NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (Public)
Friday 01 May 2020, 8.30am – 09.30am (via Microsoft Teams)

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
8.30	2020-21 (1)	Welcome, introductions and apologies	Neil Franklin	N
	2020-21 (2)	Declarations of interest	Neil Franklin	N
	2020-21 (3)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 27 March 2020 b. Actions' log	 Neil Franklin Neil Franklin	 Y Y
08.35	2020-21 (4)	Innovation at a time of crisis – capturing the good from the COVID-19 response	Thea Stein	Y
		Key issues		
08.45	2020-21 (5)	COVID-19 a. Overview b. Operational changes and issues: including Silver and Gold command c. Clinical issues: including PPE d. Quality: including outcomes, mortality, Mental Health Act Governance and work with Primary Care e. HR and workforce: including health and well-being of staff f. IT and estates: including information governance and equipment	 Thea Stein Sam Prince Steph Lawrence Ruth Burnett Jenny Allen/Laura Smith Bryan Machin	 N Y Y Y Y Y
0910	2020-21 (6)	Governance a. Proposal for holding Board meetings in 'public'	Diane Allison	Y
		Sign off /approval		
09.15	2020-21 (7)	a. Clinical Waste Contract (approved)	Bryan Machin	N
		Information for noting/discussion		
09.20	2020-21 (8)	Performance brief and domain reports a. Performance brief - March 2020	 Bryan Machin	 Y
	2020-21 (9)	Committees' assurance reports: a. Audit Committee: 17 April 2020 b. Quality Committee: April 2020 c. Business Committee: April 2020 (verbal)	 Jane Madeley Ian Lewis Brodie Clark	 Y Y N
	2020-21 (10)	a. Leeds Health and Care System Governance	Thea Stein	Y
	2020-21 (11)	a. Non-Executive Director COVID Communications plan	Thea Stein	Y
	2020-21 (12)	Non-Executive Director briefing notes: a. 2 April 2020 b. 9 April 2020 c. 16 April 2020 d. 23 April 2020	Neil Franklin	 Y Y Y Y
09.30	2020-21 (13)	Close of the public section of the Board	Neil Franklin	N

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2020-21 (4)

Meeting Trust Board Meeting 1 May 2020	**Category of paper** *(please tick one)*	
Report title: Innovation at a Time of Crisis – Capturing the Good from the COVID-19 response	**For approval**	
Responsible director Thea Stein **Report author** Kim Adams, Anna Green and Anne McGee	**For assurance**	
Previously considered by *n/a*	**For information**	✓

EXECUTIVE SUMMARY

Purpose of the report

To update board on the scale and nature of the innovative work that has taken place across the organisation in the last four weeks. Whilst this paper is focused on some of the key initiatives that have been instigated within operational services it is important to acknowledge that all Directorates have risen to the challenge of COVID-19 and have rapidly evolved new ways of working to better support the people of Leeds.

Main issues for consideration

- The Trust has undertaken a significant transformation to prepare for increased demand as a result of COVID-19
- All areas of the business have had to change as a result of this
- Change is being documented to enable us to learn from and sustain this transformation
- Learning will help inform future emergency planning
- Innovative new ways of working will be evaluated and shape future service models, ensuring we do not lose good practice
- New ways of working may need to go through several improvement cycles before becoming business as usual
- Several themes are already beginning to emerge and these have been highlighted in the accompanying report

Recommendations

The Board is recommended to:

- Note the breadth of innovation that has taken place across Leeds Community Healthcare in response to the pandemic
- Note the approach to capturing learning to inform future delivery models

Innovation at a Time of Crisis –
Capturing the Good from the COVID-19 response

Background

In response to the COVID-19 outbreak the Leeds Health and Care system has undertaken a massive transformation. The scale and timeframe for this is unprecedented. Whilst some of these changes will be time limited, some of the new ways of working need to be embedded in the way we deliver services going forward. To support this we are documenting and tracking change. Learning from the good, the challenges and the curve balls. This report provides an overview of some of our initial observations.

Rapid development of Corporate infrastructure to enable COVID-19 response

There has been significant and rapid transformation of the corporate infrastructure to lead and support the organisation through the changes highlighted above. These include:

- Establishment of gold, silver and bronze command structures to enable daily understanding and decision-making structures
- The creation of the Business Logistics Team to coordinate and support the implementation of critical workstreams to enable transformation and keep our staff safe. These include PPE supply and distribution, digital technology support, staff well-being support
- Infection Prevention & Control leadership and advice supporting all aspects of the organisation, with a specific focus on frontline service delivery
- E-Rostering system to enable understanding and drive decision-making about our staff resources
- Rapid mobilisation of IT kit and supporting infrastructure to enable working from home
- Daily communications and briefing across the organisation, supported by COVID-19 intranet
- Establishment of psychological support offer for staff, including a Listening Line, support for leaders and promotion of self-management support through Leeds Mental Well-Being service

Rapid Redeployment

Preparation for COVID-19 commenced with a rapid assessment of all service areas. All services assessed their essential and non-essential work. Services which could be closed or partially closed identified staff that could be redeployed to services which were likely to experience increased demand. Over a three week period:

- Approximately 250 members of staff were identified for redeployment
- Communication took place with patients whose services were impacted by change
- Redeployed staff undertook training, shadowing and induction to new services whilst safely closing work

Redesign

Many frontline services which remain open, together with corporate and support services, have needed to radically redesign the way support is delivered.

The current situation has provided Leeds Sexual Health with the opportunity to turn service delivery on its head, enabling them to test out doing things in drastically different way. The service which has been heavily structured around walk in services has been able to shift focus to other pathways for delivering the service e.g. telephone, postal and clinics.

Children's Speech & Language Service are developing plans to offer online training for parents to support the ongoing therapy for their children.

Re-modelling of approaches to resourcing, induction and training including streamlined induction processes for new starters, Train the trainer approach to training large volumes of staff, and use of on-line / digital training resources.

Digital

The potential for digital solutions, already being used in many areas, has significantly expanded. Digital technology is supporting with triage, clinical consultations, multi-disciplinary working, training and meetings.

CAMHS and MSK have started using technology (AccuRx/Attend Anywhere) for video consultations with patients, and a number of services including Neurology, Adult SLT, ICAN and PHINS 0-19 are in the process of getting set up by the Project Team. Service user and staff feedback will be built in to the evaluation of the project by the Research Team. Initial feelings are that this way of working can offer huge flexibility to support individualised care.

Training: E Learning for Health and other learning platforms being accessed for Statutory & Mandatory training for new starters, enabling access to training during the on-boarding period. Children's Nursing Services have developed training videos for redeployed staff.

Meetings: the majority of meetings across the organisation are now facilitated by MS Teams, enabling people working from home and disparate sites across the city to connect. The adoption of this has been rapid and successful and encompasses large and small meetings – there were 80 people at the last Leader's Network meeting.

Self-Management

Supporting self-management is an important element of patient care, empowering people to take control of their own health. Leeds Community Healthcare has experienced a lot of success with this approach in recent years. Increasing the number of people who are able to self-manage some or all aspects of their condition has also enabled teams to release further capacity to effectively manage additional demand.

