Leeds Community Healthcare NHS Trust
Board Meeting (held in public) –
Virtual meeting and live streamed
Friday 5 February 2021, 9.00am – 12.00 (noon)

Leeds Community Healthcare NHS Trust

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2020-21 (110)	Welcome, introductions and apologies:	Brodie Clark	N
9.05	2020-21 (111)	Declarations of interest	Brodie Clark	N
9.05	2020-21 (112)	Questions from members of the public	Brodie Clark	N
9.10	2020-21 (113)	Minutes of previous meeting and matters arising: a. Minutes of the meetings held on 4 December 2020 b. Actions' log	Brodie Clark	 Y Y
9.15	2020-21 (114)	Patient's story: Post Covid Rehabilitation Pathway	Steph Lawrence	N
		Quality and delivery		
9.35	2020-21 (115)	Chief Executive's report: including Covid-19 update and reset and recovery	Thea Stein	Y To follow
10.20	2020-21 (116)	Committee Chairs' Assurance Reports: a. Charitable Funds Committee: 8 December 2020 b. Nomination and Remuneration Committee: 8 December 2020 c. Audit Committee: 15 January 2021 d. Quality Committee: 25 January 2021 e. Business Committee: 27 January 2021	 Brodie Clark Brodie Clark Richard Gladman Helen Tomson Brodie Clark	 Y Y Y Y Y
10.40	2020-21 (117)	Performance brief and domain reports: December 2020	Bryan Machin	Y
10.50	2020-21 (118)	Significant Risks and Board Assurance Framework (BAF) Summary report	Thea Stein	Y
11.00	2020-21 (119)	Safe Staffing Report	Steph Lawrence	Y
11.10	2020-21 (120)	Patient Experience and Complaints six monthly report	Steph Lawrence	Y
11.20	2020-21 (121)	Serious incidents Quarter 3 report	Steph Lawrence	Y
11.30	2020-21 (122)	Mortality report	Ruth Burnett	Y
11.40	2020-21 (123)	Reducing restrictive interventions report	Steph Lawrence	Y
		For approval		
11.45	2020-21 (124)	West Yorkshire & Harrogate Integrated Care System Financial risk-share arrangements for 2020/21 (to ratify decision made on 8 January 2021 at private Board)	Bryan Machin	N
		For noting		
11.50	2020-21 (125)	Approved minutes and briefing notes **for noting**: a. Audit Committee: 15 October 2020 b. Quality Committee: 23 November 2020 c. Business Committee: 25 November 2020 d. Scrutiny Board (Adults, Health & Active Lifestyles)	Brodie Clark	 Y Y Y Y
11.55	2020-21 (126)	Board workplan	Thea Stein	Y
12.00	2020-21 (127)	Close of the public section of the Board	Brodie Clark	N

Date of next meeting (held in public)
Friday 26 March 2021 9.00am -12noon
Virtual meeting via MSTs and live streaming

Leeds Community Healthcare NHS Trust

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (113a)

Title: Draft Trust Board minutes 4 December 2020 (time 0900 to 12.00)

Category of paper: for approval
History: N/A

Responsible director: Chief Executive
Report author: N/A

Attendance

Present:		
	Brodie Clark	Trust Chair
	Thea Stein	Chief Executive
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Helen Thomson	Non-Executive Director
	Alison Lowe	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals
	Dr Ruth Burnett	Executive Medical Director
	Jenny Allen	Director of Workforce, Organisational Development and System Development (JA)
Apologies:	Professor Ian Lewis	Non-Executive Director
	Rachel Booth	Associate Non-Executive Director
	Laura Smith	Director of Workforce, Organisational Development and System Development (LS)
In attendance:		
	Khalil Rehman	Associate Non-Executive
	Diane Allison	Company Secretary
	Jenny Moran	Dental Therapist (For Item 91)
Minutes:	Liz Thornton	Board Administrator
Observers:		
Members of the public:	One member of the public present	

Item: 2020-21 (87)

Discussion points:

Welcome, introductions, apologies and preliminary business

The Chair of Leeds Community Healthcare opened the meeting by welcoming Board members, attendees and one member of the public. He explained that the meeting would be a live streamed event accessed via a link on the Trust's website.

The Trust Chair welcomed Jenny Moran a member of the Trust's staff to relay the patient story item.

An invitation had also been extended to three newly appointed non-executive directors to connect with the meeting. Two had been able to join and the Trust Chair welcomed Alison Lowe and Khalil Rehman.

Apologies

Apologies were received and accepted from Professor Ian Lewis, Non-Executive Director and Laura Smith (LS), Director of Workforce, Organisational Development and System Development.

Trust Chair's introductory remarks

Before turning to the more routine business on the Agenda, the Trust Chair provided some introductory comments to add context to the meeting discussions.

He took the opportunity to thank every team across the Trust for continuing to deliver great care. Despite the learning from the first wave of Covid-19, the second wave appeared to have raised more complex problems but the Trust's response had been outstanding and the flexibilities; the endurance; the commitment and the sheer determination to provide the best to the communities of Leeds and its partner organisations has been excellent.

The Trust Chair said that the Trust's priorities had always included the primacy of the Leeds health inequality agenda. The evidence and experience of the last nine months had increased that priority and the first presentation of the developing planning was included on the agenda for this meeting.

Working at one with the third sector and charities, the continuing cultural growth and development and the diversity and inclusion agenda remained important. He said progress was being made and he highlighted the Inclusive top 50 companies event on 2 December 2020 where the Trust's work so far had been recognised.

The signs of progress on developing the vaccination program and work on the reset program were very positive and would drive the work for the immediate future.

He observed that NHS England/Improvement was looking at the reshape and design of NHS governance arrangements. The role of 'place' was increasingly recognised and understood as central to the provider delivery and so alongside that the scope and the governance of the Integrated Care System (ICS) and commissioning arrangements was under consideration and it was important for the views of the Trust Board to be heard as part of that process.

In conclusion he said that staff across the Trust should be proud of the brilliant work they were doing. The support from the Board would not let up, not least because whilst the public started to feel that it would soon be over – for staff, there would continue to be significant work to do.

Item 2020-21 (88)

Discussion points:

Declarations of interest

Prior to the Trust Board meeting, the Trust Chair had considered the Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Board members.

Board members confirmed that they had no additional declarations of interest.

Item 2020-21 (89)

Discussion points:

Questions from members of the public

There were no questions from members of the public.

Item 2020-21 (90)

Discussion points:

a) Minutes of the previous meeting held on 2 October 2020

The minutes were reviewed for accuracy and agreed to be a correct record.

b) Items from the actions' log

There were no actions or matters arising from the minutes.

Item 2020-21 (91)

Discussion points:

Patient's story

The Executive Director of Nursing and Allied Health Professionals introduced the patient's story item and welcomed Jenny Moran, Dental Therapist to the meeting to tell the story on behalf of the patient's family.

This story was about a child who received treatment from the Trust's Community Dental service. The child had a diagnosis of Batten disease; a rare group of nervous system disorders called neuronal ceroid lipofuscinosis (NCLs) that get worse over time. Jenny explained that due to the nature of the child's illness, treatment in a high street dental surgery had proved impossible and therefore the Trust had accepted a referral in February 2020 to treat some decaying teeth that were causing pain.

Unfortunately due to an administrative error the child was not placed on the correct waiting list and the child's mum was not contacted until the service recommenced patient engagement as part of the re-set work. The child had been in severe pain with toothache throughout lockdown but her own dentist had been unable to help.

Overall the child's family felt that they had been let down let down by dental services in Leeds on a number of occasions. They had not been aware of the services the Trust could offer and the referral had not been handled in the correct way. A plan had now been put in place for the child and her ongoing treatment would be at her nearest dental clinic.

Jenny said that learning from this story had resulted in a review of the management of the dental waiting list. She said that staff in the service had responded in a very positive way and over a period of three weeks 22,000 dental records had been cleansed and a priority waiting list created in an effort to ensure that the service was meeting the need of patients appropriately and as quickly as possible.

The Trust Chair invited questions from member of the Board.

The Executive Director of Operations said that it was important for the Board to hear when patients had not experienced a good service from the Trust. She said that she had taken some learning from the story today:

- Handling initial referrals – the Quality Improvement Team could provide advice to the
- Team on this.
- A review the publicity and patient information leaflets to ensure that patients are clear about the services available to them and how they are accessed.
- An audit system could be developed, with the Quality Improvement Team's support, that would pick up errors such as this
- Availability of dental consultants – discussions were ongoing to access support from the Leeds Dental Institute.

In response to a question from the Trust Chair, the Executive Director of Operations said that the General Manager of the Specialist Business Unit (SBU) was undertaking a piece of work to look at the management of waiting list across all specialist services including musculoskeletal and podiatry. It was agreed that the outcome of this work should be reported to both the Business and Quality Committees.

In response to a question from Non-Executive Director (RG), the Executive Director of Operations confirmed that a Single Operating Procedure was in place for managing waiting lists across all services in the Trust.

The Trust Chair thanked Jenny for describing the patient's experience, her honest assessment of the initial response to the referral and the actions the Team had taken as a result of the concerns raised by the family.

Item 2020-21 (92)

Discussion points:
Chief Executive's report –including Covid-19
The Chief Executive presented her report particularly highlighting:

- Covid response
- Flu vaccine campaign
- EU Exit
- Public Launch of the Leeds Mental Wellbeing Service
- Staff survey

<u>Covid-19 vaccination programme</u>
The Executive Director of Operations provided a verbal update on the vaccination programme.

She said that the Trust was playing a full role in ensuring the Covid-19 vaccination programme would be successful and she was the Senior Responsible Owner for the programme in Leeds. A programme team has been established across the City with Leeds Teaching Hospitals NHS Trust as the lead provider with vaccines delivered from a hub at its St James's Hospital site. In addition she said that work was continuing at pace with primary care colleagues to set up the local vaccination services at a primary care network level.

The first vaccinations were scheduled to take place on 8 December 2020 for people aged 80 and over as well as care home workers and NHS workers who are at higher risk. The Trust would be allocated a small number of slots for high priority staff; including those who are known to be Clinically Extremely Vulnerable (for example, those colleagues who were shielding) and those staff would be contacted directly.

Flu vaccination programme

The Executive Director of Nursing and Allied Health Professionals reported that 72.2% of front line clinical staff had been vaccinated and further clinics were planned over the next two weeks. The Trust was hoping to achieve 80% overall.

In response to a question from Non-Executive Director (HT), the Executive Director of Nursing and Allied Health Professionals said that the roll out of the vaccine had been slow. Initially limited stocks of the vaccine had been made available to the Trust, this alongside the rules on social distancing had limited the number of bases that could be used and the challenges around PPE had all impacted on the roll out of the programme.

Staff testing

The Trust Chair asked for an update on staff testing.

The Executive Medical Director reported that kits had been distributed in the West Neighbourhood Team with 102 staff actively testing and there had been no positive results so far. Phase 2 would commence in the next week for including staff at Adel Beck, Little Woodhouse Hall, Hannah House and the Infection Prevention Control Team. Phase 3 would include some Specialist Services and the remaining Neighbourhood Teams on a staggered basis, when the online portal had been tested and was found to be stable.

Workforce

The Director of Workforce, Organisational Development and System Development (JA) reported that staff absence at the end of October was 5.2% which is higher than the previous 3 months but lower than this time last year; this had risen in light of a second wave of the pandemic and additional Covid-19 sickness absence.

The Trust Chair referred to the significant pressures on safeguarding services and the 0-19 Service outlined in the report and sought assurance that the required support was in place.

The Chief Executive reported that the Executive Director of Nursing and Allied Health Professionals (AHPs) and the Executive Director of Operations had agreed additional capacity in the Front Door service to support safeguarding. The situation was being monitored carefully. Staff were being supported by the Safeguarding Team and additional supervision was being offered where required.

Outcome: The Board:

- received and noted the Chief Executive's report and the Covid-19 update.

Item 2020-21 (93)

Discussion points:

Assurance reports from sub-committees

a) – Audit Committee 16 October 2020

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

- **Internal Audit**: the Committee had discussed the slow progress being made against the 2020-21 internal audit plan and the challenges to completing the full internal audit programme in the light of the Covid-19 response focus. Further consideration would be given to this at the next committee meeting.
- **Covid Assurance Framework**: the Committee received an update on the progress being made by the Senior Management Team (SMT) in documenting the decisions and actions in the Covid Assurance Framework.
- **Risk Appetite Statement review**: the statement had been reviewed by SMT and presented to the Committee. The Committee discussed the current risk appetite levels and agreed with the SMT's assessment that these remained appropriate.

b) – Quality Committee – 26 October 2020 and 23 November 2020

The reports were presented and the key issues discussed were highlighted, namely:

- **Little Woodhouse Hall:** the Committee received an updates on the continuing challenging position in the Unit and the progress to embed improvements. The Committee had noted that there was evidence of positive improvements and outcomes as increasing assurance.
- **Breach of Category 4 Pressure Ulcer target:** the Trust had breached the zero tolerance target for Category 4 pressure ulcers with lapses in care. The Committee received an update on the actions being taken to address the learning.
- **CQC Improvement Plan:** the Committee received an update which confirmed that the outstanding actions related to final assurance and the process was expected to be completed in January 2021.
- **Podiatry waiting lists:** were showing a significantly improved position with 300 patients still to be assessed, all of whom had appointments booked.

c) – Business Committee - 28 November 2020 and 25 November 2020

The reports were presented by the Trust Chair and Chair of the Committee and (BC) who highlighted the key issues discussed, namely:

- **Digital Strategy - plan on a page:** the Committee received an update on the implementation plan and had recognised that the programme was complex in terms of appetite for change, resource require, funding and deliverability.
- **Quarterly finance report:** the Committee received a report on the national financial regime for the second half of the year, the Integrated Care System (ICS) approach, the financial plan and the position across Leeds.
- **Sustainable development management plan:** received the plan and recommended its approval to the Trust Board at this meeting.
- **CAMHS Tier 4:** the Committee received an update on progress with. and transferring responsibility for the new build project and the current service to Leeds and York Partnership NHS Trust. The new build was progressing well and was on schedule to open in November 2021.

