NHS Leeds Community Healthcare NHS Trust

Board Meeting (Public)
Friday 29 May 2020, 8:30am – 10:00am
(via Microsoft Teams)

Time	Item no.	Item	Lead	Paper
		AGENDA		
		Preliminary business		
8:30	2020-21 (14)	Welcome, introductions and apologies	Brodie Clark	N
	2020-21 (15)	Declarations of interest	Brodie Clark	N
	2020-21 (16)	Patient's story (video): Kari's story	Steph Lawrence	N
	2020-21 (17)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 1 May 2020 b. Actions' log	 Brodie Clark Brodie Clark	 Y Y
		Key issues		
8:50	2020-21 (18)	COVID-19 a. Overview b. Operational changes and issues c. (i) Clinical issues: including PPE (ii) Care home workforce response d. Quality e. HR and workforce: including health and well-being of staff (i) Supporting Black and Minority Ethnic (BAME) Colleagues during COVID-19 (ii) Covid-19 absence summary f. IT and estates: including information governance and equipment g. Risk report	 Thea Stein Sam Prince Steph Lawrence Ruth Burnett Jenny Allen/Laura Smith Bryan Machin Thea Stein	 N N Y Y Y Y Y Y Y
9:20	2020-21 (19)	Reset and recovery	Sam Prince	Y
		Sign off /approval		
9:40	2020-21 (20)	Corporate governance report: • Board and committee effectiveness review • Audit Committee annual report 2019-20 • Committees' terms of reference review • Register of sealings	Thea Stein	Y
		Information for noting/discussion		
9:45	2020-21 (21)	Mortality annual report	Ruth Burnett	Y
	2020-21 (22)	Performance brief and domain reports Performance brief – April 2020	Bryan Machin	Y
	2020-21 (23)	Committees' assurance reports: a. Quality Committee: 18 May 2020 b. Business Committee: 20 May 2020	 Ian Lewis Brodie Clark	 Y Y
	2020-21 (24)	Minutes and notes: a. Non-Executive Director briefing notes: 7 May 2020 14 May 2020 b. West Yorkshire Mental Health Services Collaborative Committees in Common (WYMHSC C-In-C) minutes: 23 April 2020	Brodie Clark	 Y Y Y
10:00	2020-21 (25)	Close of the public section of the Board	Brodie Clark	N

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Agenda item 2020-21 (18cii)

Meeting Trust Board 29 May 2020	**Category of paper** *(please tick)*	
Report title COVID-19 Care Home Workforce Response	**For decision**	✓
Responsible Director: Executive Director of Nursing and AHP's	**For assurance**	
Previously considered by N/A	**For information**	

Summary

Regional request from the Integrated Care System (ICS) to places:

As part of the Care Home People work stream, work has taken place across the Regional Care Home and Workforce cells with colleagues from each ICS in Yorkshire and Humber to explore the associated people issues.

There was a need to understand existing best practice across Yorkshire and Humber in terms of any workforce sharing agreements and also to consider the potential for NHS lead employer style arrangements for staff to work in the care sector. LCH has already done a lot of work to understand how it could deploy staff to the care home sector and this was used in this work. There is also the opportunity through phase 2 of the national Bringing Staff Back campaign to deploy some returners into Care Homes across each ICS, but to do this they will need to be employed.

The West Yorkshire and Harrogate system has now been asked to take forward discussions on this issue and to:
(a) decide and inform NHSE if you intend to use a workforce sharing agreement to bolster care home resilience and
(b) decide and inform NHSE as to who you would like the employer to be of returners who are able to work in care homes.

ICSs may choose to have a single lead employer or a number of employers recognising the size of ICSs and importance of place based arrangements. Combining a lead employer organisation with the use of a workforce sharing agreement could provide flexibility in terms of the numbers and skills level of colleagues to be deployed. Close working between DONs, Directors of Workforce and ICS workforce leads will be key to putting in place appropriate arrangements to enable this support to care homes to be provided.

A request was made to Leeds as a place to have a proposal to take this work forward by Wednesday 27 May 2020. LCH has already done a lot of the preparatory work and is already leading a lot of clinical work across care homes and this would be seen as a natural extension of this work. The other providers in Leeds have confirmed they are content for LCH to lead this work.

Assurance and agreement
Given the very tight timescales, the information was shared with the Chair and Vice Chair of the Trust and a virtual meeting was held on Friday 23 May 2020 to discuss further with the

Director of Nursing and AHP's (DON) and Director of Workforce.

At the meeting a number of questions and clarifications were sought by the Chair and Vice Chair as below:

1. The nature of this agreement
2. How long this would be for - in the absence of any current central guidance we should build in regular review points for the work.
3. Whether our nurses would be the only nurse in a care home – this would not be the case unless we had an individual nurse who wished to do this.
4. The level of leadership involvement from the ICS and how this would be communicated.
5. Dispute resolution and escalation processes
6. The scoping of the needs of care homes in Leeds
7. Funding arrangements - which needs to be firmed up

Outcome of discussion
Agreement in principle for LCH to lead this work and be the employer for staff being deployed into care homes was given by the Chair and Vice Chair but ratification of this is now required from the Trust Board.

Recommendation:
The Board is recommended to ratify the decision for LCH to lead this work and be the employer for staff being deployed into care homes

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (18d)

Report to: Trust Board 29th 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. The key highlights are covered in the Performance Brief and associated narrative this month.

The clinical outcomes program has been adjusted in order to focus the key workstreams on Covid-related changes to practice. As services being to reset and recover, the programme will be further adapted to ensure that good clinical outcomes continue to be achieved for patients, and that services can evidence this.

Appendix 1 describes the current areas of focus covering:

- Health inequalities
- Video consultations
- Mortality surveillance
- Legs and wound care

The updates are presented in an SBAR format (**S**ituation, **B**ackground, **A**ssessment, **R**ecommendation), with Risks (Ri) included where applicable.