Neighbourhood teams have had a number of people self-isolating who have chosen to cancel all visits and rely on family members or self-management of their condition. Staff have worked with them to ensure they are confident in safely managing their own condition.

Commissioning for Outcomes

Leeds Clinical Commissioning Group has been moving towards a model of commissioning for outcomes. This involves being less prescriptive about the services and activity that needs to be delivered. Instead a series of outcomes are defined for the people who are being supported, providing opportunity to be flexible and more personalised in the way services are delivered. Assessing what matters *now*, working with partners and commissioners has seen innovative, practical solutions both within the Trust and across organisations. This has resulted in services which make effective use of resources whilst achieving better outcomes for individuals.

Historically visits to individuals who need a prompt to take medication but have no personal care needs have been the responsibility of health services. For individuals who may have had an established relationship with a care agency this can mean a shift of provider as their care needs improve. For neighbourhood teams this reduces the capacity within the team for other health care visits. A review of community workload involving commissioners and provider partners from across the health and care sector resulted in the transfer of visits for medication prompts to a Third Sector organisation. This frees up capacity within teams but has the potential to enhance the experience for the person in need of support. A third sector organisation can build in additional time for a chat, reducing social isolation and supporting welfare.

Team LCH

The organisation's approach of Team LCH has been fully realised throughout this challenging period. Everyone has pulled together around a common purpose to ensure that we are positioned as well as we can be to support the people of Leeds effectively.

The willingness to be redeployed to services that were most in need was welcomed by many staff but accompanied by understandable nervousness that they may not have the skills and competencies required by their receiving service. Feedback from a recent survey has indicated that for some staff this has been a challenge and in response the level of support for re-deployed staff is being enhanced.

Neighbourhood teams have been ensuring that people are warmly welcomed and up to speed and confident with their duties (following a period of face to face and online clinical training). The arrival of people with different skills and experiences has had unforeseen benefits for clinicians within neighbourhood teams who feel they have already learnt much from podiatrists and therapists accompanying them on induction visits.

Team Leeds

Leeds Community Healthcare has a strong history of partnership working. From sharing expertise on infection control, contributing to a collaborative approach on PPE, to delivering services in partnership there are a wealth of examples of how the Trust is working with partners in this period.

Leeds Community Healthcare have been central to supporting care homes with COVID-19 infection. Staff have volunteered to contribute extra shifts to support homes. Neighbourhood Teams have been leading multi-disciplinary team meetings with care home staff, primary care and pharmacy using digital technology to bring the right people together to support our most vulnerable citizens.

Next Steps

Whilst there has been tremendous progress over the last month, innovative new ways of working continue to emerge. Changes to practice will continue to be tracked, and mechanisms introduced to embed innovations e.g. in Children's Business Unit, each service area has a named innovation champion. Where further change can be made to support current service delivery this will be supported. All change will be captured to help inform future service models, with a focus on evaluation and measurement of outcomes to ensure sustained changes deliver improvements.

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 5b

Report to: Trust Board – 1 May 2020
Report title: COVID-19 Operations Report
Responsible Director: Executive Director of Operations

Managing the Situation

Preparing for and responding the COVID-19 pandemic within Leeds Community Healthcare NHS Trust (LCH) has been managed through command arrangements.

Responsible directors (see appendix A) hold bronze command meetings at appropriate frequency to manage the day to day operational issues associated with their workstreams.

A silver command meeting is held three times weekly to consider the demand and capacity in all critical (C1/C2 – see below) services. The meeting also reviews the staff available for redeployment. The purpose of silver command is to ensure the tactical deployment of available staff to meet patient demand.

These arrangements are supplemented by a three times weekly gold command made up of the Senior Management Team and the Chief Executive of the Leeds GP Confederation.

Individual directors also attend a mix of city wide bronze, silver and gold command system meetings.

Which services are operational?

On 19 March 2020 NHS England and NHS Improvement issued instruction through national gold command arrangements on which services community providers were expected to continue, amend or stop. This instruction mirrored the internal categorisation that LCH already had in place.

Each service has been defined as either Category 1, 2 or 3 depending on whether it fits one or more of the criteria below:

C1 - services to be continued

Suspension of the service would result in immediate risk to the health of a significant number of patients

The service is critical to maintaining patient flow

The service is critical to maintaining core business functions

C2 - services to be reviewed and elements of service to be stopped or amended

Suspension of the service would result in immediate risk to the health of a smaller number of patients

Elements of the service are critical to maintaining patient flow

Elements of the service are critical to maintaining core business functions

C3 - services to be suspended

Suspension of the service would not result in immediate risk to the health of patients

The service is not critical to maintaining patient flow

The service is not critical to maintaining core business functions

All services were asked to review caseloads and identify patients who could be discharged safely, those who would need regular contact or keeping in touch contacts. This has been a huge piece of work for services as they have effectively contacted everyone on their caseload. New ways of working have been introduced with face to face consultations where appropriate becoming the

new norm. This work is now complete.

Redeployment of staff
Approximately 450 clinical and 250 non-clinical staff have been identified for re-deployment. They have participated in core skills training and as appropriate have benefited from shadow shifts and "getting to know you" exercises with their new team.

Business and Logistics
There have been many projects and workstreams required to ensure the safe operation of services (see Appendix A). To support the organisation the Business and Logistics team has been created drawing personnel from the business team, the major change team and other aligned teams with project management experience. This team has supported the whole effort and is a change we intend to continue.

Hospital Discharge Guidance
In March NHS England and NHS Improvement published guidance on how hospital capacity was to be increased in readiness for any potential surge in demand. System leaders from LCH, Leeds Teaching Hospitals, Adults and Health and the third sector have implemented this guidance. This has resulted in the number of patients who were considered Medically Optimised for Discharge (MOFD) but awaiting a package of care in community reducing from around 280 to around 100.

Stress Testing the System Plan
Two exercises are planned for 28 April and 4 May to understand and stress test the plan to manage the impact of COVID-19 on community services (in the widest sense). System partners from primary care, LTHT, public health, hospices, care homes, adults and health, LYPFT etc will participate in this process. The first exercise will look at some early modelling work and aims to gather information and potential requests for mutual aid in the event of a community surge. The second is to run a scenario of surge to stress test the plan.

Resetting and Recovering
Early work has now commenced on resetting and recovering services. A Programme Head will be recruited to support this work which will look at re-establishing services.