Outcome: The Board noted the update reports from the committee chairs and the matters highlighted.

Item 2020-21 (94)

Discussion points:

Performance Brief and Domains Report: October 2020

The Executive Director of Finance and Resources presented the report which sought to provide assurance to the Trust Board on quality, performance, compliance and financial matters. It provided a summary of performance against targets and indicators agreed by the Board, highlighting areas of note and added additional information where this would help to explain current or forecast performance.

The Board noted that in order to relieve pressure on the corporate teams a less intensive approach to the Performance Brief had been adopted for reporting the Key Performance Indicators for October 2020.

The Board reviewed the October 2020 performance data which had also been reviewed in depth by the Quality and Business committees on 23 and 25 November 2020 respectively.

In response to a question from the Trust Chair, the Executive Director of Nursing and Allied Health Professionals said that the increase in the number of complaints received was to be expected as a result of service stand down and reflected the national trend in this area. She provided assurance that the nature and number of complaints was being monitored closely.

The Board discussed the impact of Covid-19 on waiting lists and the potential for the data to be

distorted as a result.

The Trust Chair observed that the Business Committee received a reset dashboard which provided three months of data and had received assurance that work was ongoing to test data quality and consistency. The next steps would be to develop clear narratives and plans to further address the backlog in waiting lists if necessary.

The Director of Workforce, Organisational Development and System Development (JA) highlighted some key data from the Well-Led domain at the end of October:

- Staff absence was 5.2% which was higher than the previous three months but lower than this time last year.
- Sickness absence included 1% Covid related sickness.
- Staff turnover was 9.5% which was lower than the last three months and lower than the national average figure of 12%. A deeper analysis of turnover rates for staff with less than 12 months service would be reported to the Business Committee.

In response to a question from the Chair, the Director of Workforce, Organisational Development and System Development (JA) said that in terms of overall recruitment, on average the Trust had 12-15 vacancies each month.

The Executive Director of Nursing and Allied Health Professionals (AHPs) advised that an AHP career pathway was being developed. She also confirmed that the Trust benchmarked well in terms of healthcare assistant vacancies.

The Executive Director of Finance and Resources provided a brief overview of financial performance as at the end of October 2020. He said that the report reflected the revised financial regime for the second half of 2020/21. The Trust had submitted a revised plan to NHS England/Improvement for October through to March 2021. This took into account the current expenditure and income run rates and planned service and waiting list initiatives. Covid-19 costs that had been incurred by the Trust this year were also built into the plan. He pointed out that under this regime the Trust must breakeven on income and expenditure by the end of March 2021. There was no funding or costs in the plan for the impact of the Covid-19 vaccination programme; it was expected these costs would be dealt with by additional allocations to providers.

Overall the Trust had a small underspending at the end of October of £69,000 against the revised plan.

Outcome: The Board:

- noted the present levels of performance.

Item 2020-21 (95)

Discussion points:

Significant risks and Board Assurance Framework (BAF)

The Chief Executive introduced the report which provided information about the effectiveness of the risk management processes and the controls that were in place to manage the Trust's most significant risks.

The strongest theme found across the whole risk register was staff capacity, second strongest theme was CAMHS and the joint third strongest were staff safety and the functionality of IT software.

The Board noted changes to the risk register as follows:

- Two risks currently scoring 15 or above (extreme):
  - managing the complexity of young people admitted to the CAMHS Tier 4

Inpatient Unit
- Coronavirus (Covid 19) increase in infection rates (recently escalated from 12 due to the increase in cases)
- Eleven risks scoring 12 (very high)

The Board noted the controls and planned actions for each risk. The Board noted the BAF strategic risks had been subject to scrutiny by the Quality Committee and the Business Committee at their meetings on 23 November 2020 and 25 November 2020 respectively.

In response to a question from the Chair, the Chief Executive said that the SMT had considered the scoring for high risks and a judgement had been made to keep the risk scores at 15 or above. No risks had been closed, consolidated or deescalated below 15 since October 2020.

Non-Executive Director (JM) asked about the management of risks related to Covid-19 and when the Board would receive an update on the Covid Assurance Framework. The Company Secretary confirmed that a paper would be presented to the Board at the January 2021 meeting to provide assurance that there was a robust process to capture the decisions and actions taken during the first Covid wave.

Outcome: The Board**:**
- received assurance that for new and escalated risks the planned mitigating actions would reduce the risk
- noted the additional assurances against the BAF strategic risks linked to the themes identified in the report.

Item 2020-21 (96)

Discussion points:
Health inequalities update
The Executive Medical Director presented the report which summarised the current position regarding tackling health inequalities by the Trust following the expectations set out by NHS England in July 2020 and the next steps planned.

The Board agreed that it should have direct oversight of the health inequalities programme with reports presented to the Board three times a year. It was suggested that an individual committee might receive specific reports on certain elements of the work programme for example the Quality Committee on Clinical Outcomes.

The Board discussed the proposed timeline for development of the strategy.

Non-executive directors expressed concern about the proposal for the Board to approve a fully developed strategy in June 2021 that something be presented to the Board earlier in 2021.

The Chief Executive said that it was important to note that the Trust was an active participant in the Leeds Health Inequalities Group which had developed a framework, terms of reference and key steps to tackling inequalities in the city and the Trust's strategy would sit within this context.

She said that the Trust had appointed a Health Inequalities Lead to report directly to the Executive Medical Director and the successful candidate would begin work in January 2021 to develop the strategy. She agreed that it should be possible to present a report that included a 'road map' for the developing strategy in advance along with a set of high level priorities. This report would be shared with Quality and Business Committees for scrutiny prior to being presented to the Board. .

It was suggested that this report might include detail around the themes the strategy would focus on and the achievements and successes to date.

Outcome: The Board:

- agreed that the Board should have direct oversight of the Health Inequalities work
- will receive an early report which will be include a road map and a set of high level priorities in advance of receiving the draft strategy
- will receive routine reports three times per year thereafter.

Non-Executive Director (JM) left the meeting.

The Executive Director of Operations left the meeting

Item 2020-21 (97)

Discussion points:
Infection prevention control: Board Assurance Framework for infection prevention control
The Executive Director of Nursing and Allied Health Professionals presented the report which apprised the Board of the measures in place around identified key lines of enquiry in relation to Infection Prevention Control (IPC) and Covid-19, in line with national guidance from Public Health England (PHE). She drew attention to the updates around the gaps which had been previously identified.

A Non-Executive Director (HT) welcomed the updated report which had been previously considered by the Board in June and September 2020 and now provided robust assurance about the measures in place.

Outcome: The Board:

- noted the content of the updated report.

Item 2020-21 (98)

Discussion points:
Mortality report
The Executive Medical Director presented the Mortality Report which provided assurance regarding the figures and processes within the Trust in Quarter 2 2020/21.

Outcome: The Board:

- received the assurance provided by the report regarding the Trust's mortality process within the Trust and acknowledged the high demands placed on the teams.

Item 2020-21 (99)

Discussion points:
Serious incidents summary report
The Executive Director of Nursing and Allied Health Professionals presented the report which informed the Board with assurance that serious incidents (SIs) were being managed, investigated and acted upon appropriately and that actions were being developed from the Root Cause Analysis investigations.

The Trust had identified 25 new Serious Incidents in Quarter 2 2020/21. Two incidents had been de-logged following investigation. The Trust had no 'never events' in Quarter 2 2020-21.

More robust reporting systems were now in place and a number of issues had been identified in the reporting systems during Quarter 2 including, delays in the timeframe for reporting on Strategic Executive Information System (StEIS) and the Trust's compliance with the Duty of Candour requirements.

In response to a question from the Trust Chair on the root causes of serious incidents, the

Executive Director of Nursing and Allied Health Professionals confirmed that there had been a number of issues around communication, which had led to the incidents occurring. The Patient Safety Summit, which was working well, was focussing on these issues.

Outcome: The Board:

- noted the content of the report.

Item 2020-21 (100)

Discussion points:

Reducing restrictive interventions – Little Woodhouse Hall

The Executive Director of Nursing and Allied Health Professionals presented the report which highlighted the incidence of restrictive interventions at Little Woodhouse Hall for Quarter1 and 2 2020/21. She explained that the report included information on the number of restraints and seclusions and the decisions regarding blanket restrictions. There had been one prone restraint recorded, which when reviewed had been a supportive measure and not a prolonged restraining hold in this position.

In response to a question from Non-Executive Director (RG), the Executive Director of Nursing and Allied Health Professionals confirmed that the data was made available to the Care Quality Commission and the SMT.

The Board noted that the higher number of restraint incidents in July and August 2020 reflected the care of two complex young people.

Non-executive Director (HT) felt the overall the report was very positive and reflected well on the Unit and asked for an update on the unit in general. The Executive Director of Nursing and Allied Health Professionals advised that the Safe Wards approach was ongoing, including safety huddles. Staff issues were now better managed, and workforce resource had improved. There were now five young people being cared for in the unit.

Outcome: The Board:

- received and noted the information in the report.

Item 2020-21 (101)

Discussion points:

Freedom to Speak Up Guardian: quarterly report

The Freedom to Speak Up Guardian (FTSUG) presented the report which provided an overview for the period 3 August 2020 to 4 December 2020 including themes that have emerged from the work to date, links to areas of the Trust's work and the BAME Network.

The FTSUG reported that the role was working well and that he received strong support from the Chief Executive, directors and the wider organisation. He said that the work within the Trust had engendered significant interest from other neighbouring NHS organisations including requests for peer reviews of their services.

The Trust Chair observed that the report demonstrated the powerful impact of the work undertaken by the FTSUG within the Trust and he commended the support being offered to external partners which was leading to wider national recognition.

The Chief Executive placed on record her thanks to the FTSUG for his exceptional commitment to this important work. She provided assurance that where concerns had been raised about clinical care the SMT had been made aware of the circumstance and that in every case so far the SMT was already aware that a concern had been raised.

Outcome: The Board:

- noted the report, the activity to date and placed on record its continued support in embedding the work across the Trust.

Item 2020-21 (102)

Discussion points:
Guardian for Safe Working Hours Quarterly Report
The Executive Medical Director presented the report on behalf of the Guardian for Safe Working Hours (GfSWH) which included information on the issues affecting trainee doctors and dentists in the Trust, including morale, training and working hours.

The Board reviewed the report noting; there were no exceptions to report during Quarter 2, the challenges around the engagement and training experience of paediatric trainees, the work led by the Deputy Medical Director to address this and that expressions of interest were being sort for a new GfSWH following the withdrawal of the recently appointed successor to Dr Turlough Mills.

Outcome: The Board:
- received and noted the report.

Item 2020-21 (103)

Discussion points:
Annual Workforce Equality and Diversity Report
The Director of Workforce, Organisational Development and System Development (JA) presented the report which outlined the Workforce Equality and Diversity actions and progress made during 2020-21 in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED).

She highlighted the work with the BAME staff network group, the 3rd cohort of the BAME Reverse Mentoring Programme, launch of the "I Can Be Me" campaign, introduction of BAME ambassadors and the launch of the Rainbow Badges initiative.

She said that Covid-19 had challenged the NHS, staff, patients and communities in all sorts of ways but throughout, the Trust had sought to embody its values and behaviours in its approach.

In response to a question from the Trust Chair, the Director of Workforce, Organisational Development and System Development (JA) explained that progress on equality and diversity work in relation to disability and lesbian, gay, bisexual and transgender was less mature but plans were being developed to put this work on a similar track to that of the race equality.

Outcome: The Board:
- noted the progress made over the last 12 months and received assurance that the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract were being met.

The Executive Director of Operations re-joined the meeting

Item 2020-21 (104)

Discussion points:
Sustainable Development Management Plan
The Executive Director of Operations presented the plan and supporting implementation plan. She explained that this had been reviewed by the Business Committee on 25 November 2020 and the Committee recommended that the Board should approve the plan. She confirmed that the amendments suggested by the Business Committee including outcome measures would be

presented to the Business Committee incorporated into the first update report.

Board members noted that the views of staff had positively influenced the development of the plan collected through the staff survey.

The Board noted that the first quarterly review of the plan would be brought to the Business Committee in April/May 2021.

Outcome: The Board:

- approved the plan to commence in January 2021.
- noted that the Business Committee would receive an update that included measurable outcomes.

Item 2020-21 (105)

Discussion points:
Annual General meeting: 15 September 2020
The Company Secretary presented the draft minutes for approval.

Outcome: The Board:

- approved the draft minutes as presented without amendment.

Item 2020-21 (106)

Discussion points:
Amendment to Standing Orders and Scheme of Delegation
The Company Secretary presented the proposed amendments. She reminded members that the Board had discussed its governance arrangements at an informal meeting on 6 November 2020 and agreed a temporary amendment to its standing orders with immediate effect.

The agreement was that the majority of standing orders would continue to apply, however some changes were required and these were documented in the paper presented to the Board in order for the Trust's governance arrangements to remain transparent.

The amended governance arrangements would be in place until the Board agreed that pressure on the Trust and the wider health system has been reduced sufficiently for the Trust to revert to its usual governance framework. Board members could request a review of these interim measures at any time and the Board would review them no later than 31 March 2021.

Outcome: The Board:

- noted the agreement to temporarily amend some of the Board's standing orders
- ratified this agreement at this Board meeting held in public.

Item 2020-21 (107)

Discussion points:
Approved minutes for noting
The Board received the following final approved committee meeting minutes and notes presented for information.

a. Audit Committee 17 July 2020
b. Quality Committee 21 September 2020 and 26 October 2020
c. Business Committee: 23 September 2020 and 28 October 2020
d. NED briefing notes 12 November 2020
e. Scrutiny Board: Adults, Health and Active Lifestyles 20 October 2020.
f. West Yorkshire and Harrogate Mental Health Services Collaborative – Committees-in-

Common 22 October 2020

Outcome: The Board:

- noted the final approved minutes and notes.

Item 2020-21 (108)

Discussion points:
Board workplan
The Chief Executive presented the Board work plan (public business) for information.