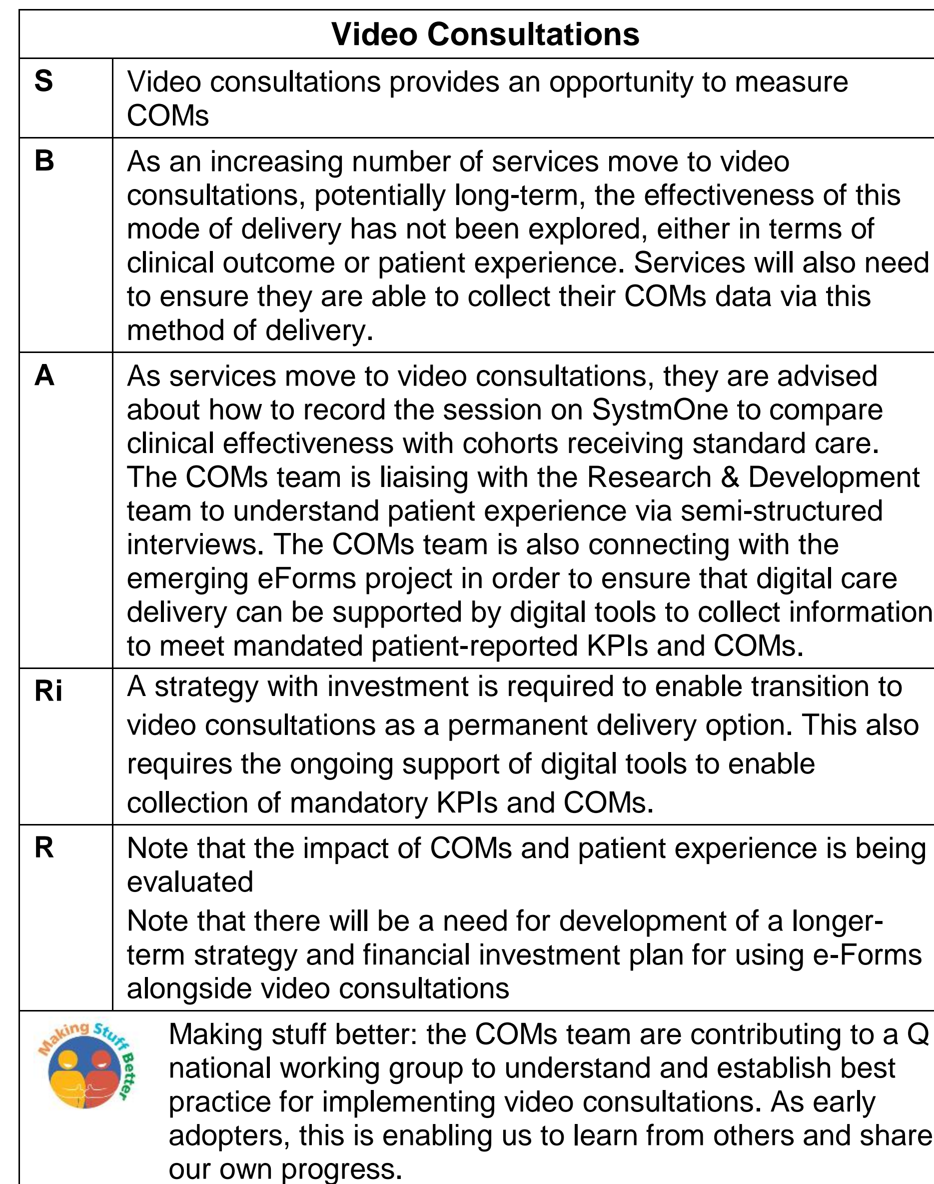
Appendix 2 contains early data regarding the breakdown of mortality data for April 2020, the addition of May data and further BI analysis will allow for more detailed narrative at the Trust Board in June.

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 to ensure that redeployment of staff and altered working methods have not resulted in an increased level of medication incidents (Appendix 3)

QAIG was stood down as a formal meeting in May 2020 due to duplication of work with Quality Committee, the time was utilised to draft the workplan and report formats for subsequent months.