Appendix A – Projects and Workstreams

Theme	Project Title	Project Description	Responsible Director
Digital Applications	MS Teams Implementation	MS Teams Implementation	Bryan Machin
Digital Applications	Video Consultation Implementation	Attend Anywhere and accurRx implementation	Bryan Machin
Logistics & Distribution	PPE Secure Storage Process	PPE Secure Storage Process - see also LR039	Bryan Machin
Digital Applications	Phone Guides	Putting together guidance on downloading Apps for work phones for both iPhone and Android	Bryan Machin
IT and Mobile Devices	Redeployed staff hardware	Phones and laptops for: Clinical staff who are redeployed, admin staff who are redeployed and staff WFH (includes LRO09, LR017 and LR019)	Bryan Machin
Digital Applications	Prison Telemedicine Support	Email received detailing information on progress made to date with mobilising prison telemedicine implementation across England in light of the COVID-19 pandemic, and actions required by you or your organisation. Further information is available in the documents attached. Regional NHSE Commissioners are also copied in to this email for information.	Bryan Machin
Digital Applications	ICE Implementation	High level process mapping across Trust - to be the assessed for VFW & ICAN	Bryan Machin
Digital Applications	Point of Care Testing	To be assessed for priority - VFW - linking with LTHT - + Clinical training of appropriate staff	Bryan Machin
Logistics & Distribution	Observation Kits	70 obs kits have been ordered - All going to Senior Ops at Stockdale. To be distributed to the teams. Process required around how these are distributed. Spreadsheet to be created to include Key contact.	Bryan Machin
Logistics & Distribution	Uniform/Scrubs Deployment		Bryan Machin
Finance & Contracting	Contract Review		Bryan Machin
Digital Applications	Digital Forms		Bryan Machin

Multi Agency Projects	Volunteers for Hospital to Home	Volunteers for Hospital to Home project - developing and embedding a new pathway that links to CCV volunteering scheme	Jenny Allen & Laura Smith
Staff Wellbeing	Staff Wellbeing Packs	Wellbeing packs for teams that are working – tea, coffee, milk, hand cream – to keep people hydrated/know that we are thinking of them	Jenny Allen & Laura Smith
Staff Resource	Self Isolation Planning	Collating and aligning people who are self isolating but unable to work with roles that they could support	Jenny Allen & Laura Smith
Staff Wellbeing	Social Distancing	Theme of work from the Wellbeing Staff Survey	Jenny Allen & Laura Smith
Staff Wellbeing	Supplies at bases/Hospitality	Theme of work from the Wellbeing Staff Survey	Jenny Allen & Laura Smith
Staff Wellbeing	Working from home	Theme of work from the Wellbeing Staff Survey	Jenny Allen & Laura Smith
Staff Resource	Recruitment	Support recruitment service with video interviews/Setting process up	Jenny Allen & Laura Smith
Research	COVID-19 R&D hub	All ongoing R&D work has been stood down; available workforce to be redeployed to support new COVID-19 research studies as they come on line, working with partner organisations across the city as required	Ruth Burnett
Outcome Measures	New ways of working: Outcome Measures	As service delivery is re-modelled, appropriate outcome measures need to be developed and monitored to ensure that individual groups are not disproportionally compromised, clinical treatment goals can still be achieved and what new ways of working result in better outcomes than previously, and therefore should be continued as we move to a recovery position	Ruth Burnett
Outcome Measures	Mortality review	Work on mortality review needs to be redesigned to ensure ABU clinicians can focus on care delivery. In addition, work to understand clusters and or excess mortality will contribute to the wider public health learning from COVID-19 (needs to link with research)	Ruth Burnett

Infection, prevention and control	Staff Testing		Ruth Burnett
Staff Resource	Redeployment of clinical staff	Resource planning with business units to redeploy clinical staff from non-essential services	Sam Prince
Multi Agency Projects	Discharge Service	Multiagency work on the discharge service for hospital and community beds	Sam Prince
Staff Resource	Admin Redeployment	Planning and implementation of non-essential admin, non-clinical and corporate staff into essential services	Sam Prince
Resource Oversight & Information	SitRep Support	Someone from logistics team to work with BI and service managers (of essential C1 services only) to sense check the data that is currently going into the report. Support to set up a process for the CBU input to the Silver Command Sit Rep Report	Sam Prince
Resource Oversight & Information	Service position	Mapping what services are still operating/ what's been stood down/ what level of service is left in services still running	Sam Prince
Patient Care	24/7 Phone Support - CAMHS	24/7 phone line for CAMHS	Sam Prince
Patient Care	ICAN Transformation COVID Response	Continue identified transformation and respond to CWOW initiatives	Sam Prince
Resource Oversight & Information	Waiting lists position: RTT and list management	SBU: Map how services are managing their waiting lists and ensure we have one approach across SBU. Link with BI re RTT and what constitutes a clock stop.	Sam Prince
Mental Health	Creation of autism friendly services		Sam Prince
Resetting and Recovery			Sam Prince
Training	Children's Nurses Filming	Filming, developing, coordinating and distributing training for children's nurses	Steph Lawrence
Clinical guidance and policy	ReSPECT	Bringing ReSPECT Project under Business Logistics Support umbrella. To implement a 'light' version of ReSPECT in GPs, LCH services, Hospices and Care Homes, this is in response to COVID-19	Steph Lawrence

Training	CSLT online training and webcasts for parents	Set up online training for parents and practitioners	Steph Lawrence
Patient Care	COVID-19 Report on Active Patients	Review the read codes being saved on SystmOne across the city that are generated from the TPP Covid-19 template	Steph Lawrence
Communication	Interactive Webinar Support	Support Thea and Jenny Allen with interactive webinar	Thea Stein
Patient Care	Supporting vulnerable patients	To undertake a Health Inequalities/ equality impact assessment to assess the impact of the new ways of working on vulnerable patients. To subsequently design some solutions for addressing this	Thea Stein
Patient Care	Therapeutic projects for LWH	Therapeutic project supplies (Gardening, iPads etc.)	Thea Stein
Resource Oversight & Information	Leeds Health Pathways	Identify person responsible to update Leeds Health Pathways	
Clinical Governance	Reporting		
Patient Care	VOT	VOT video consultation/App	

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 5c(i)

Report to: Trust Board 1 May 2020
Report title: COVID-19 Clinical issues
Responsible Director: Executive Director of Nursing and AHP's

Summary

Training and clinical preparation of staff for redeployment:

- Staff have been trained from the services that have been stood down to support the C1 services across the Trust.
- As well as receiving the required training they have also had shadow shifts and support in the teams until they feel confident to practice independently.
- Aspirant nurses have now joined the Trust – 6 from Leeds Beckett University and 12 more from University of Leeds. These are student nurses in the last 6 months of their training who will be joining us as Band 4 aspirant nurses to support the clinical response to Covid-19. A number of them are due to join the Trust as registered nurses in September 2020.

Nightingale Hospital:

- Staff identified as requested from LCH – 6 staff in total, they have been inducted by the Nightingale and will be ready to be redeployed there should the need arise. They have come from different services across LCH.

Care Homes:

- A number of teams are providing significant support to care homes and in particular; Seacroft, Beeston, Morley, Kippax and Pudsey. The support is particularly LCH staff going into care homes to provide patient specific advice but also to support care staff. This sometimes involves spending a whole shift in the care home.
- The support to care homes is across both those with and without nursing.
- A bronze control group is now established and the Director of Nursing and lead for IPC are members on this group.
- The LCH IPC Team are supporting care homes across the city with advice around IPC practice and use of PPE etc. They have also done FIT testing for staff and swabbing for residents suspected of having Covid-19.

Implementation of new pathways/Guidance:

- Review of Community Services SOP issued nationally and how this could work for our teams. We are developing a set of principles based on this and then each team will operationalise as per their service. For an example, this is how we will separate visiting patients with suspect Covis-19 from those for example, who are shielding.
- Frailty pathway launched in LCH and our teams supporting patients who choose to stay at home either due to being end of life or not wanting acute hospital admission. Supported by Community Matrons and Community Geriatricians.
- Work has commenced around rehabilitation pathways for patients recovering from Covid-19, it is being led by commissioners and with a number of our clinical staff both AHP's and nurses involved to ensure an MDT approach to rehab.