Outcome: The Board

- noted the work plan.

Item 2020-21 (109)

Discussion points:
Close of the public section of the Board
The Trust Chair thanked everyone for attending and concluded the public section of the Board meeting.

Closed at 11:45.

Date and time of next meeting
Friday 5 February 2021, 9.00am – 12.00noon
Virtual meeting
Boardroom, Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA ITEM 2020-21 (113b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 5 February 2021

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting 4 December 2020				
	None to note			

Actions on log completed since last Board meeting on 4 December 2020	
Actions not due for completion before 5 February 2021; progressing to timescale	
Actions not due for completion before 5 February 2021; agreed timescales and/or requirements are at risk or have been delayed	
Actions outstanding as at 5 February 2021; not having met agreed timescales and/or requirements	

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (116a)

Title: Charitable Funds Committee Chair's Assurance Report (meeting 8 December 2021)

Category of paper: For assurance
History: Not applicable

Responsible director: Chair of Charitable Funds Committee
Report author: Executive Director of Nursing and Allied Health Professionals

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Purpose of the report
This paper identifies the key issues for the Board from the Charitable Funds Committee held on 8 December 2020 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Charitable development updates
The arrangements for the new organisational structure of the LCH Charity arrangements are now in place and the Charitable Funds operational Group has now met for the first time. It is establishing an action plan for the work required over the coming year. This will include:

- Establishing the membership to include a member of the LCH Youth Board and looking at how the LCH charity can be promoted both internally and externally.
- The terms of reference were agreed by the Committee with one minor change. This includes the structure for how bids can be agreed and the governance in place to ensure the correct process is followed.
- The group is planning for one major event next year which will hopefully be a 3 peaks walk – this is being researched currently and plans will be formalised in the coming weeks. IN addition there is work ongoing to see if LCH can have charity places for the Leeds half marathon and a number of virtual events are being planned including on line quizzes etc. leading up to the big event next year.

Finance Report
The Director of Finance presented the finance report. There were a couple of questions in relation to the spend and explanation for this given. The report was accepted by the Committee.

LCH Charitable Funds and Related Charities Annual Report & Accounts 2019/20
This was accepted by the committee and the Letter of Representation was agreed and the Chair agreed to his signature adding to this.

Terms of Reference
The updated Terms of Reference were accepted by the committee pending one minor change.

NHS Charities Together
The Committee had a conversation about the potential to apply for further charitable funds from the NHS Charities Together and agreed if there were appropriate opportunities the Trust would consider further applications. This will be promoted within the Operational Group and at SMT

Public Board Meeting: 5 February 2021
Agenda item number: 2020-21 (116b)

Title: Nominations and Remuneration Committee – 8 December 2020: Chair Assurance Report

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Category of paper: for assurance
History: n/a

Responsible director: Chair of the Nominations and Remuneration Committee
Report author: Director of Workforce

Executive summary (Purpose and main points)

This paper identifies the key issues for the Board arising from the Nominations and Remuneration Committee meeting held on the 7th December 2020, and it indicates the level of assurance based on the evidence received by the Committee.

This was a regular quarterly meeting of the committee which had last met in September 2020.

Items discussed:

The Real Living Wage

LCH has paid the Real Living Wage to those staff impacted since 2018. The committee received and approved a paper recommending the continued payment of the Real Living wage to staff following the increase in the rate to £9.50 from November 2020.

GP Pay

The Committee considered a draft paper which set out a proposal for a remuneration schedule for GPs employed by LCH, to replace the temporary one in place for COVID-19 arrangements.

The paper attempted to identify the need for a salary scale to utilise for the employment of GPs in LCH and in the context of our continued journey to integrate primary and community care services and the evolution of service provision leading to the in-reach of GPs to community services. LCH also currently employs a small handful of GPs within services for whom there is no built in mechanism to award pay rises. Additionally, there is no mandated national salary scale for GPs although there is a recommended salary range which does not necessarily reflect the complexities and nuances of the labour market in Leeds (or in other places). The paper proposed a means by which to consistently pay GPs should they be employed by LCH in either a part time or full time capacity.

The Committee provided helpful insights and feedback on the paper which will be re-worked prior to returning to the Committee at a later date.

Recommendations

- The Board is recommended to note this information.

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (116c)

Title: Audit Committee Chair's Assurance Report (meeting 15 January 2021)

Category of paper: For assurance
History: Not applicable

Responsible director: Chair of Audit Committee
Report author: Company Secretary

Executive summary

This paper identifies the key issues for the Board arising from the Audit Committee 15 January 2021.

Items discussed:

Internal audit plan

The Committee reviewed initial thinking on audits to be included in the internal audit plan 2021/22. This included audits proposed to be carried forward from the 2020/21 plan. The same document 2021/22 plan will be presented at both the Quality and Business Committees at their meetings in January 2021 for input and consideration of how the plan would support each Committee's assurance requirements.

The Committee was concerned that the 2020/21 plan had not progressed sufficiently because of the challenges presented by the pandemic. The Head of Internal Audit advised the Committee that if the current, albeit reduced plan was completed, then there would still be sufficient work to provide an overall audit opinion. There may be a need to conduct some of this year's audit work early in quarter one 2021 to achieve that opinion. A further suggestion to be explored in case there were further risks to completing the outstanding audits planned was the possibility of completing some shorter pieces of desk top audit work that could be for example, reviews of policies etc. hence limiting the need to engage with front line operational staff. The Audit Committee requested a reworked plan for the remainder of the year which is achievable and sufficient to meet the reporting requirements and agreed that the timetable for completion may on this occasion extend into April 2021

Statutory/mandatory training internal audit recommendations

The outcome of the compliance review of statutory and mandatory training audit was published in January 2020. The Committee received an update on progress with the series of recommendations relating to the management of statutory and mandatory training within the Trust and the plan for meeting the remaining requirements of the two outstanding recommendations. This progress had taken place throughout 2020 in the context of the COVID-19 pandemic. There were two outstanding recommendations, namely completion of the statutory/mandatory compliance project and instigation of the monitoring and reporting of all 13 statutory and mandatory training subjects. The Committee recognised the continuing challenges and pressures the Workforce directorate and other stakeholder integral to this work will likely face in the next few months and that there were risks to the remaining actions being completed by the end of March 2021. The Committee requested that Quality and Business Committees are kept up to date with progress.

External audit update

The external auditors, Mazars, advised the Committee that overall, progress is on track with no significant issues arising that require reporting. The timetable Mazars is working to is later than experienced in previous years as new responsibilities have been introduced under the 2020 Code of Audit Practice. Mazars provided an update to the Committee on its completed activities and described the plan for the coming period.

Regarding the Value for Money “VfM” aspect of the audit, a new approach has been introduced which requires a commentary on VfM arrangements and does not require an audit conclusion or opinion. The commentary should address three specified reporting criteria: financial sustainability, financial governance, and improving economy, efficiency and effectiveness.

The actual audit plan will be presented at the March 2021 Committee meeting.

Data Security and Protection Toolkit (DSPT) baseline assessment

The Committee was advised that the DSPT assessment deadline has been amended to the 30 June 2021, to account for the extended 2019/20 submission year. The baseline assessment has been undertaken and the Trust is currently compliant with 11 out of 37 mandatory assertions, with an improvement plan in place to address the remaining 26 by the 30 June 2021. There is currently a risk with compliance of the DSPT, as evidence is required that could only be supported by a Security Incident Event Management (SIEM) system, for which the Trust is currently progressing procurement.

Recommendations

The Board is recommended to note this information.

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (116d)

Title: Quality Committee Chair's Assurance Report 25 January 2021

Category of paper: For Assurance

History: N/A

Responsible director: Executive Director of Nursing and Allied Health Professionals

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Report author: Assistant Director of Nursing and Clinical Governance

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Quality Committee Chairs Assurance Report

Executive summary:

This paper identifies the key issues for the Board arising from the Quality Committee meeting held on the 25th January 2021, and it indicates the level of assurance based on the evidence received by the Committee.

This was a regular business meeting of the committee, however this was held by MS teams for a reduced duration due to persisting Covid-19 pressures.

Items discussed:

Covid-19 update

Update provided by Executive Director of Nursing and Allied Health Professionals and Executive Director of Operations. At the present time, the Acute Trust are reporting a stable situation and there has been a reduction in local Care Homes with outbreaks over the last seven days. Referrals to LCH have remained static with greatest pressure being in supporting end of life care at home which has increased 40%. LCH staff have been redeployed to support the Covid-19 vaccination programme and the vaccination has been offered, and being encouraged, to all LCH staff.
Flu campaign currently at 78.9% staff vaccinated.

Reset and recovery

The Committee received confirmation that all services, following engagement with staff, re-started by September 2020 with a focus on waiting lists and backlogs. Virtual consultations are now in place in the majority of services. Work in Children's Audiology around high DNA rates identified public concern at attending appointments and this is being explored to reduce the impact of DNAs. Assurance provided that all high risk waiters are being seen. Consideration being given to low risk waiters who may become high risk due to duration of wait. Incident and complaint data is also being triangulated with waiting list impact.

CAMHS Tier 4

The Committee heard the positive story provided in the paper about the ongoing improvement work at Little Woodhouse Hall. This was noted as providing greater assurance.

Never Event

The Committee received formal notification of Never Event which occurred on 9th December 2020 of wrong site spinal injection. There was no harm to the patient. Immediate additional safety measures were put in place and an investigation commenced which is due to be reviewed next week. The investigation is being conducted in partnership with Leeds Teaching Hospitals NHS Trust (LTHT).

Performance Brief

The Committee heard that safe staffing was maintained despite the data anomalies as this is currently reported in line with Acute Trust requirements. Reporting is being worked through to align with Community provider.
The reduction in Little Woodhouse Hall incidents was noted.

Clinical Governance report
Committee were informed of the step down of Quality Walks to support the redeployment of staff and plans to re-start from 1st April 2021. Assurance was provided that monthly performance panels take place with each Business Unit to address areas of concern reflected in reports provided. Suggestions were made to enhance the business unit reports to Committee and these were noted to be fed back.

Quality Improvement Plan (CQC)
The Committee was informed that the Trust wide ligature policy is nearing completion (must do action) and a final update with the concluded plan was agreed to be provided in March 2021.

Mortality report
The Committee was informed that the Adult Business Unit had been undertaking level 2 reviews on all Covid-19 deaths, this has provided minimal additional learning and therefore the approach is being reviewed.

Risk Register
The Committee was informed that there was one extreme risk on the risk register: the continuing risk of Covid-19 infection. There were four new clinical or operational risks reported this month. The increasing use of an alternative provider for First Contact Practitioner type work within the MSK Service was noted and discussed as an increasing risk.

Patient Group Directions (PGDs)
The Committee approved the two presented PGDs

Internal audit annual plan 2021/22
The Committee reviewed the plan prior to the anticipated approval at Audit Committee on 21 March 2021. It was agreed for members to give this greater consideration prior to the next Quality Committee meeting.

Committee subgroups annual reports and terms of reference
The Committee reviewed its three subgroups' annual reports and terms of reference. Minor amendments had been suggested to some terms of reference, which were approved by the Committee.

Recommendations
The Board is recommended to note this information.

Can the Committee assure the Board on the following strategic risks?	Agenda items reviewed:	Overall level of assurance provided:	Additional comments:
RISK 1.1 Does the Trust have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards?	Performance Brief (effective domain) Clinical Governance report Mortality report Never event Internal Audit Plan MHAG minutes QAIG minutes	Reasonable Assurance	
Risk 1.2 Are there sufficient clinical governance arrangements in place for new care models?	N/A		Need to further look at this in relation to agenda setting
RISK 1.3 Is the Trust maintaining and continuing to improve service quality?	LWH assurance update Performance Brief (safe and caring domain) Clinical Governance report Quality improvement plan (CQC) Risk register report QAIG minutes	Reasonable Assurance	Noted significant improvement in assurance around Little Woodhouse Hall Requirement to tighten up reporting of escalations to Quality Committee
RISK 1.4 Is the Trust engaging patients and the public effectively?	N/A		Need to further look at this in relation to agenda setting
RISK 1.5 Is the Trust's altered (Covid) capacity affecting the quality of service delivery and patient outcomes	Covid-19 update Reset and Recovery Risk register report Clinical Governance report Performance Brief (safe and caring domain)	Reasonable Assurance	Significant discussion around Covid-19 and re-set and recovery

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (116e)

Title: Business Committee Chair's assurance report 27 January 2021

Category of paper: For assurance
History: Not applicable

Responsible director: Business Committee Chair
Report author: Business Committee Chair

Executive summary (Purpose and main points)
This report identifies the key issues for the Board from the Business Committee held on 27 January 2021 and provides assurance on how well its strategic risks are being managed. The level of assurance is based on the information in the papers and other information received and the Committee's discussion.

Items discussed:

Covid update
The Committee received an update on the local situation including current infection rates, the number of patients in hospital with this disease, plans to increase critical care capacity and the latest information on the vaccination programme. A similar update will be provided to the Board.

Workforce Report (Covid)
The report included information on how the Trust is supporting staff to keep well and at work through this period and how staff resource is being maximised as well as an update on the Health and Wellbeing action plan. In terms of staff health and safety, the ongoing focus was ensuring that staff can operate within a safe working environment, and continuing support for staff that are clinically, extremely vulnerable and are required to shield.

Reset and Recovery
The Executive Director of Operations presented the Committee with an update on the Reset and Recovery Programme. On the whole, the aims and objectives of the project were being met. All services restarted between June and September 2020 and the backlog had started to reduce. Work was now needed to establish unacceptable waiting times for patients whose clinical presentation was not urgent.

There had been progress with transforming services, and a significant number of staff have engaged with this part of the project. Transformation had been impacted to some degree by the second Covid wave from November 2020. The Committee was shown an example of the performance dashboard being developed for services which highlights activity levels and progress in adopting new methods and channels. The Committee heard about the work being done to reduce waitlists and that the Trust was working with Healthwatch to ensure that patients would have access to the digital offer, as well as the additional wraparound support that third section organisations could offer patients.