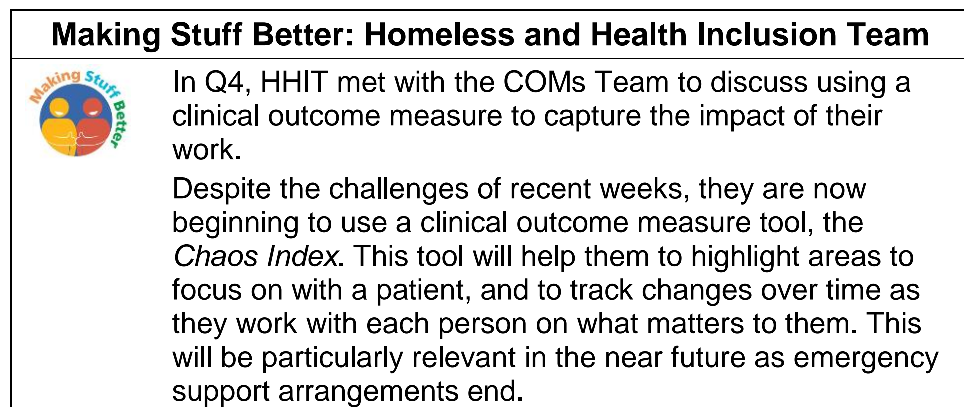
Appendix 1: Clinical Outcomes Programme

	Health Inequalities
S	The need to understand the changes to service delivery that may create or exacerbate health inequalities
B	Health Inequalities are one of the key reasons clinical outcomes work is important within services, and therefore has run as a 'golden thread' through much of the development work. However, there are concerns that some of our patient communities may disproportionately be affected by the necessary changes to service delivery
A	The necessary changes to service delivery may impact on health inequalities because of a person's protected characteristics or because of other factors, including access to use of digital alternatives. Work across the clinical outcomes agenda is looking to understand this as part of its broader evaluation. As a starting point, work is underway to investigate the demographics of those currently failing to attend important face-to-face appointments. This is being done by a manual audit of the data in order to react with the necessary responsiveness. Findings from this work will be used to inform any changes in the way the Trust engages with any communities who are at risk from non-attendance.
Ri	Additional redeployed resource has been required to manually audit this data. Increased responsiveness of the business intelligence team via increased capacity and capability to extract clinical intelligence would enable ongoing monitoring of health inequalities in accessing our care.
R	Note evaluation of services continuing to deliver face-to-face care via audit, to compare broad demographic indicators (ethnicity, language, postcode) to understand whether those CNA/DNA compared to overall demographic of the caseload Note inclusion of health inequalities as a fundamental part of the outcomes agenda

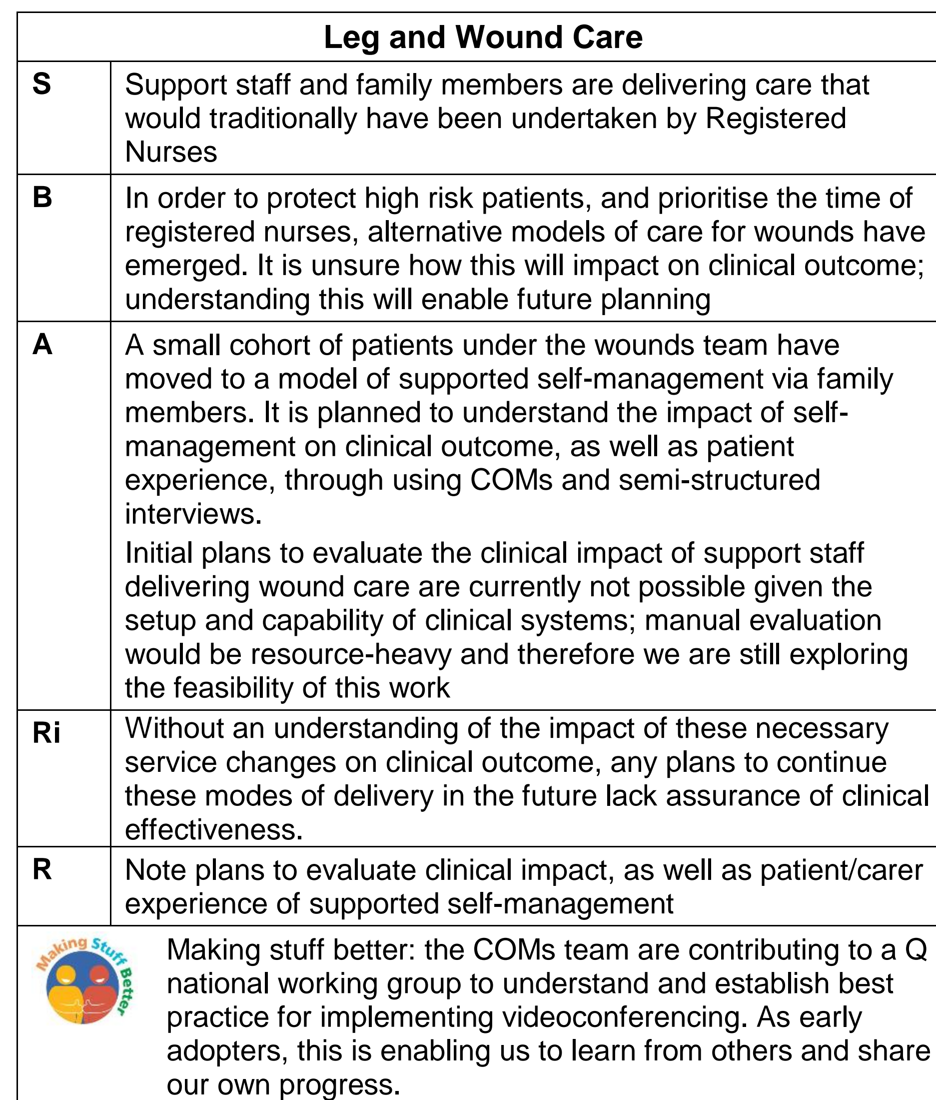


	Video Consultations
S	Video consultations provides an opportunity to measure COMs
B	As an increasing number of services move to video consultations, potentially long-term, the effectiveness of this mode of delivery has not been explored, either in terms of clinical outcome or patient experience. Services will also need to ensure they are able to collect their COMs data via this method of delivery.
A	As services move to video consultations, they are advised about how to record the session on SystmOne to compare clinical effectiveness with cohorts receiving standard care. The COMs team is liaising with the Research & Development team to understand patient experience via semi-structured interviews. The COMs team is also connecting with the emerging eForms project in order to ensure that digital care delivery can be supported by digital tools to collect information to meet mandated patient-reported KPIs and COMs.
Ri	A strategy with investment is required to enable transition to video consultations as a permanent delivery option. This also requires the ongoing support of digital tools to enable collection of mandatory KPIs and COMs.
R	Note that the impact of COMs and patient experience is being evaluated Note that there will be a need for development of a longer-term strategy and financial investment plan for using e-Forms alongside video consultations
	Making stuff better: the COMs team are contributing to a Q national working group to understand and establish best practice for implementing video consultations. As early adopters, this is enabling us to learn from others and share our own progress.

Mortality Surveillance	
S	The need to understand changing mortality patterns of those in our care
B	The organisation has a well-established process for understanding mortality for those in our care. During COVID-19, we have seen an increase in mortality rate, as expected given the national context. Understanding these deaths (both related and unrelated to the pandemic) in more depth will inform our care, in conjunction with our partner organisations, in the coming months.
A	The role of the COMs Team is to support the existing processes. It will focus on a more in-depth evaluation of the mortality date to understand the demographic. This work is being additionally supported by a medical student, and will be limited by their capacity during their placement with us.
R	Note that this work will support the work of the Adult Business Unit in understanding and learning from those who die in our care.