General

- A weekly clinical drop in session to be set up led by Director of Nursing for clinical staff to raise concerns/ask questions via MS Teams.

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 5c (ii)

Report to: Trust Board 1 May 2020
Report title: COVID-19 PPE Report
Responsible Director: Executive Director of Finance and Executive Director of Nursing and AHP's.

Summary

This report considers PPE (Personal Protection Equipment) from two perspectives, logistics and clinical usage.

PPE Logistics (Point of Origin to Point of Distribution)

The Trust is working within a system that has been established nationally to "push" stock to all Trusts on an algorithm based on assessed need and previous usage. Initially this did not serve LCH well and led to an almost daily need to escalate potential and actual shortages.

Whilst the position has improved it is still not sensitive enough to LCH's requirements which means we are still escalating the risk of running out of items; obtaining sufficient supplies of hand sanitiser has been a consistent theme. We are receiving items we do not need but we have ensured that such items are made available to local partners who do. Equally, local partners have made their excess stock available to LCH.

As the Board is aware, the national availability of PPE items has been variable with acute shortages of some items and problems with distribution of some items that were available.

Given the risk of running out of items the Trust joined with health and social care partners across Leeds and Bradford to directly order a shipment of PPE from China. As of 26 April this supply has not yet materialised and is well overdue.

The Trust has received large and small donations of PPE from companies, voluntary groups and national crowdfunded groups. These have been welcomed and acknowledged. The Trust has had to reject some offers where the quality of the items offered does not meet our requirements.

In the unprecedented circumstances we found ourselves, the Trust was initially unable to assess how much of the range of PPE items it actually needed in each service. No supply management system existed, teams ordered items like gloves and aprons when they needed them with no problems. We had no knowledge of what PPE already existed at each team base, nor how much was used over any given period.

Significant progress has been made to create a stock ordering, management and supply to teams system. A Trust team was created comprising staff from Infection Prevention and Control, Clinical teams, procurement, supplies and managers with no previous experience in this area. This team has worked closely with an enhanced supplies team at LYPFT, with whom we have a longstanding SLA. Whilst still in need of refinement we have now developed a model that has identified how many of each PPE item each team is likely to need to maintain a local base stock of typically 7 day usage. The local base stock is topped up once or twice a week as part of a regular distribution. This information is now being used to inform the national system of our requirements

and there are early signs that this is beginning to influence the national push stock that we are receiving into our central warehouse. In the event that any team needs to requisition additional items, an emergency distribution system remains in place.

Regionally, health organisations across the West Yorkshire and Harrogate ICS have begun to work together to seek out alternative supplies to the national “push” stock system and to have a single point of quality assurance for supplies that may be available from non-conventional sources.

Overall, the national availability of PPE remains a high risk but excellent progress has been made within LCH, with the support of colleagues at LYPFT, to develop systems, processes and a central stock that mitigates that risk as far as we are able.

PPE (clinical)

There are discrepancies with PPE advice and guidance from the evidence based information from PHE that we are being advised to follow and that issued by professional bodies and for example, the resus council.

The discrepancies are around what is classed as an Aerosol Generating Procedure (AGP) and it is difficult at times as LCH are following the PHE guidance as advised and as per the evidence base but some partners are following other guidance e.g. from professional bodies. This can cause anxiety and confusion for our staff that are working in integrated teams and across pathways.

The IPC team continue to support staff and teams in correct use of PPE including where to don and doff PPE when working in patients homes in the absence of national guidance on this and this includes disposal of waste safely.

FIT testing for staff requiring FFP3 masks continues where teams are undertaking AGP’s and this is being facilitated by the IPC team and staff in other services that are currently stepped down.

There have been some issues with use of PPE in custodial settings where the advice we are following is at odds with the advice the prison have been given. We continue to work through these issues and concerns.

There is regular information in the lunchtime briefs for staff around the latest PPE guidance.

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Agenda item 2020-21 (5d)

Report to: Trust Board 1st May 2020
Report title: COVID-19 Quality Report
Responsible Director: Executive Medical Director

Summary

Review of incidents, complaints and deaths continues as normal, with a particular focus on staff redeployment, new pathways for care delivery to ensure early identification of any related rise in patient care issues or risk. Of note:

- There has been a significant rise in serious incidents reported via STEIS with 7 in February and 18 reported in March. There is more detail in the performance brief in relation to this. The March incidents are yet to undergo full review and therefore it is possible some of these could be de-logged as serious incidents. However, there is a piece of work underway to analyse this further and look at any emerging themes and trends which will included looking at whether there are any clusters in certain teams. Further detail will be provided as this is available.
- No change from expected mortality figures in March, but early analysis of April data suggests marked increase on expected for the month. Work underway to ensure data set for April allows analysis of care homes, shielded patient caseload, ethnicity and end of life care.

The clinical outcomes program has been adjusted in order to focus the key workstreams on Covid-related changes to practice: alternative models of wound care, videoconferencing contact with patients, mortality and health inequalities. We are linked in with regional and national work looking at clinical outcome measures, and with regional and national Covid19 research.

Medicines management pathways to support new ways of working as being closely monitored, logged appropriately on the risk register, and reviewed in conjunction with the incident data for the associated services. Covid19 NICE guidance released is being reviewed with relevant services as applicable.

In line with national guidance issued at the end of March, processes relating to Quality Challenge +, Friends & Family Test, routine NICE guidance work, library services have been paused to allow focus on Covid-related priorities.

The Quality Assurance & Improvement Group met in shadow form on 23rd April, and the proposed TOR were approved by Quality Committee on 27th April. QA&IG will continue to meet monthly to review key data and developments related to the impact of Covid19 and delivering care during these times.

The MHA Governance Group met on 20th March, with Helen Thomson as new Chair and new administrative support for the minutes provided by LYPFT. The revised TOR were approved by Quality Committee on 27th April and the improvement in quality of the minutes was also noted.

Work with primary care is coordinated with mutual attendance at Silver Command meetings. A joint daily sitrep for neighbourhood teams and PCNs has been developed and is shared at both.

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Agenda item 2020-21 (5e)

Report to: Trust Board 1 May 2020

Report title: COVID-19 Workforce Report

Responsible Director: Director of Workforce

Summary

This short paper provides and update for the Board on key workforce themes and actions undertaken to date as part of the LCH COVID-19 pandemic response.

1. *Absence Recording and Reporting:*

- Staff absence is recorded and reported upon daily a day in arrears – please see attached the report for Tuesday 28th April;
- Overall absence has been consistently reported at similar rates with the organisation seeing a 2%-2.5% COVID-19 related absence rate i.e. people who have or believe they are ill with the virus; this figure is higher in the ABU;
- Within the region and nationally, COVID-19 related absence equates to more than 50% of overall sickness absence – at LCH this accounts for approximately one third of our overall sickness absence;
- Our overall levels of absence are lower than those reported nationally. Our capacity is manageable at the moment;
- We commenced staff testing over two weeks ago. 190 staff have been referred for testing since 9 April. With the arrival of a national online booking system, staff are now able to self-refer for testing.