Estate Strategy
The Committee was advised of the Trust's intention to commission a project to align the estates strategy with clinical service strategies. The Committee was keen that the project scope needed to involve partners in the City so that whilst the Trust was shaping its own provision, it could also understand and incorporate the aspirations of the City.

Performance Brief
The Committee recognised that the current Key Performance Indicators did not fully take into account the impact the pandemic is having on service delivery. Staff turnover was currently low and stable however there a risk that this could change post-pandemic across the country as staff consider their futures. The Committee

discussed the staff safety incidents including violence and aggression and requested a further breakdown including incidents of racial abuse. For the finance section of the Brief, the Committee was informed that the Integrated Care System would achieve its aggregate goal.

Health and Safety Compliance Report
The Committee received an update on the progress with the action plan that had been produced in response to the Health and Safety Executive's inspection and subsequent findings. The plan is regularly monitored by the Health and Safety Group and there has been significant progress made.

Internal Audit Annual Plan
The Committee reviewed the draft internal audit plan for 2021/22. The Committee debated the possible inclusion of an audit on waiting lists, but agreed that this would need to be appropriately timed as an early review may just confirm what is already known. Members were asked to consider the draft plan and feedback further suggestions for audits to the Executive Director of Finance and Resources.

Recommendations
The Board is recommended to note this information.

Recommendation: The Board is recommended to note the assurance levels provided against the strategic risks

The Business Committee provides the following levels of assurance to the Board on the these strategic risks	Agenda items reviewed	Overall level of assurance provided	Additional comments
RISK 2.2 Is the Trust delivering **contractual requirements?**	• Performance brief and domain reports (contractual penalties and waiting times) • Operational and non-clinical risks register • Reset and Recovery	Reasonable	Concerns remain about waiting times but this is not impacting on contractual requirements at this time
RISK 2.5 Is the Trust delivering on its **agreed income and expenditure** position?	• Performance brief and domain reports (Finance) • Estate Strategy	Reasonable	
RISK 3.1 Does the Trust have **suitable and sufficient staff capacity and capability** (recruitment, retention, skill mix, development)?	• Performance brief and domain reports (turnover) • Workforce update • Covid update • Appraisal internal audit	Reasonable	
RISK 3.2 Is the Trust addressing the **scale of sickness** absence?	• Performance brief and domain reports (Well-led) • Workforce update • Covid update • Health and Safety Compliance Report	Reasonable	
RISK 3.5 Has the Trust **developed and embedded a suitable health and safety management** system?	• Health and Safety Compliance Report • Health and Safety group minutes • Performance brief and domain reports (staff incidents)	Reasonable	Progress is being made with the Health and Safety Executive action plan. There were numerous examples throughout the Committee agenda that demonstrated the Trust's commitment to maintaining staff health and wellbeing
Risk 3.6 Is the Trust maintaining **business continuity** in the event of significant disruption?	• Reset and Recovery • Covid update	Reasonable	

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (117)

Title: Performance Brief and Domain Reports

Category of paper: For assurance
History:
Senior Management Team – 20 January 2021
Quality Committee 25 January 2021
Business Committee 27 January 2021

Responsible director: Executive Director of Finance and Resources
Report author: Head of Business Intelligence

Executive summary (Purpose and main points)

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

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

The report focuses on performance against the KPIs agreed before the commencement of the financial year and before the start of the Covid-19 pandemic. Performance against any of the indicators has been adversely affected by the impact of the pandemic on services and the Trust's normal business and this is explained, where relevant.

This report does not seek to describe how service delivery is recovering nor how the current wave of Covid and the lockdown is having a further impact; that is covered elsewhere on the agenda.

As previously agreed by the Board, whilst the KPIs have been produced as usual, the narrative is briefer and focuses on key items for escalation.

The main issues for consideration are detailed on pages 2 and 3 of the Performance Brief

Recommendations

The Board is recommended to:

- note present levels of performance

Performance Brief – December 2020

Leeds Community Healthcare NHS Trust

Purpose of the report

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

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

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This report does not seek to describe how service delivery is recovering nor how the current wave of Covid and the lockdown is having a further impact; that is covered elsewhere on the agenda.

As previously agreed by the Board, whilst the KPIs have been produced as usual, the narrative is briefer and focuses on key items for escalation.

Committee Dates

Senior Management Team – 20th January 2021
Quality Committee – 25th January 2021
Business Committee – 27th January 2021
Trust Board – 5th February 2021

Recommendations

Committees and the Board are recommended to:

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

Main Issues for Consideration

In the **safe** domain the Trust has targets of;

- 0 Category 4 Pressure Ulcers (PU's) where lapses in care are confirmed
- <9 Category 3 PU's where lapses in care are confirmed
- <14 Unstageable PU's where lapses in care are confirmed

To date we have exceeded targets with lapses in care confirmed in 2 x Category 4 pressure ulcers and 10 Category 3 pressure ulcers. In addition to improvement work within the Trust, benchmarking activity is also taking place, being led by the Assistant Director of Nursing with support of the incident manager and Clinical Pathway Lead for Integrated Care to identify areas of improvement and learning for the Trust. The Director of Nursing is also conducting an audit of all Category 3 pressure ulcers reported year to date deemed as having lapses in care to ascertain whether there have been any mis-categorisations.

In the **caring** domain 95.7% of community patients who responded reported their experience as good or very good. In December there were 9 complaints, 35 concerns and 104 compliments. 1 complaint and 3 concerns related to Covid-19.

The **effective** section focuses on the capacity of services to complete the backlog of NICE guidance implementation in Q4 in light of the current lockdown position and pressure and the system. Details of Unexpected Deaths in Community Bed Bases and 1 SUDIC are presented.

In the **well-led** domain the overall sickness absence rate for December is 5.5% (short-term absence 1.5% and long-term absence 4%). At the start of the pandemic sickness absence was over 6%. The positive news is that since then, the sickness absence rate month on month has been consistently lower when compared to 2019. Also of note, is the reduction in sickness absence rates for those areas that have been experiencing significant service pressure. This could be attributable to the increased focus on supporting staff's mental health and wellbeing during the pandemic.

There continues to be a significant focus on supporting staff health & wellbeing, which continues to be flexed to meet emerging need.
This month turnover is at its lowest of 9.1% and Stability rate at its highest of 90.2%, that we have seen since April 2018. Staff leaving within the first 12 months of employment is now reporting at 15.1 %, below the 20% target. Cumulatively, these areas give high levels of confidence in overall workforce stability.

Overall Compliance levels for Statutory & Mandatory training remains steady at 92.5%.

A continuation of a downward trend in overall appraisal rate at 79.6% is noted.

NHS England has indicated that the current **finance** regime will continue into quarter 1 of 2021/22. At the time of writing there are no further details as to the level of funding that will be available nationally or locally.

The planned year end position for this year was break-even.

Overall at 31 December 2020 the Trust had an underspending of £1.3m more than the planned position.

The forecast year end position is for a surplus. The management of this position is under active discussion with the CCG and partner Trusts in Leeds and with the ICS.

Capital expenditure is running £0.6m less than planned this is after un-planned Covid related expenditure. The Trust expects the Covid-19 expenditure to be funded centrally. Orders for estates work and IT kit have been placed and expenditure is expected to commence in January. The Trust has a revised forecast capital expenditure for 2020/21 of £3.106m.

Safe – December 2020

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

Leeds Community Healthcare NHS Trust

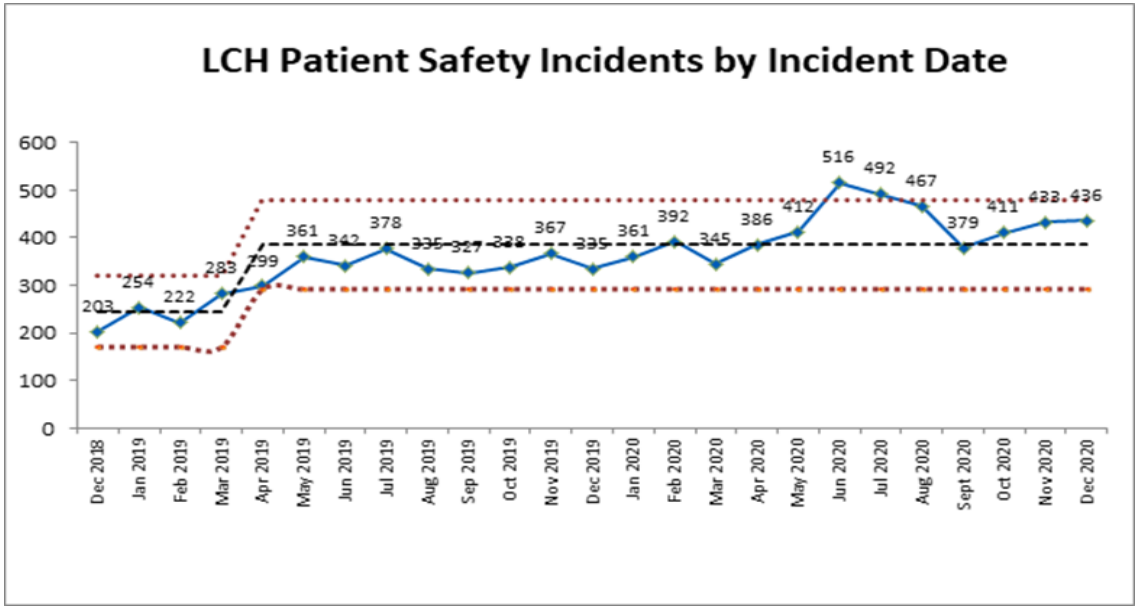
Safe - people are protected from abuse and avoidable harm	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
Overall Safe Staffing Fill Rate - Inpatients	SL	>=97%	-	●	2020/21	100.7%	94.0%	82.1%	87.6%	84.7%	84.9%	
					2019/20	94.7%	97.1%	97.7%	98.3%	94.9%	97.0%	
Patient Safety Incidents Reported in Month Reported as Harmful	SL	1.06 to 1.73	1.97	●	2020/21	2.12	1.97	1.64	1.93	1.92	1.83	
					2019/20	1.18	1.40	1.28	1.52	1.41	1.40	
Serious Incident Rate	SL	0 to 0.1	0.05	●	2020/21	0.05	0.06	0.04	0.04	0.07	0.05	
					2019/20	0.04	0.04	0.05	0.09	0.05	0.06	
Validated number of Patients with Avoidable Category 3 Pressure Ulcers	SL	8	9	●	2020/21	3	5	0	0	1	1	
					2019/20	2	0	0	2	3	5	
Validated number of Patients with Avoidable Category 4 Pressure Ulcers	SL	0	2	●	2020/21	1	1	0	0	0	0	
					2019/20	0	0	0	0	0	0	
Validated number of Patients with Avoidable Unstageable Pressure Ulcers	SL	12	11	●	2020/21	4	4	0	0	3	3	
					2019/20	-	-	-	-	-	-	
Number of teams who have completed Medicines Code Assurance Check 1st April 2019 versus total number of expected returns	RB	No Target	50%	●	2020/21	50%	58%	61%			61%	

Safe Staffing

Little Woodhouse Hall and Hannah House has maintained safe staffing throughout the Quarter. Staffing numbers are reviewed on a daily basis in line with the clinical need and there are well established systems in place to be flexible with staffing numbers across the inpatient units and with other Children's teams for example the Continuing Care Team. During this Quarter there was a cancellation of one night for one child at Hannah House due to low staffing levels.

Trend of Leeds Community Healthcare (LCH) Patient Safety Incidents by Month

The SPC chart below shows incident activity within normal variation. It is worth nothing that there has been a reduction in reports received from Little Woodhouse Hall (62 in November and 54 in December) and this is in part due to the changing cohort of young people in the unit.



Update of ongoing Serious Incident (SIs) Investigations

In December 2020, ten incidents were reported on StEIS as SI's. A request was made to de log one following further review, leaving nine for LCH to investigate, these were:

- 3 x Category 3 pressure ulcers;
- 2 x falls;
- 3 x Unstageable pressure ulcers;
- 1 x wrong site injection reported by MSK this is a Never Event.

All are currently under investigation.

Incidents occurring in December 2020

There were 747 incidents recorded in Datix in the month, of these 436 (58%) were recorded as LCH patient safety incidents.

The breakdown of LCH patient safety incidents by month and level of harm is depicted in the table below:

Month	LCH Patient Safety Incidents by Severity			Total
	Low and No Harm	Moderate Harm	Major Harm	
December	381 (87.4%)	39 (8.9%)	16 (3.67%)	436*
November	389 (89.8%)	37 (8.5%)	7 (1.6%)	433
October	383 (93.2%)	23 (5.6%)	5 (1.2%)	411
September	334 (88.1%)	36 (9.5%)	9 (2.4%)	379
August	421 (90.1%)	41 (8.8%)	5 (1.1%)	467
July	443 (90.6%)	37 (7.6%)	9 (1.8%)	489
June	433 (87%)	53 (11%)	9 (2%)	495
May	354 (91%)	30 (8%)	4 (1%)	388
April	351 (91%)	31 (8%)	2 (1%)	384

**December figures may be subject to slight change as incidents occurring in this month can be reported within the start of January and are still subject to review and possible amendments.*

Summary of Moderate Harm Incidents (occurring in December)

39 Moderate harm incidents were reported in the month. Incident categories are broken down below:

- 28 x Skin Damage (21 x Pressure ulcers; 4 x Deep Tissue Injury (DTI); 2 x Device related Pressure Ulcers; 1 x diabetic foot ulcer) 27
- 5 x Falls
- 2 x Self Harm
- 1 x Delayed Clinical Assessment
- 2 x Traumatic skin damage (meatal tears). Improvement work has taken place with WPaMS and CUCS to agree a consistent approach to reporting and scrutiny of these incidents.
- 1 has been rejected as not deemed moderate harm on further review.