Making Stuff Better: Homeless and Health Inclusion Team	
Making Stuff Better	In Q4, HHIT met with the COMs Team to discuss using a clinical outcome measure to capture the impact of their work. Despite the challenges of recent weeks, they are now beginning to use a clinical outcome measure tool, the *Chaos Index*. This tool will help them to highlight areas to focus on with a patient, and to track changes over time as they work with each person on what matters to them. This will be particularly relevant in the near future as emergency support arrangements end.



Leg and Wound Care	
S	Support staff and family members are delivering care that would traditionally have been undertaken by Registered Nurses
B	In order to protect high risk patients, and prioritise the time of registered nurses, alternative models of care for wounds have emerged. It is unsure how this will impact on clinical outcome; understanding this will enable future planning
A	A small cohort of patients under the wounds team have moved to a model of supported self-management via family members. It is planned to understand the impact of self-management on clinical outcome, as well as patient experience, through using COMs and semi-structured interviews. Initial plans to evaluate the clinical impact of support staff delivering wound care are currently not possible given the setup and capability of clinical systems; manual evaluation would be resource-heavy and therefore we are still exploring the feasibility of this work
Ri	Without an understanding of the impact of these necessary service changes on clinical outcome, any plans to continue these modes of delivery in the future lack assurance of clinical effectiveness.
R	Note plans to evaluate clinical impact, as well as patient/carer experience of supported self-management
Making Stuff Better	Making stuff better: the COMs team are contributing to a Q national working group to understand and establish best practice for implementing videoconferencing. As early adopters, this is enabling us to learn from others and share our own progress.

Appendix 2: Mortality figures for April 2020

In light of the Covid19 pandemic, which arrived in the UK at the end of Quarter 4 19/20, April data has been included early in the report to highlight the change to mortality rates seen across the month. Assurance is therefore provided that we were able to identify this early, are monitoring trends, and have adapted our reporting systems rapidly to ensure that detailed and appropriate analysis of this data can take place.

- Data for adults shows a total of 405 deaths recorded. In April 2020, deaths in all neighbourhood areas were higher than the mean reported over the previous two years.
- Deaths in three of the thirteen neighbourhood areas were higher than the upper control limit of reporting; deaths in two neighbourhood areas were equal to the upper control limit. Deaths recorded in the other eight neighbourhood areas were within the control limits.
- Deaths of older adults were higher in April 2020 than in the previous three months.
- Data released by the Office for National Statistics[1] shows a total of 239 deaths of Leeds care home residents between 10 April and 1 May, with 110 linked to coronavirus.

The mortality review process continues to be utilised, with reviews prioritised for patients in Community Care Bed and Care Home settings. Work to further understand the impact of coronavirus on mortality is being taken forward through the Clinical Outcome Measures and research workstreams.

Tables 1-3 highlight the early analysis of April 2020 data. Further narrative will be added once detail from the mortality review process is known.

Observations:

- Increase in number of expected deaths
- Increase in deaths at home / CH under LCH care – apprx 305 in April 2020 compared with 105 in April 2019
- VoED at home/CH maintained despite increase in numbers (increased at home)
- Evidence of recognition of EoLC needs and advance care planning
- NTs with highest number of deaths are Middleton 47, Kippax 47 and Seacroft 42. All other NT deaths were in 20s and 30s apart from Holt Park 9 and Wetherby 14
- Need to consider potential impact on staff of delivering such an increase in EoLC.

Table 1: Deaths in Neighbourhood areas[2], April 2020

Neighbourhood Area	Lower control total	Upper control total	Mean	Deaths recorded April 2020
Middleton	7.9	47.5	27.7	52
Seacroft	4.4	46.2	25.3	46
Kippax	10.8	33.5	22.1	45
Meanwood	4.8	42.1	23.5	39
Woodsley	1.0	34.8	17.9	34
Armley	10.7	34.3	22.5	32

[1] Number of deaths in care homes notified to the Care Quality Commission, England - Office for National Statistics

[2] Accessed from PIP, 6 May 2020

Pudsey	4.6	33.8	19.2	30
Yeadon	7.2	32.4	19.8	27
Chapeltown	2.7	34.8	18.7	26
Morley	5.1	35.2	20.1	25
Beeston	1.5	21.2	11.3	23
Holt Park	1.6	23.1	12.3	13
Wetherby	3.1	17.3	10.2	13
TOTAL	**-**	**-**	**250.6**	**405**

Table 2: Adult deaths by age category[2]

Age group	Jan-20	Feb-20	Mar-20	Apr-20
19-25	-	-	-	-
26-59	19	11	24	14
60-69	17	31	27	40
70-79	59	60	62	84
80-89	97	89	104	158
Over 90	65	39	63	110
TOTAL	**257**	**230**	**280**	**406**

Table 3: Adult deaths by sex (April 20) [2]

M	198
F	208

LCH NT EPaCCS data – April 2020/19

Patients with an EPaCCS record known to Neighbourhood Teams (NTs)	**April 2020**	**April 2019**
Patients recorded on EPaCCs before death (0-4 weeks)	25%	30%
Total number of expected deaths	**381**	**181**
% with **Actual Place of Death** (APoD) recorded	84.5%	93.4%
Died at Home	42%	33%
Died in Care Home	38%	25%
Died in hospice	9%	23%%
Died in hospital	11%	19%
% with APoD and **Preferred Place of Death** recorded	78%	89%
1st choice PPD achieved	88.6%	75%
1st or 2nd choice PPD achieved	90.6%	78.8%
Verification of expected death (VoED) by NT (home and CH)		
Verification of expected death home	85%	79%
Verification of expected death CH	68%	67%

Appendix 3: Incidents Involving Medication – Early Review of April 2020 Data

In April 2020, 40 incidents involving medication attributable to LCH were reported; this is within the control total (chart 1). Two of these incidents caused harm to patients; this is also within the control total (chart 2).