2. *Health and Well-being of Staff:*

- It is widely recognised nationally, regionally and in LCH that the emotional and psychological impact on staff in managing through a global pandemic will be significant;
- The national offer to staff including counselling, access to various well-being apps, psychological support and helplines for issues including bereavement has been well published to staff;
- Additionally our local offer includes Occupational Health services, access to our Employee Assistance Programme (EAP) and the commencement of a listening and support service run primarily by our OD and I team. To date a small number of staff (5) have accessed the listening & support service.
- The Trust is also working with leaders and managers to develop a specific leadership and management offer of support through this crisis. The OD&I team are specifically working with this cohort to understand their learning & support needs;
- A survey was recently carried out with staff on health and well-being; there were over 170 respondents and much extremely positive feedback on the support and communications that the Trust is offering to staff at this time;
- Other themes from this survey included the need to do some further work on supporting our staff working from home, social distancing and supporting more groups in terms of further supplies of food and drinks through working hours. A project management team has been identified to take these themes forward.

3. Resourcing:

- As the Board are aware many C2 and C3 services have been paused in this period and as a result we have been redeploying a significant number of staff.
- To support this redeployment, training programmes have been developed and delivered for statutory and mandatory training required. Of 250 individuals identified for clinical redeployment, 190 have received training in core subjects including Falls Preventions, Medicines Administration and Basic Observations & Vital Signs, along with a range of other introduction support.
- Additionally, we have been on a recruitment drive sourcing new staff from a variety of channels including the national Bring Back Staff (BBS) campaign, student nurses joining the national register early as aspirant nurses and generally recruiting to our internal Bank;
- To date, the numbers joining the Trust are 7 BBS returners, 18 student nurses from Leeds Beckett and Leeds University and 16 new staff joining our Bank from our own recruitment campaign. Almost 90 existing LCH staff and recent leavers have also offered additional hours to the Trust on a bank basis
- To support the introduction of new staff into the organisation, two induction programmes have been run on day one for staff with 13 new starters and 18 students having attended these to date;

4. Terms and Conditions / Working with our TU Colleagues:

- A weekly call takes place between the Director of Workforce and the Staff Side Chair, to discuss live and anticipated employment-related issues; the Chair of the JNC is also invited to this call;
- A temporary approach for making temporary changes to employment policies has been agreed with Staff Side colleagues, through which changes like the recent extension of the maximum paid period of Carer Leave (from 1 week to 2 weeks) can be rapidly discussed and approved. This approach and any changes agreed through it will be in place until 30 June 2020 in the first instance;
- The HR team is working with managers to support staff who find themselves in a range of challenging situations linked to caring commitments and ability to carry out substantive or alternative work from home. All available flexibility and discretion within our terms & conditions and policies can be used in support of staff and services;
- All of our internal discussions are underpinned by the twice weekly updates that are arriving from NHS Employers on terms and conditions – all of the information disseminated from national colleagues is reviewed, actioned, discussed as required and then implemented locally.
- The Workforce team is regularly contributing to the growing bank of FAQs managed by our Communications colleagues and kept on our dedicated COVID-19 intranet pages;

5. Staff Engagement and Morale:

- We are relatively confident that the morale of staff remains good throughout this pandemic; staff are understandably anxious about their own health and that of their families, particularly those staff working on the front line with COVID patients but we are doing all that we can to support those staff;
- Indicators of positive morale include regular check ins on this with TU colleagues, comparatively low absence levels, continued trend of low numbers of employee relations cases and the feedback received in the health and well-being survey referenced above;
- We are working closely with our disability and particularly BME network given their understandable concern regarding the reported impact of COVID-19 in BME communities and amongst BME health and care staff. This is now the subject of a national inquiry.
- Weekly Chief Executive-led check ins have been set up through Microsoft Teams with the Leaders Network which are really well attended: +75 last week;

Jenny Allen & Laura Smith, 28 April 2020

Leeds Community Healthcare NHS Trust

Employee Absences by Business Unit

The number of employees absent by day, overall and by each Business Unit

Data up to 27/04/2020

Please note:

- This data has been produced using data within both ESR and HealthRoster (eRostering system), it is transformed and blended to produce a consistent output. This data will reflect what is input into the system only.
- Data is extracted from our systems at 09:00 each morning (including weekends), and reports on the previous day. Reports will be updated by 10:00 each day.
- Unlike traditional workforce data, this dataset is counting heads and not fte.
- Other Leave includes: Other Authorised Absence - Unpaid, Time Owing, Compassionate Leave - Non-Immediate Family, Bereavement Leave - Paid, Suspended - Paid Other Leave - Paid
- Where we have multiple absences on the same day, for different reasons, by default we have used the HealthRoster record and excluded all other absences. The data will not be 100% accurate and if more accuracy is required then the source data should be interrogated.
- There are other known issues with the data, which we are working on to mitigate or correct.
- The headcount and sickness absence excludes bank staff.

Organisation Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3163	Count	% of 3163
Annual Leave	77	2.5%	78	2.5%	90	2.9%	121	3.9%	33	1.1%	36	1.1%	95	3.0%
Maternity	69	2.2%	68	2.2%	68	2.2%	68	2.2%	68	2.2%	68	2.1%	68	2.1%
Other Leave	9	0.3%	10	0.3%	8	0.3%	7	0.2%	5	0.2%	5	0.2%	9	0.3%
Self Isolation- Unable to Work from Home	88	2.8%	90	2.9%	87	2.8%	81	2.6%	80	2.6%	79	2.5%	74	2.3%
Sickness due to Covid-19	61	1.9%	63	2.0%	73	2.3%	74	2.4%	75	2.4%	74	2.3%	67	2.1%
Sickness due to other cause (long term)	88	2.8%	90	2.9%	90	2.9%	90	2.9%	88	2.8%	88	2.8%	89	2.8%
Sickness due to other cause (short term)	43	1.4%	39	1.2%	41	1.3%	44	1.4%	44	1.4%	44	1.4%	49	1.5%
Special Leave	39	1.2%	34	1.1%	31	1.0%	29	0.9%	26	0.8%	26	0.8%	31	1.0%
Total	**474**	**15.1%**	**472**	**15.0%**	**488**	**15.6%**	**514**	**16.4%**	**419**	**13.4%**	**420**	**13.3%**	**482**	**15.2%**

Organisation Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3137	Count	% of 3163	Count	% of 3163
Self Isolation- Working from Home	160	5.1%	167	5.3%	164	5.2%	161	5.1%	162	5.2%	163	5.2%	157	5.0%
Total	**160**	**5.1%**	**167**	**5.3%**	**164**	**5.2%**	**161**	**5.1%**	**162**	**5.2%**	**163**	**5.2%**	**157**	**5.0%**