Summary of Major Harm Incidents (occurring in December)

16 major harm incidents were reported in December; fourteen of these were falls, one pressure ulcer and one self-harm.
3 of the 16 have been discussed at Serious Incident Decision Meetings (SIDM) and have all concluded to have no lapses in care. The remaining 13 incidents have review dates booked in January 2021

Category 4 Pressure Ulcer update

None reported

SIDM Outcomes in November

61 incidents were heard at SIDM meetings in December, the outcome of those incidents is depicted below.

Total no.	No lapses in care & no further investigation required	Progressed to Internal Investigation	Progressed to comprehensive RCA as potential lapses in care (SI)	Further details required
61	44(72 %)	4(6.5%)	9(15%)	4(6.5%)

Of the 61 incidents discussed, nine incidents heard in December were progressed to serious incident investigations, these are detailed below:

- Pressure ulcers (3 Unstageable, and 2 Category 3)
- 2 falls; (i) A patient under the Pudsey NT fell overnight at home and sustained a left proximal femoral fracture. (ii) A patient under the Armley NT had an unwitnessed fall at home and sustained a fractured distal femur to the right leg.
- 1 Never Event where a patient under the MSK team received an injection to the wrong site
- 1 Near miss; Although a near miss incident, it was felt there was potential additional learning for the organisation to gain from further investigation and analysis.

The rationale for those incidents not requiring further review was not always clearly documented in the SIDM outcome box or the progress notes. Where the information was recorded it included: unwise decision making by the patient as the contributing factor to an incident, confirmation that observations had been continuously reviewed prior to an incident, patients being fully involved in their care planning, specific clinic location/times being requested by a patient that led to a delay in treatment and earlier appointments being declined by the patient and a re-categorisation of a pressure ulcer by the review meeting.

An action will be taken to review the 72 hour template to ensure feedback from the review meetings is documented to facilitate inclusion in the SIDM outcome box.

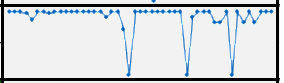
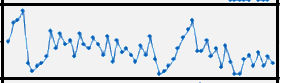
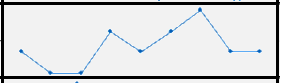
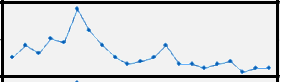
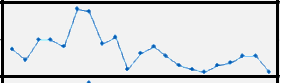
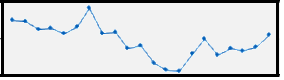
To what extent did LCH follow the duty of candour procedure?

There were 4 incidents reported in December which met the criteria for duty of candour. In each of the incidents that met the criteria of a safety notifiable incident, LCH carried out a 72 hr review to understand the initial facts in relation to what happened, what went wrong and what we could have done better. LCH informed the people affected, apologised to them, provided an explanation of how we would investigate and explored if they wished any specific questions to be answered within the investigation. This process was followed in all four cases (100%). Of these cases all four progressed to a Serious Incident investigation to identify individual and organisational learning and subsequent action / improvement plans.
Of these four cases, all (100%) have been provided with a letter confirming the initial discussion within the LCH standard of 10 days.

Caring – December 2020

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

Leeds Community Healthcare NHS Trust

Caring - staff involve and treat people with compassion, kindness, dignity and respect	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Inpatient and Community (FFT)	SL	>=95%		●	2020/21					95.7%	95.7%	
					2019/20	96.7%	96.6%	91.8%	97.6%	96.8%	94.5%	
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Inpatient Care (FFT)	SL	>=95%		●	2020/21					-	-	
					2019/20	85.7%	90.7%	100.0%	83.3%	100.0%	95.7%	
Percentage of Respondents Reporting a "Very Good" or "Good" Experience in Community Care (FFT)	SL	>=95%		●	2020/21					95.7%	95.7%	
					2019/20	96.7%	96.6%	91.7%	97.8%	96.8%	94.5%	
Total Number of Formal Complaints Received	SL	No Target	83		2020/21	19	35	8	12	9	29	
					2019/20	62	59	20	12	16	48	
Total Number of Formal Complaints Received Related to COVID-19	SL	No Target	11		2020/21	1	5	3	1	1	5	
					2019/20	-	-	-	-	-	-	
Number of Formal Complaints Upheld	SL	No Target	28		2020/21	14	9	1	2	2	5	
					2019/20	19	37	12	8	5	25	
Number of Formal Complaints Responded to within timeframe	SL	No Target	59		2020/21	20	17	9	9	4	22	
					2019/20	33	50	23	13	15	51	
Number of Compliments Received	SL	No Target	653		2020/21	148	244	75	82	104	261	
					2019/20	-	-	-	-	-	-	

Friends and Family Test (recommenced December)

Overall, in December 95.7% of community patients who responded reported their experience as good or very good. There have been no FFT responses for Inpatient services in December.

Comments received via FFT in December have included:

- *Your personal and efficient service was first class. It restored my confidence after a fall. The exercises were clear and enjoyable. Thank you. Excellent.*
- *I was shocked at the speed of this service and delighted with the care and quality it was amazing and what a fabulous experience to have in a terrible time.*

- *Was good but more difficult to interact than with a face to face discussion. Having said that this was offset by not having to travel and doesn't take up as much of my time. The session was very clear.*
- *I have been thankful to have had N helping me; she has always done what she said she would, always called when said she would and I have trusted her. She has done more for me than anyone else has ever done. I have felt able to tell her my thoughts even when I have felt sad about them and she has listened to me and helped me plan ways to manage these.*

Complaints, Concerns and Claims

The table below highlights the number of complaints and concerns that have been received by the Organisation in December 2020.

Feedback	December 2020 Received
Complaints	9
Concerns	35
Compliments	104
Clinical Claims	0
Non-clinical Claims	0

- 100% (9/9) complaints received in December were acknowledged within 3 working days.
- 100% (4/4) complaints were responded to within 180 days
- There were 28 active complaints on the caseload in December.

Covid-19

We have received 1 Covid-19 related complaint in the month of December. The complaint was received by CAMHS and is related to significant delays in access to treatment; the length of waiting lists, miscommunication related to service access and lack of support. This investigation is ongoing.

There have been 3 Covid-19 related concerns; 1 of these was for the Health Visiting team in Yeadon. The concern was raised via an MP on behalf of a mother who states her child is having feeding issues and is concerned that help has not been as immediate or freely available since the pandemic. The service is creating an action plan to support Mum and baby.

The other 2 Covid-19 related concerns have been received by PET and Facilities; with enquiries on guidance in relation to community staff supporting Covid-19 testing in peoples' homes and how to access guidance on this, and sign in procedures at Morley Health Centre, respectively.

43% of Covid-19 related contact received into PET in December required signposting to other organisations/services. This has increased from 12.3% in the previous month, and is being communicated to partners in the city to agree signposting processes and to share information to support the 'no closed door' policy to support enquiries across organisations.

Effective

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

Leeds Community Healthcare NHS Trust

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
CAMHS T4 - Percentage of inpatients admitted who have had a Care and Treatment Review undertaken within 18 weeks of admission.	SL	100%	100%	●	2020/21	100%	100%	-	-	-	-	
CAMHS T4 - Percentage of inpatients who have had a Care and Treatment Review undertaken every 3 months.	SL	>=95%	100%	●	2020/21	100%	100%	-	-	-	-	
CAMHS T4 - Percentage of inpatients who have been screened for alcohol and tobacco usage and offered advice/interventions as appropriate	SL	100%	100%	●	2020/21	100%	100%	100%	100%	100%	100%	
Number of NICE guidelines with full compliance versus number of guidelines published in 2018/19 applicable to LCH	RB	100%*		●	2020/21	85%	87%	87%			87%	
Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	RB	No Target			2020/21	54%	56%	56%			56%	
Clinical Outcome Measures - Percentage of services at stage 3; measures agreed and services have access to them	RB	75%*			2020/21							
Clinical Outcome Measures - Percentage of services at stage 6; using measures with some patients some of the time	RB	60%*			2020/21							
Number of unexpected deaths in Community Care Beds by quarter	RB	No Target			2020/21	1	0	0	0	2	2	
Number of deaths reported through the SUDIC process year by quarter	RB	No Target			2020/21	1	1	0	1	0	1	
NCAPOP audits: number started year to date versus number applicable to LCH	RB	100%*		●	2020/21	0%	0%	33%			33%	
Priority 2 audits: number completed year to date versus number expected to be completed in 2020/21	RB	100%*		●	2020/21	7%	19%	21%			21%	
Total number of audits completed in quarter	RB	No Target			2020/21	4%	9%	36%			36%	

CAMHS

The CAMHS Tier 4 service is currently achieving all of the goals in the effective domain.

NICE Guidelines

Following discussion with services, agreement has been reached to pause completion of MCAC for services where their clinic base remains closed and no medicines management activities are being undertaken. Services have agreed to prioritise completion of the MCAC as and when clinical sites are reopened.

The NICE guidance implementation position is unchanged from Q2. Discussions are ongoing with Business Unit Quality Leads as how services can be supported to prioritise NICE guidance implementation during Reset & Recovery.

The main issue in this area is the capacity of services to complete the backlog of NICE guidance implementation in Q4 in light of the current lockdown position and pressure and the system. Guidance on what can be stood down would be appreciated; however, it is recommended that for any applicable COVID-19 NICE guidance, implementation is accelerated and completed within a three month time period given the clinical urgency of managing the pandemic.

Clinical Outcome Measures

Due to the focus of services on more pressing concerns, the role of the COMs team has been to support services (and the organisation) through Reset and recovery; hence no data has been collected in this area. Self-assessment is recommencing in Q4; we intend to be able to recommence reporting from next quarter.

Unexpected Deaths in Community Bed Bases

There were 2 unexpected deaths in community bed bases in December. These deaths have been reviewed at Level1 and have no concerns raised regarding the care they received. As all deaths in a CCB are automatically case reviewed by a consultant geriatrician there is always a robust scrutiny of CCB deaths.

There were 3 deaths in the Alliance CCBs in December, 2 unexpected and 1 expected.

The deaths occurring on the 7th and 16th were classified as unexpected (both patients were in their 90s and the deaths whilst not anticipated for that day were not unpredictable). No concerns have been raised and the death occurring on the 7th has already been case reviewed in the December Mortality Review Meeting. Positive feedback was provided to the team with regards to the care. The patient who passed away on the 16th was discharged into long term nursing home care on the day of their death and sadly passed away that night.

The expected death on the 25th December was a palliative patient who passed away peacefully in their sleep. No concerns were raised regarding the care on the level 1 review.

SUDICs

In November 2020 a 3 year old child died. The child had input from a range of LCH services (PHINS, ICAN and Dietetics), had significant developmental delay and was reliant on parents for all of their care. We are awaiting results from standard post mortem.

Clinical Audit

Most of the NCAPOP audits remain on hold nationally due to COVID-19. The number of audits commenced depends on which audits have been reinstated by the overarching provider. The Learning Disability audit has been commenced and is progressing according to the timeframe stated. This will be the 3rd round of the audit..

There has been progress made with commencing and completing priority 2 audits during Q3. Even though the overall % remains, it is expected that this will increase by the end of Q4 but it is unlikely that all audits will be completed according to the number identified on the rolling clinical audit programme 20-21.

Responsive – December 2020

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

Leeds Community Healthcare NHS Trust

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	SP	>=92%	81.4%	●	2020/21	88.7%	76.5%	75.7%	80.0%	80.6%	80.6%	
					2019/20	99.3%	98.7%	97.1%	97.6%	97.6%	97.6%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	SP	0	0	●	2020/21	0	0	0	0	0	0	
					2019/20	0	0	0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	SP	>=99%	28.7%	●	2020/21	24.1%	19.4%	25.9%	32.1%	33.4%	33.4%	
					2019/20	100.0%	94.1%	97.9%	100.0%	100.0%	100.0%	
% Patients waiting under 18 weeks (non reportable)	SP	>=95%	73.6%	●	2020/21	69.2%	71.9%	72.7%	73.2%	71.7%	71.7%	
					2019/20	97.9%	98.4%	97.8%	97.8%	97.7%	97.7%	
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	SP	>=95%	99.2%	●	2020/21	99.3%	99.3%	99.1%	98.8%	99.4%	99.1%	
					2019/20	99.9%	99.3%	98.2%	98.7%	99.3%	98.7%	
IAPT - Percentage of people referred should begin treatment within 6 weeks of referral	SP	>=75%	56.8%	●	2020/21	37.9%	58.1%	68.4%	69.2%	82.0%	73.2%	
					2019/20	57.4%	48.0%	41.1%	42.8%	36.6%	40.4%	

Performance against the 18-week referral to treatment standard is below expectations. The standard has been missed in all specialties except Growth and Nutrition.

	Nov 2020						Dec 2020					
Specialty	**Pct Currently Waiting Under 18Weeks**	**Total**	**Waiting Over 18Wks**	**Average Wait (weeks)**	**Median Wait (weeks)**	**95th Percentile**	**Pct Currently Waiting Under 18Weeks**	**Total**	**Waiting Over 18Wks**	**Average Wait (weeks)**	**Median Wait (weeks)**	**95th Percentile**
CH - P AUD	72.8%	767	209	11.5	10.0	25.0	76.2%	858	204	11.3	9.9	24.9
CPC (CHICS)	93.2%	146	10	7.8	5.7	19.7	89.3%	150	16	7.5	5.0	19.0
GAN	100.0%	2	0	9.2	9.2	9.7	100.0%	3	0	7.4	4.1	13.1
Gynaecology	100.0%	53	0	14.0	14.0	15.7	80.0%	15	3	15.1	17.0	18.7
MSK	100.0%	1	0	7.0	7.0	7.0						
PND	89.7%	262	27	9.0	7.9	19.9	89.5%	276	29	9.3	8.1	21.6
Total	**80.0%**	**1231**	**246**				**80.6%**	**1302**	**252**			

Whilst not mandated nationally the Trust uses the same 18-week wait standard for non-reportable waits and the Trust is performing at 71.4% against this standard.