In response to the COIVID-19 pandemic, staff were redeployed from C2 and C3 services to support C1 services, including Neighbourhood Teams. Key roles for redeployed staff include medication support to patients. As part of the redeployment process, over 300 staff attended a medicines management training session, which outlined the risks involved in medicines administration, and how to minimise these.

Anecdotal reports suggest that measures put in place to support redeployed staff have maintained safe medication administration during April 2020, including:

- ‘buddy shifts’;
- medication training;
- signposting to Neighbourhood Pharmacy Technicians to provide ongoing support;
- comprehensive team induction.

It was highlighted on a national pharmacy webinar that many Trusts have seen an increase in medication incidents during the current pandemic, but review of our current data suggests that LCH has not seen a similar increase. The Medicines Management team continue to monitor and investigate, but early feedback suggests that this is due to a combination of

- LCH protocol for keeping paper medical records in patients homes
- An increased level of staffing in many neighbourhood teams secondary to redeployment

Chart 1: Reported incidents involving medication attributable to LCH (April 2020)

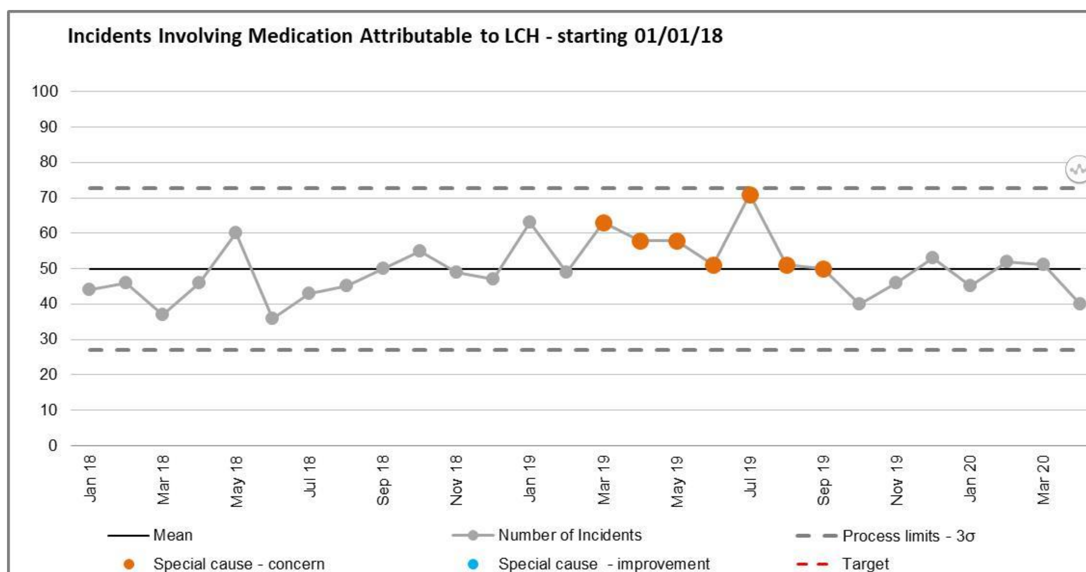
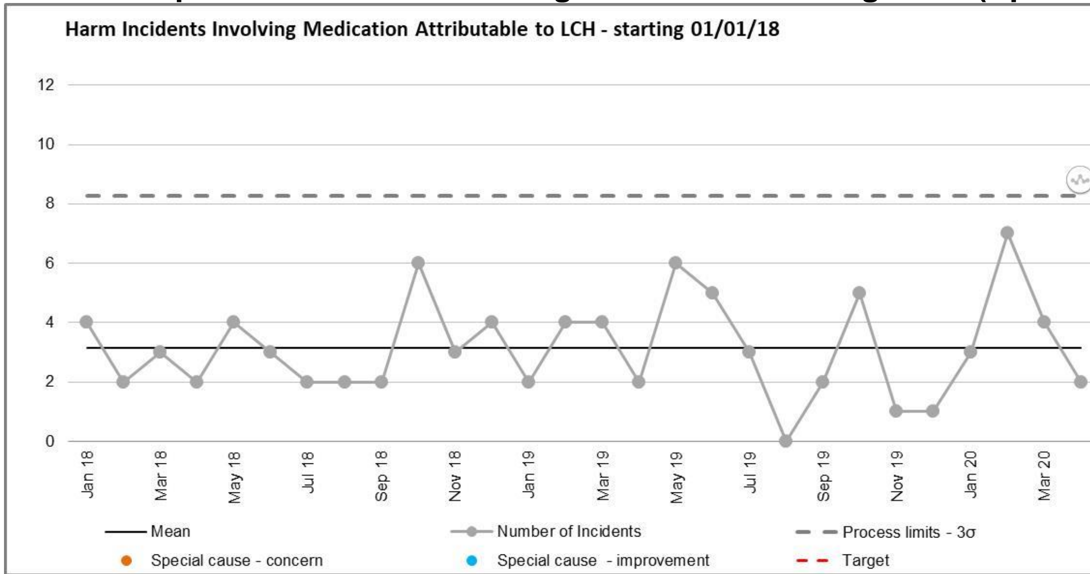


Chart 2: Reported incidents involving medication causing harm (April 2020)



Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (18ei)

Report to: Trust Board 29 May 2020
Report title: Supporting Black and Minority Ethnic (BAME) Colleagues during COVID-19
Responsible Director: Director of Workforce

Background

- Emerging evidence that is currently being reviewed by Public Health England shows that black, Asian and minority ethnic (BAME) communities are disproportionately affected by COVID-19. This concerning evidence suggests that the impact may also be higher among men and those in the higher age brackets.