Adult Business unit Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 1002	Count	% of 1002
Annual Leave	38	3.8%	38	3.8%	45	4.5%	50	5.0%	22	2.2%	22	2.2%	38	3.8%
Maternity	32	3.2%	32	3.2%	32	3.2%	32	3.2%	32	3.2%	32	3.2%	31	3.1%
Other Leave	8	0.8%	10	1.0%	8	0.8%	6	0.6%	4	0.4%	5	0.5%	9	0.9%
Self Isolation- Unable to Work from Home	37	3.7%	39	3.9%	37	3.7%	30	3.0%	29	2.9%	28	2.8%	26	2.6%
Sickness due to Covid-19	30	3.0%	30	3.0%	40	4.0%	43	4.3%	45	4.5%	44	4.4%	35	3.5%
Sickness due to other cause (long term)	36	3.6%	36	3.6%	37	3.7%	38	3.8%	37	3.7%	37	3.7%	38	3.8%
Sickness due to other cause (short term)	18	1.8%	16	1.6%	17	1.7%	17	1.7%	16	1.6%	16	1.6%	19	1.9%
Special Leave	13	1.3%	13	1.3%	9	0.9%	10	1.0%	9	0.9%	9	0.9%	9	0.9%
Total	**212**	**21.2%**	**214**	**21.4%**	**225**	**22.5%**	**226**	**22.6%**	**194**	**19.4%**	**193**	**19.3%**	**205**	**20.5%**

Adult Business unit Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 999	Count	% of 1002	Count	% of 1002
Self Isolation- Working from Home	61	6.1%	67	6.7%	63	6.3%	65	6.5%	65	6.5%	65	6.5%	59	5.9%
Total	**61**	**6.1%**	**67**	**6.7%**	**63**	**6.3%**	**65**	**6.5%**	**65**	**6.5%**	**65**	**6.5%**	**59**	**5.9%**

Specialist Business Unit Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 826	Count	% of 826
Annual Leave	22	2.7%	18	2.2%	21	2.5%	27	3.3%	6	0.7%	9	1.1%	25	3.0%
Maternity	15	1.8%	15	1.8%	15	1.8%	15	1.8%	15	1.8%	15	1.8%	16	1.9%
Other Leave		0.0%		0.0%		0.0%	1	0.1%	1	0.1%		0.0%		0.0%
Self Isolation- Unable to Work from Home	29	3.5%	29	3.5%	29	3.5%	30	3.6%	30	3.6%	30	3.6%	28	3.4%
Sickness due to Covid-19	16	1.9%	17	2.1%	19	2.3%	17	2.1%	16	1.9%	16	1.9%	18	2.2%
Sickness due to other cause (long term)	19	2.3%	20	2.4%	20	2.4%	21	2.5%	21	2.5%	21	2.5%	19	2.3%
Sickness due to other cause (short term)	9	1.1%	8	1.0%	8	1.0%	9	1.1%	10	1.2%	10	1.2%	14	1.7%
Special Leave	13	1.6%	11	1.3%	11	1.3%	10	1.2%	9	1.1%	9	1.1%	8	1.0%
Total	**123**	**14.9%**	**118**	**14.3%**	**123**	**14.9%**	**130**	**15.8%**	**108**	**13.1%**	**110**	**13.3%**	**128**	**15.5%**

Specialist Business Unit Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 826	Count	% of 826
Self Isolation- Working from Home	40	4.8%	40	4.8%	37	4.5%	35	4.2%	37	4.5%	37	4.5%	38	4.6%
Total	**40**	**4.8%**	**40**	**4.8%**	**37**	**4.5%**	**35**	**4.2%**	**37**	**4.5%**	**37**	**4.5%**	**38**	**4.6%**

Children's Business Unit Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 882	Count	% of 882
Annual Leave	13	1.5%	18	2.1%	16	1.8%	31	3.5%	5	0.6%	5	0.6%	21	2.4%
Maternity	18	2.1%	17	1.9%	17	1.9%	17	1.9%	17	1.9%	17	1.9%	17	1.9%
Other Leave	1	0.1%		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%
Self Isolation- Unable to Work from Home	10	1.1%	10	1.1%	10	1.1%	10	1.1%	10	1.1%	10	1.1%	10	1.1%
Sickness due to Covid-19	11	1.3%	12	1.4%	11	1.3%	11	1.3%	11	1.3%	11	1.2%	10	1.1%
Sickness due to other cause (long term)	25	2.9%	26	3.0%	25	2.9%	23	2.6%	22	2.5%	22	2.5%	25	2.8%
Sickness due to other cause (short term)	15	1.7%	13	1.5%	14	1.6%	15	1.7%	15	1.7%	15	1.7%	12	1.4%
Special Leave	12	1.4%	9	1.0%	10	1.1%	8	0.9%	7	0.8%	7	0.8%	10	1.1%
Total	**105**	**12.0%**	**105**	**12.0%**	**103**	**11.8%**	**115**	**13.1%**	**87**	**9.9%**	**87**	**9.9%**	**105**	**11.9%**

Children's Business Unit Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 875	Count	% of 882	Count	% of 882
Self Isolation- Working from Home	41	4.7%	42	4.8%	45	5.1%	41	4.7%	41	4.7%	41	4.6%	41	4.6%
Total	**41**	**4.7%**	**42**	**4.8%**	**45**	**5.1%**	**41**	**4.7%**	**41**	**4.7%**	**41**	**4.6%**	**41**	**4.6%**

Operations Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215
Annual Leave		0.0%	1	0.5%	3	1.4%	5	2.3%		0.0%		0.0%	7	3.3%
Self Isolation- Unable to Work from Home	12	5.6%	12	5.6%	11	5.1%	11	5.1%	11	5.1%	11	5.1%	10	4.7%
Sickness due to Covid-19	4	1.9%	4	1.9%	3	1.4%	3	1.4%	3	1.4%	3	1.4%	2	0.9%
Sickness due to other cause (long term)	5	2.3%	5	2.3%	5	2.3%	5	2.3%	5	2.3%	5	2.3%	4	1.9%
Sickness due to other cause (short term)	1	0.5%	1	0.5%	1	0.5%	2	0.9%	2	0.9%	2	0.9%	3	1.4%
Special Leave	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	3	1.4%
Total	**23**	**10.7%**	**24**	**11.2%**	**24**	**11.2%**	**27**	**12.6%**	**22**	**10.2%**	**22**	**10.2%**	**29**	**13.5%**

Operations Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215	Count	% of 215
Self Isolation- Working from Home	12	5.6%	12	5.6%	13	6.0%	13	6.0%	13	6.0%	14	6.5%	13	6.0%
Total	**12**	**5.6%**	**12**	**5.6%**	**13**	**6.0%**	**13**	**6.0%**	**13**	**6.0%**	**14**	**6.5%**	**13**	**6.0%**

Corporate Directorate Absence Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 211	Count	% of 211
Annual Leave	4	2.0%	3	1.5%	5	2.5%	8	4.0%		0.0%		0.0%	4	1.9%
Maternity	4	2.0%	4	2.0%	4	2.0%	4	2.0%	4	2.0%	4	1.9%	4	1.9%
Sickness due to Covid-19		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%	2	0.9%
Sickness due to other cause (long term)	3	1.5%	3	1.5%	3	1.5%	3	1.5%	3	1.5%	3	1.4%	3	1.4%
Sickness due to other cause (short term)		0.0%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%
Special Leave		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%	1	0.5%
Total	**11**	**5.6%**	**11**	**5.6%**	**13**	**6.6%**	**16**	**8.1%**	**8**	**4.0%**	**8**	**3.8%**	**15**	**7.1%**