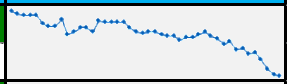
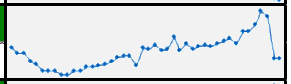
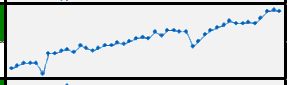
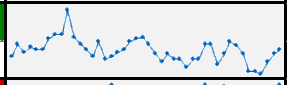
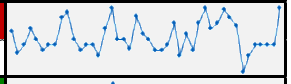
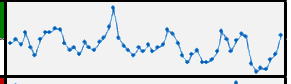
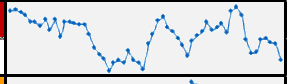
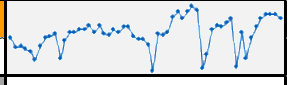
There is a requirement for 99% of patients referred for a diagnostic test to be seen within 6 weeks of referral; in LCH this applies solely to children's audiology which is currently breaching this target. This service was stopped nationally at the start of the first wave of COVID-19 in line with the national guidance.

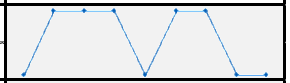
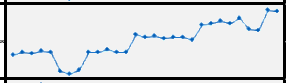
In IAPT (Improving Access to Psychological Therapies) the service has met the standard to ensure people begin treatment within 18 weeks (99.1%). For many months now patients have been entering treatment within 6 weeks, but the measure related to this has not reflected that achievement as it is based on the dates of patients ending care and this means that the measure is heavily lagged. It has now caught up and for the first time this year the service is achieving the target.

Well-Led – December 2020

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

Leeds Community Healthcare NHS Trust

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
Staff Turnover	LS/JA	<=14.5%	-	●	2020/21	11.4%	10.0%	9.5%	9.3%	9.1%	9.1%	
					2019/20	13.1%	13.0%	13.3%	13.5%	13.1%	13.1%	
Reduce the number of staff leaving the organisation within 12 months	LS/JA	<=20.0%	-	●	2020/21	21.6%	24.9%	14.8%	14.9%	15.1%	15.1%	
					2019/20	20.1%	17.3%	17.8%	18.1%	17.8%	17.8%	
Stability Index	LS/JA	>=85%	-	●	2020/21	88.6%	89.9%	90.1%	89.9%	90.2%	90.2%	
					2019/20	87.6%	85.7%	86.4%	87.2%	87.6%	87.6%	
Short term sickness absence rate (%)	LS/JA	<=2.2%	-	●	2020/21	1.0%	1.4%	1.7%	1.9%	1.5%	1.5%	
					2019/20	1.5%	1.5%	1.5%	2.1%	2.1%	2.1%	
Long term sickness absence rate (%)	LS/JA	<=3.6%	-	●	2020/21	3.3%	3.5%	3.5%	4.2%	4.0%	4.0%	
					2019/20	3.9%	3.4%	3.9%	4.2%	3.8%	3.8%	
Total sickness absence rate (Monthly) (%)	LS/JA	<=5.8%	-	●	2020/21	4.3%	4.9%	5.2%	6.1%	4.5%	4.5%	
					2019/20	5.4%	4.9%	5.3%	6.3%	5.9%	5.9%	
AfC Staff Appraisal Rate	LS/JA	>=95%	-	●	2020/21	81.8%	83.6%	83.3%	80.4%	79.6%	79.6%	
					2019/20	84.6%	85.6%	86.2%	87.0%	85.2%	85.2%	
6 universal Statutory and Mandatory training requirements	LS/JA	>=95%	-	●	2020/21	91.3%	93.2%	93.2%	92.5%	92.5%	92.5%	
					2019/20	93.8%	90.9%	91.5%	91.4%	92.0%	92.0%	
Medical staff appraisal rate (%)	RB	100%	-	●	2020/21							
					2019/20	100.0%	100.0%	100.0%			100.0%	

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3	Time Series
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	LS/JA	>=52.0%	-		2020/21		71.0%	Staff Survey			-	
					2019/20	71.1%	81.6%				-	
Percentage of staff who are satisfied with the support they received from their immediate line manager	LS/JA	>=52.0%	-		2020/21			Staff Survey			-	
					2019/20	73.3%	61.2%				-	
'RIDDOR' incidents reported to Health and Safety Executive	BM	No Target	5		2020/21	2	2	1	0	0	1	
					2019/20	-	-	-	-	-	-	
WRES indicator 1 - Percentage of BME staff in the overall workforce	LS/JA	No Target	-		2020/21	10.9%	10.7%	10.8%	11.0%	11.1%	11.1%	
					2019/20	9.8%	10.0%	9.7%	10.1%	10.0%	10.0%	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	LS/JA	No Target	-		2020/21	4.1%	3.9%	3.8%	4.4%	4.4%	4.4%	
					2019/20	3.3%	3.7%	3.6%	3.7%	3.6%	3.6%	
Total agency cap (£k)	BM	3229	1857		2020/21	1857	550	262	86	209	557	
					2019/20	1158	1220	358	316	351	1025	
Percentage Spend on Temporary Staff	BM	No Target	6.2%		2020/21	5.0%	3.9%	4.5%	3.0%			
					2019/20	6.2%	6.2%	5.8%	6.0%	6.0%	5.9%	

Retention

The overall trend continues to be positive with turnover continuing to reduce and now reporting at 9.1% which is below the 2020/21outturn target of 14.5%. The stability rate is 90.2% which is positive and above the target of 85%. A contributory factor on both indices will be the instability of the labour market due to the Covid-19 pandemic.

Staff leaving within the first 12 months of employment is reporting at 15.1% which is below the target of 20%. An HRBP has been undertaking a piece of work, analysing workforce starter and leaver data between 01/01/19 and 31/12/20, to look at what action could be taken to protect against this new starter turnover. This includes exploring turnover trends to help identify "flight risk" periods, which is the period when individuals have started actively pursuing other opportunities, and to look at options for targeted intervention, for key staff groups. Headlines from this work will be shared with the Business Committee.

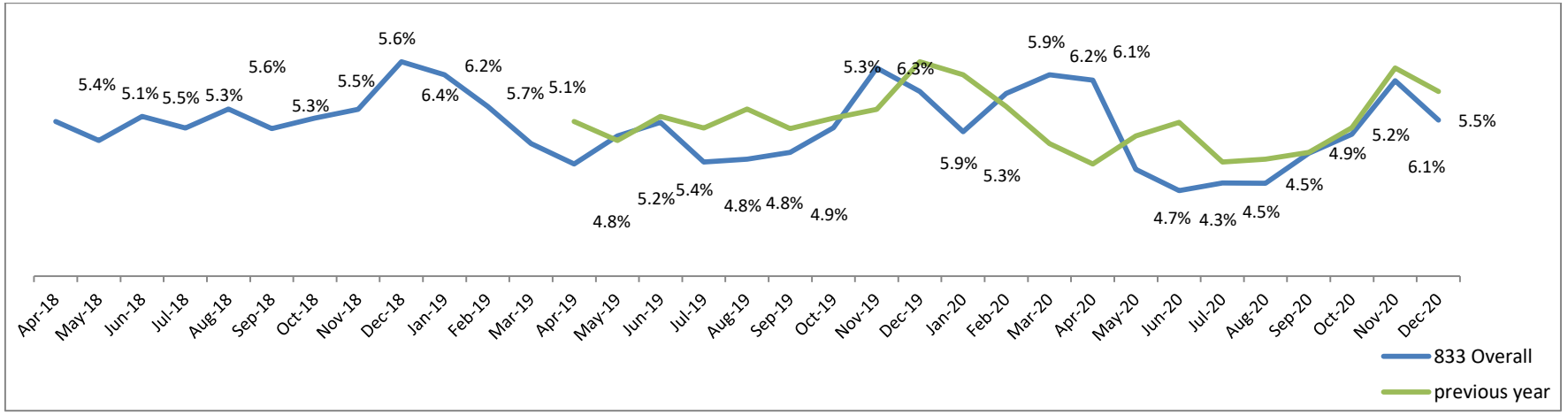
Work across a range of areas such as recruitment, health and wellbeing and increasing support to leaders, with flexible approaches to staff engagement, contributes overall to increased confidence in high levels of workforce stability.

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

Sickness Absence

On reviewing the sickness absence data since the start of the pandemic and comparing this to the sickness absence the previous year, some interesting observations to report this month.

Sickness absence at the start of the pandemic March and April 2020 rose to over 6% which was to be expected. However, the good news is that since then, month on month during 2020 the sickness absence rate has been consistently lower than that in 2019, as shown below (Blue line)



The overall Sickness absence for December is 5.5% (short-term absence 1.5% and long-term absence 4%). 0.3% of short term absence is due to Infectious Diseases and 1.34% of long- term absence is due to Anxiety, Stress and Depression, which is an improvement of 0.47% since from last month . Also of note, is the improvement in sickness absence levels for some of the areas that are currently experiencing significant service pressures due to the Covid-19 pandemic; Adult Business Unit showing an improvement of 1.4% and Specialist Business Unit an improvement of 1.2% from last month.

Taking all of this into account, there has been a clear positive impact on reduction in sickness absence during the pandemic. This could in part, be due to the increased focus around supporting staffs mental wellbeing, together with a more open approach to actively listen and engage with staff, and flex our health and wellbeing offer accordingly.

Of concern though, is the significant increase in the overall level of sickness absence within the Corporate Directorate at 4.9%; with 4.6% of this being attributable to long term absence. This is due to a variety of reasons, with 1.5% infectious diseases and just over 1% due to Anxiety, Stress and Depression. The HRBP is linking in with the appropriate Managers to offer support.

Appraisal

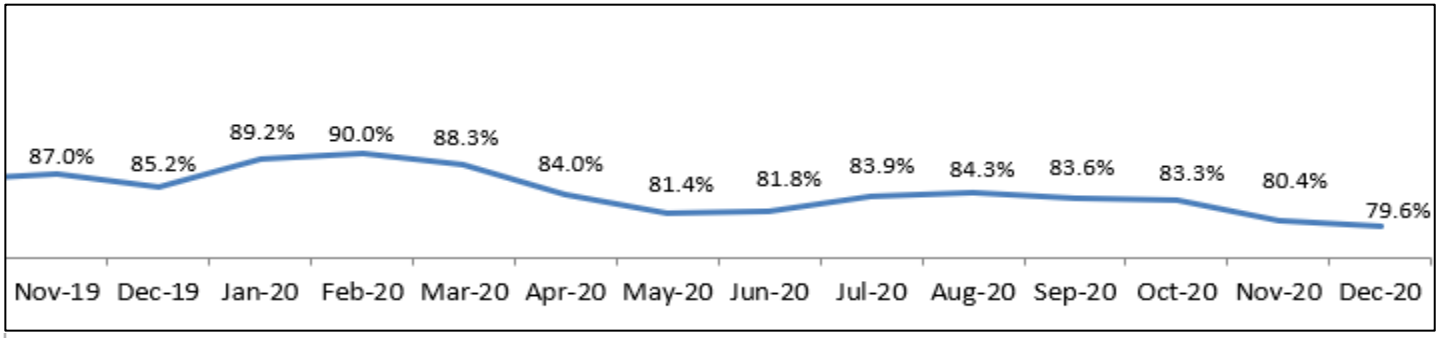
The Appraisal position for December has reduced by 0.8% from November to an overall compliance rate of 79.6%, which is the first time in 12 months that compliance has fallen below 80%.

This drop is expected due to the significant service delivery pressures being experienced across parts of the Trust, during the Covid-19 pandemic. Authorisation has been given to suspend appraisals temporarily if required.

The small drop in overall compliance rate falls across the Adults (-1.6%) and Specialist (-1.1%) Business Units and Corporate Directorate (-1.1%) (Further detail below)

Support will continue to be offered to encourage completion of appraisals in a timely manner, as appropriate.

Overall Trust Wide Appraisal Rate – December 2020

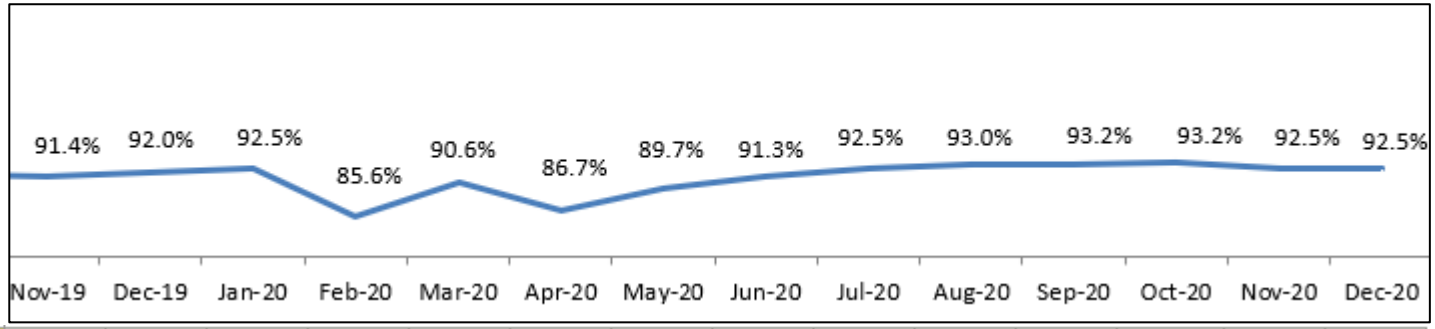


833 Overall	Imp Traj to 95%	87.0%	85.2%	89.2%	90.0%	88.3%	84.0%	81.4%	81.8%	83.9%	84.3%	83.6%	83.3%	80.4%	79.6%
833 Adult Business unit		83.9%	81.4%	86.3%	88.7%	87.4%	82.0%	75.8%	73.3%	78.0%	80.6%	79.2%	78.7%	73.6%	72.0%
833 Children's Business		88.2%	87.3%	92.0%	92.4%	89.9%	87.2%	88.1%	91.3%	91.0%	89.2%	87.9%	87.1%	87.0%	87.9%
833 Corporate Directorate		84.6%	80.5%	86.5%	89.9%	91.1%	85.4%	79.1%	75.9%	77.8%	83.6%	78.9%	80.1%	76.8%	75.7%
833 PCN Business Unit			0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	13.3%	12.5%	11.1%	8.0%
833 Operations		91.7%	91.2%	94.4%	93.4%	91.3%	85.5%	84.3%	84.3%	89.5%	90.2%	91.9%	91.8%	90.2%	89.6%
833 Specialist Business		88.6%	87.4%	88.7%	88.4%	86.7%	83.8%	81.9%	83.7%	84.9%	83.9%	84.9%	85.4%	82.0%	80.9%

Statutory and Mandatory Training

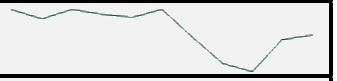
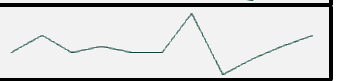
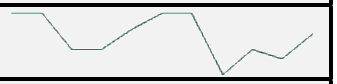
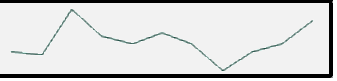
The overall Statutory & Mandatory training rate once again remains steady for December at 92.5% with no change from the previous month.
Work has commenced on the Statutory & Mandatory Compliance Project with meetings held throughout December with Subject Matter Experts.
A full project plan has now been developed, together with a supporting paper for consideration by the Audit Committee.