- Media reports have stated that almost two thirds of 119 NHS workers who have died following COVID-19 diagnosis were BAME, compared with approximately 20% of the NHS workforce

- The reasons for this are not yet fully understood, but the health inequalities present for BAME communities have long been recognised.

LCH Approach

- LCH's BAME network has been active, impactful and growing in its size and influence for over two years under the leadership of network chair Kulvant Sandhu; and with support from the LCH Board, who have also benefited from the Reverse Mentoring scheme spearheaded by the network.

- The BAME Staff Network is meeting virtually every week, supporting and advocating for LCH's BAME workforce and providing a safe space for discussions. A member of SMT is invited to be in attendance each week. So far the meetings have been very positive and well attended.

- The LCH approach to supporting BAME colleagues during the COVID-19 pandemic has been co-produced with the BAME network.

- An open letter ***(Appendix 1)*** was sent to all BAME colleagues within the Trust on 4 May 2020, to acknowledge concerns around the emerging evidence showing how COVID-19 is disproportionately affecting people from BAME communities; and to provide reassurance of the Trust's actions in response.

- The letter provided assurance that BAME colleagues will have the opportunity to have their voices heard, know their concerns will be listened to and acted upon where possible.

- A range of resources have been published to support ongoing arrangements (previously circulated):

  - The Trust has produced its own a risk assessment template to be completed by managers for colleagues who are vulnerable to COVID-19. The risk assessment covers different risk categories to form a risk mitigation plan for individuals. The assessment contains separate links for different groups of vulnerable staff. In addition to BAME staff, it can be used for those in the extremely vulnerable category and pregnant workers.

  - A comprehensive framework designed to help managers feel supported to have thorough, sensitive and comprehensive conversations so that those from different backgrounds can be treated with greater civility, respect, and compassion.

  - Virtual guidance sessions to help managers use the framework effectively have been held w/c 11

May 2020 and w/c 18 May 2020. The sessions have been well attended and co-facilitated by the Directors of Workforce with BAME network members, the LCH Risk & Safety Manager, and the LCH Freedom to Speak Up Guardian. The sessions emphasise the importance of a “people before process” approach, seeking above all to listen to, acknowledge and understand the individual situations and concerns of BAME colleagues.

- BAME staff have volunteered as associate Freedom to Speak up Guardians (FTSUG) – nine individuals have already undertaken the first stage of training provided by the Trust’s FTSUG and the Chair of the BAME Staff Network; and are actively offering support to BAME staff.

- Line managers have been asked to undertake conversations with BAME team members in their services during May 2020.
- To date, BAME colleagues are reporting largely positive experiences in relation to the conversations. A small number of negative experiences are being followed up in order that improvements can be made.
- Assurance is being sought that the conversations have taken place; and further reporting on this will follow. Additionally, a survey of BAME staff views on the quality of the conversations as well as further reflections with managers on their perceptions of how the conversations have gone are planned.
- Finally, we are also considering as a Trust the inclusion of BAME staff voice in our decision making processes at this time; an EDI impact assessment will take place for us to understand this better and discussions with the BAME network are taking place on the safe involvement of BAME staff in the building assessment work.

Jenny Allen & Laura Smith

Director of Workforce

24 May 2020

Appendix 1: Open letter to BAME Colleagues on COVID-19

Dear BAME (Black, Asian and Minority Ethnic) colleague,

This is an open letter to all our BAME colleagues within the trust. We want to acknowledge concerns you may have around the emerging evidence showing how COVID-19 is disproportionately affecting people from BAME communities. The reasons behind this are multifaceted and not yet fully understood. However we are aware that many of you may be feeling anxious about this risk, we wanted to provide you with some reassurance of what the trust is doing to address it.

What we are doing

We want to ensure all our BAME colleagues have the opportunity to have their voices heard, knowing their concerns will be listened to and acted upon where we can. We held our first virtual meeting jointly between the trust's BAME staff network and Thea and Laura one of the Directors of Workforce last week, to create a safe space for these discussions. We plan to hold these on a regular basis at different times every week – so look out for the list of times and dates in the future in our comms. If you would like to join these meetings and be part of the BAME staff network simply email lch.bame@nhs.net. If you prefer to engage with these meetings without joining the BAME staff network please email bridget.lockwood@nhs.net to be invited to future virtual meetings.

There has also been some recently published new guidance regarding how best to support our BAME colleagues who may be impacted from COVID19.

We are implementing the guidance and are asking all line managers to have a conversation with their BAME staff, giving the opportunity to raise any concerns and agree solutions together to ensure you feel supported and safe whilst you continue to work.

Support available to you

We also acknowledge that for some BAME colleagues raising concerns with their line managers or having these sensitive discussions can be a challenge. We want to ensure there is support available for this too. If BAME staff feel they would like to be supported when they have these discussions with their managers, or wish to raise concerns to someone independent, they can contact the Freedom To Speak Up Guardian John Walsh on lch.freedomtospeakup@nhs.net or on 07949 102354.

We have also created BAME Freedom To Speak-Up Champions who are also available to support BAME colleagues having these discussions, as well as listen to any concerns BAME colleagues wish to raise in confidence. If BAME staff would like

a BAME Freedom To Speak Up Champion to support them please either get in touch with lch.freedomtospeakup@nhs.net or lch.bame@nhs.net. These champions are volunteers from the BAME Staff Network and are supported by John Walsh.

We also recognise that some managers may want to have support in doing these conversations so we are working through ways in which we can provide support and a framework for the conversations for you – this support will be shared this week.

Finally the trust also has a range of support which is available to all staff such as the Listening & Support Service from the OD team. An additional element of this Service is that any BAME colleague wishing to speak specifically with a BAME member of staff, you can request to do so where you will be contacted by Trina Glynn who is a member of that service and part of the BAME Staff Network.