Corporate Directorate Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 198	Count	% of 211	Count	% of 211
Self Isolation- Working from Home	4	2.0%	4	2.0%	4	2.0%	5	2.5%	4	2.0%	4	1.9%	4	1.9%
Total	**4**	**2.0%**	**4**	**2.0%**	**4**	**2.0%**	**5**	**2.5%**	**4**	**2.0%**	**4**	**1.9%**	**4**	**1.9%**

PCN Business Unit Working From Home Summary	21/04/2020		22/04/2020		23/04/2020		24/04/2020		25/04/2020		26/04/2020		27/04/2020	
Status	Count	% of 11	Count	% of 11	Count	% of 11	Count	% of 11	Count	% of 11	Count	% of 13	Count	% of 13
Self Isolation- Working from Home	2	18.2%	2	18.2%	2	18.2%	2	18.2%	2	18.2%	2	15.4%	2	15.4%
Total	**2**	**18.2%**	**2**	**18.2%**	**2**	**18.2%**	**2**	**18.2%**	**2**	**18.2%**	**2**	**15.4%**	**2**	**15.4%**

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (5f)

Report to: Trust Board 1 May 2020
Report title: COVID-19 IT, Estates and Facilities Report
Responsible Director: Executive Director of Finance and Resources

Summary

Information Technology

- Additional remote access capability has been built and rolled out.
- Additional laptops purchased, obtained from national stock or repurposed internally and configured for roll out for redeployed staff and to enable home working
- Mobile phones purchased and rolled out for same
- Video consultation capability developed. 'Attendanywhere' configured for Leeds Mental Wellbeing Service, Community Neurology, Speech adnd Swallowing. Public Health Integrated Nursing, Integrated Children's Service, Health Case Management, End of Life and Podiatry being scoped for set up. Information guides for this and accuRx developed.
- Information Governance consequences of this and many aspects of the NHS Covid-19 response are significant; the IG team are advising on all aspects of the work and assessing and dissemination of amendments to national regulations
- Microsoft Teams has become the default NHS virtual meeting software; information guides written, training and support provided to new users. LCH now has over 150 'teams' set up. Continued roll out to Neighbourhood Teams

The scale and speed of change required of the IT team and the staff who have rolled out the new technology solutions has been met by a fantastic response. Consideration continues to be given to the resilience of the IT infrastructure and the support that is needed for the new solutions and ways of working.

Estates and Facilities

- Reconfiguration of some buildings to enable 'hot' and 'cold' community and primary care sites

The response to the changing ways in which primary care and our community services have needed to work has led to the initiation of early thinking about how the Trust and Primary Care Networks should proceed with estate planning across the city, with recognition of the need for even more integrated working than our recently approved Estate Strategy envisaged. There will also be implications for the planning of a replacement for Stockdale House.

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AGENDA ITEM 2020-21 (9b)

Report to: Trust Board
Report title: Quality Committee 27 April 2020: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Assistant Director of Nursing
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 27 April 2020 and indicates the level of assurance based on the evidence received by the Committee where applicable. Given the national context of Covid-19 at the point of the meeting the April meeting took place via MS Teams with reduced membership.

COVID-19 update incorporating business continuity
The Executive Director of Nursing and Executive Medical Director provided an update on the current position. This confirmed that command and control arrangements continue; now incorporating a daily SITREP report for LCH and Primary Care Networks (PCNs). Whilst referral activity in to LCH remains reduced at present, Neighbourhood Teams are seeing an increase in end of life care specifically in Care Homes. Additional command and control meetings for Care Homes and PPE have been established and have LCH representation.
The risk management of our caseloads is being reviewed in line with the National Standard Operating Procedure (SOP) for community services to ensure care is delivered in the most appropriate way to support both staff and patients. The older person with frailty pathway has also been implemented across the city and is delivering a more co-ordinated approach to provide enhanced care at home to those people in Leeds who request an alternative to hospital admission for COVID-19. The addition of a Leeds 7 day geriatrician advice line is felt to be enhancing this. Ongoing work regarding the recovery of some services is now taking place, and priorities are being co-ordinated with the city priorities. Work has also commenced on the rehabilitation pathway to support recovery of our patients from Covid-19.
LCH have identified staff to be released to support the Harrogate Nightingale Hospital if this is required.

Draft terms of reference for Quality Assurance and Improvement Group (QAIG)
The Executive Medical Director provided a comprehensive reflection of the shadow QAIG that took place last week with the merger of the three previous sub-groups (CEG, PSEGG, Mortality review). The draft terms of reference reflect the same functions as the three previous sub-groups. The Committee were happy to approve the terms of reference. A review of the group effectiveness will be undertaken in October 2020.

Internal audit report Patients Safety Experience Governance Group (PSEGG) – Reasonable assurance
The internal audit report of PSEGG was noted as reasonable assurance and the audit findings support the move to the revised QAIG. It was noted that the actions identified within the internal audit report will be embedded within the new QAIG.

Mental Health Act Governance Group
Non-Executive Director (HT) gave feedback on the last meeting, which was her first meeting as chair of the MHA Governance Group. She acknowledged the support from LYPFT. The next meeting is scheduled for June and whilst the group recognise there is further development work to do, this meeting is progressing positively. The terms of reference and work plan for this group were approved by Quality Committee members.

Quality Committee work plan

It was acknowledged that the following items were not discussed as per work plan due to COVID-19:

- Quality account ceased as per national direction
- CCG Clinical Quality Review Group meeting minutes not received as meeting cancelled

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2020-21 (12d)

Leeds Community Healthcare NHS Trust
NEDs COVID Update Briefing Meeting
23 April 2020

Present: Thea Stein(TS), Neil Franklin (NF), Brodie Clark (BC), Jane Madeley (JM), Richard Gladman (RG), Ian Lewis (IL) and Helen Thomson (HT)

Note Taker: Liz Thornton
Apologies:
In Attendance: N/A

Item	Discussion Points	Action
1.	**Clinical** • **PPE** ➢ A stock control system has been established with a Project Manager in place with central store at LYPFT. The 'push supply' process was working well and the vast majority of front line services and teams received a delivery of COVID19 related PPE 'push stock' at the end of last week which was based on the information gathered about current stock levels and minimum requirements. ➢ Some items were in short supply nationally such as the Clinell universal wipes and long sleeved aprons/gowns. The Trust's requirements for these have been escalated. Concerns had been raised about a batch of aprons which were thinner than usual- this had been addressed. ➢ A Leaders Network event had been held via MST earlier in the day attended by approximately 80 members of staff. No concerns had been raised about PPE and all staff reported that they felt well supported by the Trust. ➢ A city wide mutual aid scheme was in place to supply PPE if stocks permitted. ➢ A copy of the Trust's response to a request for information from the regional branch of Unison in relation to PPE had been circulated and was noted (attached at Annex1). **Questions** In response to a question from NF, TS responded that as far as she was aware the requirement for PPE in care homes was identical to that in a community setting. Good work continued across the city to ensure that care homes were part of the supply chain and received the PPE they needed. This system was being co-ordinated by the Council and LCH staff were aware of the process to tell Care home staff if asked.	
2.	**HR and people issues** • **Staff absence figures** ➢ The latest figures (up to 21 April 2020) had been circulated and were noted. ➢ Across all business units and corporate services some staff were identified as self-isolating but unable to work from home. Work was underway to assess whether there was any meaningful work which they go do from home. ➢ Annual leave figures were down by around 4% in the Trust from the benchmark at this time of year (7-8%). Staff were being encouraged to take time off – maybe long weekends or a day in the middle of the week or whole weeks. ➢ Ideally annual leave levels should return to between 7 and 8% in the coming	