Overall Trust Wide Statutory & Mandatory Training Rate – December 2020



833 Overall	Imp Traj to 95%	91.4%	92.0%	92.5%	85.6%	90.6%	86.7%	89.7%	91.3%	92.5%	93.0%	93.2%	93.2%	92.5%	92.5%
833 Adult Business unit		90.8%	91.1%	91.4%	84.1%	89.0%	84.9%	85.8%	89.1%	90.4%	91.1%	90.9%	90.8%	89.5%	89.4%
833 Children's Business		91.9%	92.8%	93.4%	85.9%	92.2%	89.4%	91.8%	93.4%	94.1%	94.4%	94.7%	94.5%	94.5%	94.5%
833 Corporate Directorate		90.6%	91.2%	91.5%	85.3%	90.7%	79.3%	89.6%	86.9%	89.7%	88.8%	88.6%	89.0%	89.1%	89.2%
833 PCN Business Unit			0.0%	80.0%	86.7%	65.9%	58.5%	65.4%	59.6%	70.9%	60.0%	70.7%	72.5%	68.9%	65.9%
833 Operations		93.1%	94.6%	93.8%	87.0%	92.9%	88.2%	91.3%	91.9%	93.1%	93.4%	93.7%	93.9%	93.8%	93.1%
833 Specialist Business		91.5%	91.9%	92.9%	86.9%	90.6%	88.4%	92.5%	93.4%	94.7%	95.4%	95.8%	96.1%	95.4%	95.5%

Staff Safety Incidents

Safe- people are protected from abuse and avoidable harm	2019 - 2020	2020-2021			12m Total	Trend
	Q4	Q1	Q2	Q3		
Number of physical aggression incidents patients against staff	2	6	7	26	41	
Number of verbal abuse incidents against staff	11	6	24	27	68	
Number of staff moving and handling incidents	0	3	5	7	15	
Number of staff sharps/needlestick injuries	0	5	3	8	16	
Number of staff slip, trip and fall incidents	0	5	7	13	25	

As small number of staff safety incidents by category are reported each month, thematic review is difficult. Incidents over the last twelve months (January 2020 to December 2020) were reviewed collectively to establish themes for this report. Areas to note from this report are as follows:

1. Physical abuse, assault or violence

An inpatient at Little Woodhouse Hall accounted for the majority of recorded incidents in Q2 and Q3. The Custody suites recorded 6 cases of assault and YOI reported three cases. Seven incidents involved the assault of staff by dementia patients.

2. Verbal aggression

The most prevalent theme was the verbal/aggressive abuse that staff received over the phone due to the delay in treatment as a result of the pandemic; seventeen incidents were recorded. Verbal and aggressive behaviour was also displayed towards staff within the patient's home setting;

- Fourteen incidents involved patients who had a mental health condition and were agitated - some patients were annoyed that staff arrived late to provide their treatment.
- Six family members were rude, abusive, and aggressive towards staff.
- The Police Custody and the Young Offenders Institute saw an increase in young people swearing at staff.
- CAMHS recorded a number of verbal and intimidating behaviours by an individual patient.

3. Moving and Handling

The largest reason for moving and handling incidents involved staff manoeuvring hoists and furniture applying/removing bandages and dressings, all within the patient's home settings.

4. Sharps/needle-sticks

The majority of incidents were related to diabetic patient visits by the neighbourhood teams. The reported cause was often the removal of the needle from patients or unsafe disposal of sharps. Sharps and needle-stick incidents are monitored by the Infection Prevention and Control Group who meet on a bi-monthly basis.

5. Slips, trips and falls

Three members of staff fell on wet floors, two members of staff slipped on the floor with no reasons identified.

Two reported incidents involved staff falling from vehicles and two staff fell down the stairs due to being distracted.

6. Next steps

The importance of services having suitable and sufficient risk assessments in order to minimise risks to staff will be raised.

Finance – December 2020

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

Leeds Community Healthcare NHS Trust

Finance	Responsible Director	Target - YTD	YTD	Forecast	Financial Year	Q1	Q2	Oct	Nov	Dec	Q3
Net surplus (-)/Deficit (+) (£m) - YTD	BM	-1.2	-2.3		2020/21	0.0	0.0	-0.9	-2.1	-2.3	-2.3
Capital expenditure in comparison to plan (£k)	BM	1709	998		2020/21	417	518	-48	63	48	63
CIP delivery (£k)	BM	455	1199		2020/21	399	401	133	133	133	399
COVID specific costs identified and submitted (£k)	BM	No Target	1140		2020/21	570	357	79	134		

NHS England has indicated that the current finance regime will continue into quarter 1 of 2021/22. At the time of writing there are no further details as to the level of funding that will be available nationally or locally.

Income & Expenditure (I&E) Summary

Under the interim financial regime (table 1) for 2020/21 the Trust's actual I&E surplus or deficit has been adjusted back to balance for the first six months of the year. Effectively this means the Trust started Month 07 with a breakeven position as all income and expenditure variances to the end of Spetember had been balanced off to zero.

The Trust submitted a plan to NHS England/Improvement for the second half of the year which reflects the expected expenditure on business as usual, reset and recovery and any known additional service investments such as the covid rehabiliatation service. The planned outturn is to breakeven on income and expenditure for the year.

At the end of December the Trust's surplus is runnign ahead of the planned position. Income is accounted for equally over the 6 months from October to March. Expenditure is expected to be initially less than income but increasing to exceed income as the year progresses as service and waiting list initiatives are implemented. Accordingly, a £1.2m surplus was planned for the year to the end of December; this was exceeded by £1.1m.

Within the cost base, pay expenditure is in line with plan; this includes Covid-19 related costs. There were net 25 vacancies in December. Non-pay expenditure is £0.1m more than the revised plan for December again this includes additional expenditure on Covid costs.

Income

The Trust is receiving nationally calculated block payments from NHS Leeds CCG, NHS Wakefield CCG (as host of the ICS) and NHS England commissioners. These do not reflect current contractual expectations but are based on historic values adjusted for the Trust's estimated expenditure for the latter half of the year.

Overall income is expected to be £1.3m more than planned; this is in respect of training and development income following the issue of the quarter 3 schedule, more seconded staff income than planned and additional income from Local Authority commissioners for the Track and Trace service. An underperformance on Contract Income is due to classification of the October payment in advance from NHS England.

£41k for income due to the Trust for Covid Vaccination costs incurred is included in income.

Pay and Non-pay Expenditure & Vacancies

Pay expenditure year to date and forecast is in line with plan, including Covid-19 related expenditure.

There were a *net* 25 WTE vacancies for December; this is 15 more than for November. There are 15 vacancies in the Adult Business Unit and 13 for Estates.

Agency staffing costs in December were £209k bringing the total for the year so far to £1.9m. As an indicator, this would be well within the agency cap that was set pre-Covid.

The plan for remainder of the year includes the current run rate on pay plus the additional pay in respect of waiting list initiatives. The Trust will be seeking to ensure that the recurrent contract with the CCG is adjusted to reflect the new services agreed in year.

Non-pay, including Covid-19 related expenditure, is £189k underspent at the end of December. There has been an increase in the run rate as services begin to reset. The main area of overspending is in other expenditure where the unidentified and historic CIPs sit. The Trust has reserves to support service and waiting list initiatives as these are implemented.

Delivery of Cost Improvement Plans

The national calculated income for the Trust assumes delivery of a 1% CIP for the second half of the year. This will be assumed to be delivered if the Trust achieves its target financial position of breakeven.

Capital Expenditure

The Trust has a revised capital resource limit (CRL) requirement of £3.106m for the year. This includes:

- the initial Board approved capital expenditure plan of £2.55m
- £105k of Covid-19 related capital expenditure already incurred
- a prospective Covid capital bid of £370k for additional IT kit required this year to maintain remote service delivery
- £61k approved for critical infrastructure expenditure following a national initiative.

The approved CRL currently only stands at £2.028m. The Trust has formally requested an increase however there is a significant delay approving bids and/or issuing formal documentation in support of capital funding decisions. This does present some risk of the Trust breaching its approved CRL but management of capital spend and a current £0.4m slippage on the Trust's original capital programme means the risk is low. The Trust has offered the £0.4m slippage to the ICS should the CRL adjustment be actioned. Table 5 does not include the expected approvals.

Year to date capex is £0.6m behind planned spend; most of this is in respect of estates expenditure where orders have been placed for work to commence in January and IT where new specifications have meant orders were held until the new year commenced.

Cash

The Trust's cash position remains very strong with £45.3m in the bank at the end of the month.

Better Payment Practice Code

The Trust's cumulative Better Payment Practice Code performance has exceeded the 95% target for paying invoices within 30 days for all measures for December.

Appendix 1 – December 2020

Retention Background Data

Leeds Community Healthcare NHS Trust

In December 2020 there were 25 leavers across the Trust.

The distribution of leavers by Business Unit and Staff Group is set out below:

Business Unit	December 20 Leavers
Adult Business unit	10
Children's Business Unit	6
Corporate	0
Specialist Business Unit	8
Executive Directors	0
Operations	1
Primary Care Network	0
Grand Total	**25**

Staff Group	December 20 Leavers
Additional Clinical Services	5
Additional Prof Scientific & Technical	2
Administrative and Clerical	3
Allied Health Professionals	5
Nursing and Midwifery Registered	9
Medical and Dental	1
Estates	0
Grand Total	**25**

Appendix 2 – December 2020

Detailed Financial Data Tables

Leeds Community Healthcare NHS Trust

Table 1 Income & Expenditure Summary	December Plan WTE	December Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Forecast Variance £m	Forecast Variance Last Month £m
Income									
Contract Income			(121.8)	(120.9)	0.9	(165.7)	(164.8)	0.9	(0.3)
Other Income			(9.8)	(11.7)	(1.9)	(11.4)	(13.6)	(2.2)	(1.0)
Total Income			***(131.6)***	***(132.6)***	***(1.0)***	***(177.1)***	***(178.4)***	***(1.3)***	***(1.3)***
Expenditure									
Pay	2,924.6	2,899.9	91.6	91.6	0.0	123.5	123.5	(0.0)	(0.0)
Non pay including reserves & non recurrrent			36.8	36.9	0.1	51.0	52.5	1.5	1.3
Total Expenditure	***2,924.6***	***2,899.9***	***128.4***	***128.5***	***0.1***	***174.5***	***176.0***	***1.5***	***1.3***
EBITDA	**2,924.6**	**2,899.9**	**(3.2)**	**(4.1)**	**(0.9)**	**(2.6)**	**(2.4)**	**0.2**	**(0.0)**
Depreciation			1.5	1.6	0.0	2.1	2.0	(0.0)	(0.0)
Public Dividend Capital			0.4	0.2	(0.2)	0.6	0.3	(0.3)	(0.0)
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.1	0.1	0.1
Impairment			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Payable			0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	0.0
Retained Net Surplus	**2,924.6**	**2,899.9**	**(1.2)**	**(2.3)**	**(1.1)**	**0.0**	**(0.0)**	**(0.0)**	**(0.0)**
	Variance =	**(24.7)**							

Table 2 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	Nov £k	Dec £k	YTD Actuals £k
Directly employed staff	9,231	9,426	9,449	9,313	9,326	9,725	9,622	9,826	9,785	85,703
Seconded staff costs	266	292	184	356	315	150	252	261	274	2,350
Bank staff	252	246	256	220	195	206	201	231	262	2,069
Agency staff	294	242	213	220	167	164	262	86	209	1,857
Total Pay Costs	**10,043**	**10,207**	**10,102**	**10,109**	**10,003**	**10,244**	**10,337**	**10,404**	**10,531**	**91,979**

Table 3 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	625	598	(28)	(23)	
Clinical Supplies & Services	14,258	13,549	(709)	(889)	
General Supplies & Services	3,882	3,901	19	20	
Establishment Expenses	4,941	4,465	(476)	(413)	
Premises	11,167	10,926	(241)	(165)	
Other non pay	921	2,166	1,245	1,258	
Total Non Pay Costs	**35,794**	**35,605**	**(189)**	**(212)**	**(211)**

Table 4 Savings Schemes M07-M12	2020/21 YTD Plan £k	2020/21 YTD Actual £k	2020/21 YTD Variance £k	2020/21 Annual Plan £k	2020/21 Forecast Outturn £k	2020/21 Forecast Variance £k	2020/21 YTD Variance %
Estates savings	20	20	0	40	40	0	0%
Non Pay Inflation	100	100	0	200	200	0	0%
Procurement savings	38	0	(38)	75	0	(75)	-100%
Continence products	13	13	0	25	25	0	0%
Travel & lease cars	75	75	0	150	150	0	0%
Stationery	5	5	0	10	10	0	0%
Contribution from new investments	125	125	0	250	250	0	0%
IT Kit	63	63	0	125	125	0	0%
Un-identified CIP agreed by SMT	18	0	(18)	35	0	(35)	-100%
Total Efficiency Savings Delivery	**455**	**400**	**(55)**	**910**	**800**	**(110)**	**-12%**

