how we reach out to our partners as well as how we enable our partners e.g. deaths of rough sleepers and the improving population health programme. • Service user voice and coproduction doesn't come through strongly – add more on how this has helped to challenge and shape. **Programme Structure** KS drew members' attention to the proposed workstream and team structures with the positioning of the suicide prevention work being discussed. SM advised that challenges had arisen as the remit of the work stretched outside of the specialist trusts to wider community-based work that crossed over with Public Health. Work is underway to ensure the right areas are being completed and led in the right places; thus, creating equal ownership of the work. **ACTION 10/10**: SM/KS to pick up 'supporting the workplace outside of the NHS' e.g. MH first aiders to private sector with Sarah Smith, improving population health programme as broader MH prevention is one of their priorities. **ACTION 11/10**: Any further comments on the structure to be relayed to KS. Next steps; MHLDA strategy to be finalised by November so that it can be linked to the overarching ICS strategy to be published early December.	**SM/KS** **ALL**
6	**Governor/Non-Executive Director (NED) Event on 22nd October** *Following on from today's strategy discussion – what should the focus for that meeting be?* AM asked members to comment on the focus of the joint NED and governor event on 22 October: • Progress since last meeting; background to agreed workstreams; what not doing; good news stories; making a difference • Strategy must accelerate areas that haven't managed to achieve yet; an understanding of what it means for us as organisations • Steady state commissioning briefing – working together to deliver something better; not merger/privatisation. • CAMHs unit update • Service user stories wherever possible; involve governors/NEDs • Ensure time for discussion – facilitated sessions work best and create energy	
7	**Any other business:** RW asked for feedback from the group ahead of a call with Amanda Pritchard, Chief Operating Officer who is completing a piece of work for the NHS board around what support NHSI gives to the system in winter and how should we engage.	

Item	Discussion / Actions	By whom
	• Biggest challenge for LYPFT is older adults; consistent challenges around delayed transfers of care (DTOC). If there is some way of being able to put pressure on the system for all the partners to unlock the DTOC challenge in older adults this would have significant benefit for LYPFT and the acute trust. • BDCFT face same challenge particularly with the interface with the care home sector • If performance managed mental health DTOC separately to the overall system DTOC rate that would be welcomed. • Fragility of the care home sector. • Sense of their understanding of CQC expectations and consequent impact on our capacity.	
8	**Summary (including actions) and items for escalation:** AM summarised and highlighted the key areas for board feedback: • All taking these minutes through public board with exception of private items. • Developing performance indicators and dashboard; draft to be presented at the next meeting • Approved the risk management framework • Update received on CAMHS unit; valid reasons for the 15 months delay behind original plans, now expecting an opening date of September 2021. • Report on steady state commissioning, developments and progress; draft reporting mechanism to be presented at next meeting. • Agreed the Independent Sector Learning Disability Placements Memorandum of • Programme strategy and programme structure discussed and will undergo further development until ready to feed into the ICS strategy; discussing it in our boards. • NED/Governor event agenda.	
	Date and Time of Next Meeting: Tuesday 21 January 2020, Small Conference Room, Wellbeing and Learning Centre, SWYPFT, Fieldhead Hospital, Ouchthorpe Lane, Wakefield, WF1 3SP.	

Item	Discussion / Actions	By whom

Glossary

ATU	Assessment and Treatment Unit
BDCFT	Bradford District Care Foundation Trust
CQC	Care Quality Commission
CAMHS	Child and Adolescent Mental Health Services
C-In-C	Committees in Common
CCG	Clinical Commissioning Group
DTOC	Delayed Transfers of Care
ICS	Integrated Care System
LD	Learning Disabilities
LCH	Leeds Community Healthcare NHS Trust
LYPFT	Leeds and York Partnership NHS Foundation Trust
MHLDA	Mental Health, Learning Disabilities and Autism
MoU	Memorandum of Understanding
NCM	New Care Model
NED	Non-Executive Director
NHSE/I	National Health Service England / Improvement
SWYPFT	South West Yorkshire Partnership NHS Foundation Trust
TCP	Transforming Care Programme
VCH	Voluntary and Community Sector
WY&H	West Yorkshire & Harrogate
WY&H HCP	West Yorkshire & Harrogate Health and Care Partnership
WY&H ICS	West Yorkshire & Harrogate Integrated Care System (internal reference to WY&H HCP)
WYMHSC C-In-C	West Yorkshire Mental Health Services Collaborative Committees in Common