	weeks as this is a key sign that the organisation was taking care of itself, listening and doing what was needed to do to prepare for significant changes post pandemic and the long term change of pace and of working. ➢ The Trust's annual leave policy had not been changed and it was unlikely the NHS nationally would allow significant amounts of leave to be carried over at the end of the year. Service pressures would increase when lockdown was over and increased applications for annual leave would be difficult to manage. This is therefore being monitored and discussed - further national guidance was being sought. • **Testing** ➢ Staff testing was working well and the Trust continued to refer staff each day. ➢ The Trust had been invited to join a pilot to test 500 individuals in the community (patients and staff) who were asymptomatic – more details would be available in due course. **Post meeting note: The Trust was unsuccessful in being part of this scheme so this is not going ahead.** **Questions** RG asked whether staff were finding it difficult to access the testing site in Leeds and whether any data was available on the results. In response TS said that a small number of staff had reported difficulties in travelling to the site but overall this did not seem to be a problem. In terms of data no precise information was available at the current time but TS was hopeful that she would be able to share some meaningful data soon. This was because the central service was not making the data available and the Trust was unaware how many people had turned up to appointments or the overall outcomes. BC referred to the support for staff health and wellbeing and asked whether the trade unions were supporting the push to encourage staff to take annual leave. TS responded that the partnership work with the unions was very positive and constructive including issues around encouraging the uptake of annual leave. JM observed that business legislation had been changed to say where it is "not reasonably practicable" for a worker to take some or all of their statutory leave entitlement as a result of the effects of Covid19, the worker is entitled to carry forward such untaken leave into the next two leave years and she wondered whether this impacted on the national agreements in the NHS. TS agreed to check with the Director of Workforce. In response to a question from IL about the Trust's involvement in the pilot, TS said that the precise details of who would be covered were not clear and the Trust was waiting for more detail including whether it would also cover care homes.	TS
3.	**Care homes** ➢ Integrated support was being provided across the city - social care, primary care and LCH. ➢ City wide Bronze Command had been established to support the response in care homes. ➢ IPC work in relation to care homes would look at two areas initially: o Patients discharged without testing o Evidence which suggested that infections began to spread in dementia units ➢ LCH recovery hubs - a cluster of patients had tested positive in both units. Both were currently run at half capacity. As patients had not been referred not because it was closed.	

	Questions HT asked about the legal position of LCH staff working in care homes and indemnity issues. TS responded that LCH staff were not working under the direction of the care home and support was provided as an enhanced element of the offer from the Neighbourhood Teams. BC asked if any work had been done to assess how many staff might be needed to work in care homes over the coming weeks. TS said that the curve of patients in care homes was rising steeply but no clear modelling was available. RG asked about the support in place for LCH staff who were working in care homes. TS responded that additional support had been put in place including 1:1 debriefs at the end of shifts. She added that she was confident that staff across the Trust were being supported well. The results from a recent staff survey about health and wellbeing had been very positive with a good response rate.	
4.	**Modelling and rehabilitation** ➢ Beginning to model Covid19 health and care recovery – initially around the recovery of patients who have been in ICU including those on ventilators. ➢ A separate post Covid19 rehabilitation service would not be set up – this would form part of an enhanced integrated Neighbourhood Team offer. ➢ Guidance has been developed in partnership with geriatricians to support the clinical management for frail older people affected by COVID-19 (either confirmed or clinically probable) to be cared for in their home (including care homes). Based upon the Leeds Breathlessness Pathway - Primary Care Colleagues are also developing guidance. **Questions** IL asked if there was any data emerging about the numbers of patients who would require rehabilitation in the community and whether in the main this would be the elderly. TS said that currently the numbers were small but this was expected to rise significantly and would include the elderly and working age populations. More detailed information would be provided when it became available.	
5.	**Re-setting the business** ➢ Discussions beginning in SMT and also raised at Leadership Network with a positive response. ➢ A programme of work would be established to specifically manage re-set and recovery – led at a senior level and reporting to the Executive Director of Operations. An internal job advert would be posted shortly for a fixed term post of 4-6 months. The SMT would be designated as the Re-set and Recovery Programme Board to provide assurance to the Board. **Questions/observations** BC welcomed this as an important initial step in ensuring that lessons were learnt from managing the pandemic and how these might impact on managing service delivery in the future and continuing the partnership working with other organisations across the city would be essential to this.	
5.	• **Supporting BAME staff** ➢ A conversation has begun with BAME staff about the impact of Covid19 on BAME communities and health care staff. ➢ The first virtual meeting of the BAME network is scheduled for 29 April 2020 – 55 individuals have already expressed a wish to attend. ➢ TS had also spoken to Yvonne Coghill, Director WRES Implementation at NHS	

	England to discuss the Trust's actions to support BAME staff. Yvonne had agreed to join the BAME network call next week and was very positive about the Trust's response. **Questions** No questions were raised.	
6.	**Any other business** None raised.	
7.	**Outstanding points to be answered when possible:** **Staff Testing** Data on: • the number of staff tested • outcomes **Care homes** • Modelling/assessment of the number of LCH who will need to work in care homes **Rehabilitation** • Data/modelling on the number of patients requiring rehabilitation in the community	

Annex A

RESPONSE TO A REGIONAL REQUEST FROM UNISON FOR INFORMATION ON PPE

- **22 04 2020**

In response to your recent enquiry to our Chief Executive I hope this information from Leeds Community Healthcare NHS Trust is helpful

1) How likely is this situation in your organisation and which bits of equipment are most likely to run out?
    a. It is possible but is being managed. The items that occasionally run low vary week on week. At present we believe we have acceptable stock of most items except clinical wipes (escalated as an issue) and we are assessing our requirement for gowns over the coming weeks. To date we have had sufficient available...

2) Will this affect your ICU over the next few days?
    a. We don't run an ICU

3) How will we know if supplies really are running out and the organisation isn't just trying to eke out existing stocks?
    a. This Trust currently does not currently expect this situation

4) Are local clinical and infection control leads briefing staff and union reps about their plans in advance of this occurring so staff are not faced with this position at the start of a shift?
    a. We are not in this position. More generally we have a daily brief and are keeping all staff fully informed through that communication of how we are working with our local community based teams to order, manage and distribute PPE to them.

5) Will clinical leaders be there to reassure staff that e.g. working with a fabric gown covered by a plastic apron mitigates the risk?
    a. We are not in this position but have a culture of visible leadership across our many staff bases.

6) What steps has the organisation taken to seek additional supplies and when do they anticipate having new stock?
    a. We have consistently escalated particular item shortages on the prescribed routes. In partnership with other local health and care organisations we have independently sourced PPE from China. We have also gratefully received donations of quality approved PPE from local and national organisations.