The trust recognises how serious these concerns are for our BAME colleagues and is committed to ensuring you all feel safe and supported whilst continuing to be valued members of all our teams.

Thank you,

Thea Stein, Chief Executive
Kulvant Sandhu, Named Nurse for MCA and Dementia | Chair of LCH BAME Staff Network
John Walsh, OD Lead/Freedom To Speak Up Guardian
Anne Cherry, UNISON Representative and Staffside Chair

Leeds Community Healthcare NHS Trust

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Employee Absences by Business Unit

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

Data up to 25/05/2020

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.

Click here to see graphs of these data

Organisation Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172
Annual Leave	158	5.0%	175	5.5%	175	5.5%	209	6.6%	147	4.6%	147	4.6%	781	24.6%
Maternity	68	2.1%	71	2.2%	71	2.2%	71	2.2%	71	2.2%	71	2.2%	71	2.2%
Other Leave	5	0.2%	9	0.3%	9	0.3%	8	0.3%	3	0.1%	3	0.1%	101	3.2%
Self Isolation- Unable to Work from Home	50	1.6%	46	1.5%	45	1.4%	44	1.4%	43	1.4%	42	1.3%	42	1.3%
Sickness due to Covid-19	35	1.1%	34	1.1%	31	1.0%	28	0.9%	25	0.8%	25	0.8%	20	0.6%
Sickness due to other cause (long term)	80	2.5%	80	2.5%	81	2.6%	82	2.6%	83	2.6%	84	2.6%	73	2.3%
Sickness due to other cause (short term)	47	1.5%	48	1.5%	49	1.5%	53	1.7%	49	1.5%	46	1.5%	32	1.0%
Special Leave	19	0.6%	19	0.6%	22	0.7%	21	0.7%	20	0.6%	20	0.6%	8	0.3%
Training Development	1	0.0%	2	0.1%	1	0.0%	1	0.0%	1	0.0%	1	0.0%		0.0%
Total	**463**	**14.6%**	**484**	**15.3%**	**484**	**15.3%**	**517**	**16.3%**	**442**	**13.9%**	**439**	**13.8%**	**1128**	**35.6%**

Organisation Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172	Count	% of 3172
Self Isolation- Working from Home	139	4.4%	140	4.4%	141	4.4%	137	4.3%	133	4.2%	132	4.2%	90	2.8%
Total	**139**	**4.4%**	**140**	**4.4%**	**141**	**4.4%**	**137**	**4.3%**	**133**	**4.2%**	**132**	**4.2%**	**90**	**2.8%**

Adult Business unit Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004
Annual Leave	70	7.0%	71	7.1%	69	6.9%	88	8.8%	44	4.4%	44	4.4%	256	25.5%
Maternity	29	2.9%	31	3.1%	31	3.1%	31	3.1%	31	3.1%	31	3.1%	31	3.1%
Other Leave	5	0.5%	8	0.8%	8	0.8%	6	0.6%	3	0.3%	3	0.3%	42	4.2%
Self Isolation- Unable to Work from Home	22	2.2%	20	2.0%	19	1.9%	19	1.9%	19	1.9%	19	1.9%	19	1.9%
Sickness due to Covid-19	22	2.2%	22	2.2%	19	1.9%	18	1.8%	18	1.8%	17	1.7%	13	1.3%
Sickness due to other cause (long term)	31	3.1%	31	3.1%	31	3.1%	32	3.2%	33	3.3%	33	3.3%	28	2.8%
Sickness due to other cause (short term)	22	2.2%	24	2.4%	23	2.3%	24	2.4%	22	2.2%	21	2.1%	15	1.5%
Special Leave	2	0.2%	4	0.4%	3	0.3%	3	0.3%	3	0.3%	3	0.3%	1	0.1%
Total	**203**	**20.2%**	**211**	**21.0%**	**203**	**20.2%**	**221**	**22.0%**	**173**	**17.2%**	**171**	**17.0%**	**405**	**40.3%**

Adult Business unit Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004	Count	% of 1004
Self Isolation- Working from Home	53	5.3%	54	5.4%	53	5.3%	50	5.0%	48	4.8%	47	4.7%	36	3.6%
Total	**53**	**5.3%**	**54**	**5.4%**	**53**	**5.3%**	**50**	**5.0%**	**48**	**4.8%**	**47**	**4.7%**	**36**	**3.6%**

Specialist Business Unit Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825
Annual Leave	34	4.1%	41	5.0%	46	5.6%	56	6.8%	47	5.7%	47	5.7%	242	29.3%
Maternity	17	2.1%	17	2.1%	17	2.1%	17	2.1%	17	2.1%	17	2.1%	17	2.1%
Other Leave		0.0%	1	0.1%	1	0.1%	2	0.2%		0.0%		0.0%	27	3.3%
Self Isolation- Unable to Work from Home	10	1.2%	8	1.0%	8	1.0%	8	1.0%	7	0.8%	6	0.7%	6	0.7%
Sickness due to Covid-19	3	0.4%	3	0.4%	3	0.4%	2	0.2%	1	0.1%	2	0.2%	2	0.2%
Sickness due to other cause (long term)	24	2.9%	24	2.9%	24	2.9%	23	2.8%	23	2.8%	23	2.8%	20	2.4%
Sickness due to other cause (short term)	10	1.2%	11	1.3%	11	1.3%	13	1.6%	13	1.6%	12	1.5%	8	1.0%
Special Leave	11	1.3%	9	1.1%	11	1.3%	10	1.2%	10	1.2%	10	1.2%	4	0.5%
Training Development	1	0.1%	2	0.2%	1	0.1%	1	0.1%	1	0.1%	1	0.1%		0.0%
Total	**110**	**13.3%**	**116**	**14.1%**	**122**	**14.8%**	**132**	**16.0%**	**119**	**14.4%**	**118**	**14.3%**	**326**	**39.5%**

Specialist Business Unit Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825	Count	% of 825
Self Isolation- Working from Home	34	4.1%	37	4.5%	36	4.4%	37	4.5%	37	4.5%	37	4.5%	28	3.4%
Total	**34**	**4.1%**	**37**	**4.5%**	**36**	**4.4%**	**37**	**4.5%**	**37**	**4.5%**	**37**	**4.5%**	**28**	**3.4%**

Children's Business Unit Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882
Annual Leave	35	4.0%	42	4.8%	41	4.6%	43	4.9%	37	4.2%	37	4.2%	230	26.1%
Maternity	17	1.9%	18	2.0%	18	2.0%	18	2.0%	18	2.0%	18	2.0%	18	2.0%
Other Leave		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%	14	1.6%
Self Isolation- Unable to Work from Home	9	1.0%	9	1.0%	9	1.0%	8	0.9%	8	0.9%	8	0.9%	8	0.9%
Sickness due to Covid-19	6	0.7%	6	0.7%	6	0.7%	5	0.6%	4	0.5%	4	0.5%	4	0.5%
Sickness due to other cause (long term)	18	2.0%	18	2.0%	19	2.2%	19	2.2%	19	2.2%	20	2.3%	19	2.2%
Sickness due to other cause (short term)	11	1.2%	9	1.0%	10	1.1%	12	1.4%	11	1.2%	10	1.1%	7	0.8%
Special Leave	4	0.5%	3	0.3%	6	0.7%	6	0.7%	5	0.6%	5	0.6%	2	0.2%
Total	**100**	**11.3%**	**105**	**11.9%**	**109**	**12.4%**	**111**	**12.6%**	**102**	**11.6%**	**102**	**11.6%**	**302**	**34.2%**

Children's Business Unit Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882	Count	% of 882
Self Isolation- Working from Home	41	4.6%	37	4.2%	40	4.5%	38	4.3%	36	4.1%	36	4.1%	17	1.9%
Total	**41**	**4.6%**	**37**	**4.2%**	**40**	**4.5%**	**38**	**4.3%**	**36**	**4.1%**	**36**	**4.1%**	**17**	**1.9%**

Operations Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216
Annual Leave	11	5.1%	11	5.1%	12	5.6%	13	6.0%	12	5.6%	12	5.6%	42	19.4%
Maternity	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%	1	0.5%
Other Leave		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%	2	0.9%
Self Isolation- Unable to Work from Home	9	4.2%	9	4.2%	9	4.2%	9	4.2%	9	4.2%	9	4.2%	9	4.2%
Sickness due to Covid-19	3	1.4%	2	0.9%	2	0.9%	2	0.9%	2	0.9%	2	0.9%	1	0.5%
Sickness due to other cause (long term)	4	1.9%	4	1.9%	4	1.9%	5	2.3%	5	2.3%	5	2.3%	4	1.9%
Sickness due to other cause (short term)	2	0.9%	2	0.9%	3	1.4%	2	0.9%	2	0.9%	2	0.9%	1	0.5%
Special Leave	2	0.9%	3	1.4%	2	0.9%	2	0.9%	2	0.9%	2	0.9%	1	0.5%
Total	**32**	**14.8%**	**32**	**14.8%**	**33**	**15.3%**	**34**	**15.7%**	**33**	**15.3%**	**33**	**15.3%**	**61**	**28.2%**

Operations Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216	Count	% of 216
Self Isolation- Working from Home	7	3.2%	8	3.7%	8	3.7%	8	3.7%	8	3.7%	8	3.7%	5	2.3%
Total	**7**	**3.2%**	**8**	**3.7%**	**8**	**3.7%**	**8**	**3.7%**	**8**	**3.7%**	**8**	**3.7%**	**5**	**2.3%**

Corporate Directorate Absence Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220
Annual Leave	8	3.6%	10	4.5%	7	3.2%	9	4.1%	7	3.2%	7	3.2%	11	5.0%
Maternity	4	1.8%	4	1.8%	4	1.8%	4	1.8%	4	1.8%	4	1.8%	4	1.8%
Other Leave		0.0%		0.0%		0.0%		0.0%		0.0%		0.0%	16	7.3%
Sickness due to Covid-19	1	0.5%	1	0.5%	1	0.5%	1	0.5%		0.0%		0.0%		0.0%
Sickness due to other cause (long term)	3	1.4%	3	1.4%	3	1.4%	3	1.4%	3	1.4%	3	1.4%	2	0.9%
Sickness due to other cause (short term)	2	0.9%	2	0.9%	2	0.9%	2	0.9%	1	0.5%	1	0.5%	1	0.5%
Total	**18**	**8.2%**	**20**	**9.1%**	**17**	**7.7%**	**19**	**8.6%**	**15**	**6.8%**	**15**	**6.8%**	**34**	**15.5%**

Corporate Directorate Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220	Count	% of 220
Self Isolation- Working from Home	3	1.4%	3	1.4%	3	1.4%	3	1.4%	3	1.4%	3	1.4%	3	1.4%
Total	**3**	**1.4%**	**3**	**1.4%**	**3**	**1.4%**	**3**	**1.4%**	**3**	**1.4%**	**3**	**1.4%**	**3**	**1.4%**

PCN Business Unit Working From Home Summary	19/05/2020		20/05/2020		21/05/2020		22/05/2020		23/05/2020		24/05/2020		25/05/2020	
Status	Count	% of 12	Count	% of 12	Count	% of 12	Count	% of 12	Count	% of 12	Count	% of 12	Count	% of 12
Self Isolation- Working from Home	1	8.3%	1	8.3%	1	8.3%	1	8.3%	1	8.3%	1	8.3%	1	8.3%
Total	**1**	**8.3%**	**1**	**8.3%**	**1**	**8.3%**	**1**	**8.3%**	**1**	**8.3%**	**1**	**8.3%**	**1**	**8.3%**