Table 5 Capital Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.8	0.3	(0.5)	1.3	1.2	(0.1)
Clinical Equipment	0.2	0.1	(0.1)	0.3	0.2	(0.1)
IT Equipment	0.3	(0.0)	(0.3)	0.5	0.5	0.0
Electronic Patient Records	0.3	0.2	(0.1)	0.5	0.3	(0.1)
Covid-19 retrospective IT bid		0.1	0.1		0.1	0.1
Covid-19 prospective IT bid		0.2	0.2		0.4	0.4
Covid-19 video conferencing		0.0	0.0		0.0	0.0
Totals	**1.6**	**1.0**	**(0.6)**	**2.6**	**2.7**	**0.1**

Table 6 Statement of Financial Position	Plan 31/12/20 £m	Actual 31/12/20 £m	Variance 31/12/20 £m	*Opening 01/04/20 £m*	Planned Outturn 31/03/21 £m	Forecast Outturn 31/03/21 £m	Forecast Variance 31/03/21 £m
Property, Plant and Equipment	31.1	30.3	(0.7)	*30.8*	31.4	31.5	0.1
Intangible Assets	0.2	0.2	(0.0)	*0.2*	0.2	0.2	0.0
Total Non Current Assets	**31.2**	**30.5**	**(0.7)**	***31.1***	**31.6**	**31.7**	**0.1**
Current Assets							
Trade and Other Receivables	8.1	9.6	1.5	*9.8*	8.1	8.1	0.0
Cash and Cash Equivalents	45.1	45.3	0.1	*33.1*	44.9	44.9	0.0
Total Current Assets	**53.2**	**54.9**	**1.7**	*42.9*	**53.0**	**53.0**	**0.0**
TOTAL ASSETS	**84.5**	**85.4**	**0.9**	***73.9***	**84.6**	**84.6**	**0.1**
Current Liabilities							
Trade and Other Payables	(24.9)	(24.6)	0.2	*(15.5)*	(26.0)	(25.6)	0.5
Provisions	(0.7)	(0.8)	(0.0)	*(0.8)*	(0.8)	(0.8)	0.0
Total Current Liabilities	**(25.6)**	**(25.4)**	**0.2**	***(16.2)***	**(26.8)**	**(26.4)**	**0.5**
Net Current Assets/(Liabilities)	**27.6**	**29.5**	**1.9**	***26.6***	**26.1**	**26.6**	**0.5**
TOTAL ASSETS LESS CURRENT LIABILITIES	**58.9**	**60.0**	**1.1**	***57.7***	**57.7**	**58.3**	**0.5**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	***0.0***	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**58.9**	**60.0**	**1.1**	***57.7***	**57.7**	**58.3**	**0.5**
TAXPAYERS EQUITY							
Public Dividend Capital	0.4	0.4	(0.0)	*0.4*	0.5	1.0	0.5
Retained Earnings Reserve	25.7	26.9	1.1	*24.5*	24.5	24.5	0.0
General Fund	18.5	18.5	0.0	*18.5*	18.5	18.5	0.0
Revaluation Reserve	14.2	14.2	(0.0)	*14.2*	14.2	14.2	0.0
TOTAL EQUITY	**58.9**	**60.0**	**1.1**	***57.7***	**57.7**	**58.3**	**0.5**

Table 7 BPPC Measure	Performance YTD	Target	RAG
NHS Invoices			
By Number	100%	95%	G
By Value	100%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	98%	95%	G

Table 8 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	62	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	18.3	1	20%	0.2
Underlying performance	I&E margin	2%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-42%	1	20%	0.2
Overall Use of Resources Risk Rating					**1.0**

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (118)

Title: Significant Risks and Board Assurance Framework (BAF) report

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Category of paper: for assurance
History: Senior Management Team 20 January 2021

Responsible director: Chief Executive
Report author: Risk and Safety Manager / Company Secretary

Executive summary (Purpose and main points)

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

The narrative on threats and opportunities provides the Board with an understanding of the internal and external environment within which the Trust operates.

The strongest theme found across the whole risk register is staff capacity, the second strongest theme is Children and Adolescent Mental Health Service, the third strongest theme is the functionality of Information Technology (IT) software, and the fourth is staff safety. There is also a theme of delays in providing services due to Coronavirus (COVID 19) based on the risks currently recorded on the risk register and additional risks that are currently being assessed with a view to being included on the register.

There is one risk with a current score of 15 (extreme):

- Risk 1002, Coronavirus (COVID 19) increase in infection rate

There are twelve risks scoring 12 (very high). Two of these have been recently added to the risk register:

- Risk 1023 Potential inaccuracies when recording the method of contact (face to face, virtual, by phone)
- Risk 1025 Information Technology (IT) Helpdesk Support Capacity

A Board Assurance Framework (BAF) summary has not been produced as there has been limited committee activity since the last Board meeting in December 2020. The risk themes have been aligned with the BAF risks to highlight the impact that the risks recoded on the risk register may have on the delivery of the Trust's strategic objectives.

Recommendations

The Board is recommended to**:**

- For new and escalated risks, consider whether Board is assured that planned mitigating actions will reduce the risk
- Seek additional assurance against Board Assurance Framework BAF strategic risks that are linked to the strong themes identified in this report

Significant Risks and Board Assurance Framework (BAF) report

1 Introduction

1.1 The risk register report provides the Board with an overview of the Trust's material risks currently scoring 15 or above after the application of controls and mitigation measures. IT describes and analyses all risk movement, the risk profile, themes and risk activity.

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks).

1.3 The report provides a description of risk movement since the last register report was received by the Board (December 2020), including any new risks, risks with increased or decreased scores and newly closed risks.

1.4 The report seeks to reassure the Board that there is a robust process in place in the Trust for managing risk. Themes identified from the risk register have been aligned with BAF strategic risks in order to advise the Board of potential weaknesses in the control of strategic risks, where further action may be warranted.

2 Background

This paper has previously been considered by the senior management team (SMT) at their meeting on 20 January 2021.

3 Board Assurance Framework Summary

3.1 The purpose of the BAF is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively or highlights that certain controls are ineffective or there are gaps that need to be addressed.

Definitions:

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

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

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

3.4 A Board Assurance Framework (BAF) summary has not been produced as there has been limited committee activity since the last Board meeting in December 2020. The risk themes have been aligned with the BAF risks to highlight the impact that the risks recorded on the risk register may have on the delivery of the Trust's strategic objectives.

4 Risks by theme

4.1 For this report, the 59 risks currently on the risk register (the 'here and now' risks) have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework. This themed approach gives a more holistic view of the risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance on the management of risk.

4.2 Themes within the current risk register are as follows:

4.2.1 The strongest theme across the whole risk register is staff capacity:

- due to an increase in service demand
- as a result of services being paused as a response to COVID 19
- staff absence due to sickness
- vacancies including difficulties recruiting staff to posts

Specifically: Eleven risks are related to staff capacity due to an increase in service demand; five risks are related to services being paused in response to COVID 19, resulting in an increased workload; six risks concern vacancies, including difficulties recruiting staff to posts; two risks are concerned with staff absence due to sickness

4.2.2 The second strongest theme is Children and Adolescent Mental Health Services (CAMHS):

- working environment risks
- development of new build
- waiting list

Of these: Seven risks relate to CAMHS Tier 4 (problems with existing building, development of new build including audit processes, the complexity of patients and access to Prevention and Management of Violence and Aggression (PMVA training); two risks are CAMHS Community (waiting times, ligature risk in community bases); one risk relates to the subcontractor offering a reduced CAMHS service to Adel Beck and Wetherby Young Offenders Institute.

4.2.3 The third strongest theme is Information Technology (IT) systems which are not sufficient to meet the requirements of the Trust or services which use them including:

- Use of SystmOne for recording the method of patient contact
- Electronic Staff records (ESR) use across the Trust
- Electronic Patient records for Neighbourhood Teams
- OrderComms and Lille for Leeds Sexual Health
- Inability to printing Pathology labels
- Potential data breaches due to use of Zoom

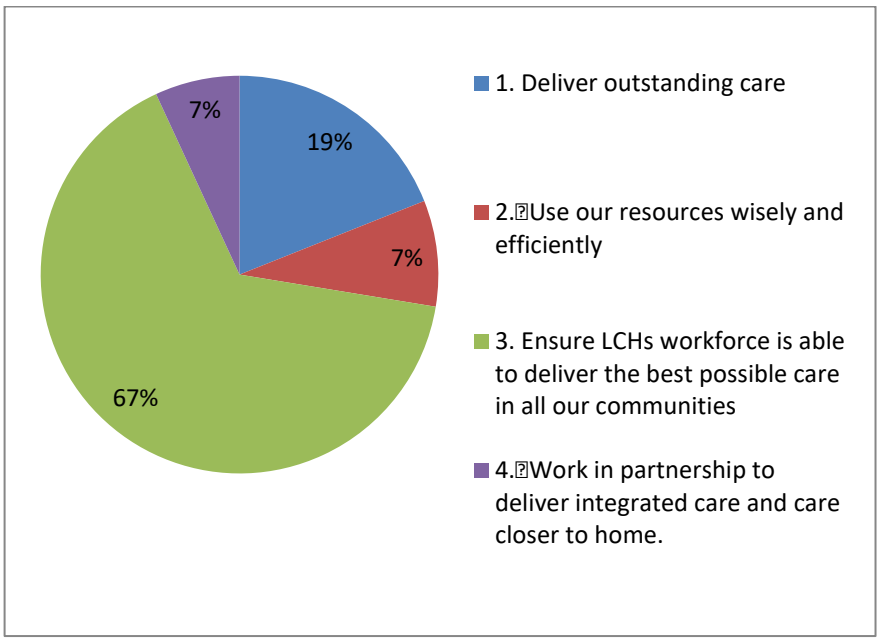
4.2.4 The fourth strongest theme is staff safety:

- COVID 19 (personal protective equipment and at risk staff)
- Working environment (lone working, violence and aggression, manual handling and storage)
- Inadequate procedures (oxygen storage and transportation)

4.2.5 There is also a theme of patient safety risk because of delays in providing services due to the impact of the pandemic. This is based on the risks currently recorded on the risk register and additional risks that are currently being assessed with a view to being included on the register. The additional risks under assessment include reduced staff capacity due to testing and self-isolation, and staff capacity when resources are required to be diverted to the vaccine programme.

4.3 Risk alignment with strategic objectives

Risks on the risk register are aligned to the Trust's strategic objectives. Risks can affect the achievement of more than one objective and ultimately the non-delivery of strategic objectives will affect the Trust's vision to 'provide the best possible care to every community we serve'. For the purposes of analysis for this report, each risk has been aligned with the one strategic objective it most directly affects.



The majority of risk directly affects achievement of the workforce strategic objective: 'Ensure LCH's workforce is able to deliver the best possible care in all our communities'. This correlates with the themes from the risk register and with the risk scoring on the Board Assurance Framework i.e. staff capacity and capability is the highest scoring BAF risk.

4.4 The emergence of material risks, strong risk themes and their correlation with BAF strategic risks could mean that the controls in place to manage strategic risks are not sufficiently robust. It is recommended that the Board and appropriate committees seek additional assurance against these BAF strategic risks.

4.4.1 The BAF strategic risks linked to the strongest themes within the risk register, are as follows:

Risk register theme: Staff capacity
BAF Risk 2.2 delivering contractual requirements
BAF Risk 3.1 having suitable and sufficient staff capacity and capability
BAF Risk 3.2 the scale of sickness absence

Risk register theme: CAMHS
BAF Risk 1.3 maintaining and continuing to improve service quality
BAF Risk 2.1 delivering principal internal projects
BAF Risk 2.2 delivering contractual requirements
BAF Risk 2.5 delivering the income and expenditure position agreed with NHSI

Risk register theme: Information Technology (IT) systems
BAF Risk 1.3 maintaining and continuing to improve service quality
BAF Risk 2.2 delivering contractual requirements
BAF Risk 2.4 maintaining the security of IT infrastructure

Risk register theme: Staff safety
BAF Risk 3.1 having suitable and sufficient staff capacity and capability
BAF Risk 3.2 the scale of sickness absence

5 Risk register movement

5.1 There is one risk with a current score of 15 (extreme) or above on the Trust risk register as at 7 January 2021:

Risk 1002 Coronavirus (COVID 19) increase in infection rate.

Description: As a result of the national situation of Covid-19 spread there is a risk of a local increase in cases / outbreaks in Leeds which could have an impact on workforce and service delivery.

Risk score: 15 (extreme)
Risk score movement: None

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6 New or escalated risks (scoring 15+)

6.1 No new risks scoring 15+ have been added to the risk register.

6.2 No risks have been escalated to a score of 15+ since November 2020

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

7.1 No risks have been closed, consolidated or deescalated below 15 since November 2020

8 Summary of risks scoring 12 (high)

8.1 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not contained to extreme risks. Senior

managers are sighted on services where the quality of care or service sustainability is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

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

ID	Description	Rating (current)
859	CAMHS inpatient unit risk – environmental concerns	12
874	Sickness levels – Neighbourhood Teams	12
877	Risk of reduced quality of patient care in neighbourhood teams due to an imbalance of capacity and demand	12
913	Increasing numbers of referrals for complex communication assessments in Integrated Children's Additional Needs Service (ICAN)	12
982	Provision of Educarers in Specialist Inclusion Learning Centres	12
999	Absence of defined audit tool and process in Adolescent Inpatient services	12
1006	Concern with ongoing patients safety incidents within one of the Neighbourhood Teams	12
1015	Delays in treatment for podiatry patients due to COVID 19	12
1017	Delay to improving the Electronic Patient Record system (EPR)	12
1019	Long waiting list for patients for type 2 diabetes structured education	12
1023	Potential inaccuracies when recording the method of contact (face to face, virtual, by phone)	12
1025	Information Technology (IT) Helpdesk Support Capacity	12

9 New or escalated risks (scoring 12)

9.1 Two new risks scoring 12 have been added to the risk register since November 2020:

New Risk 1023

Initial risk score 12 (high)
Current risk score 12 (high)
Target risk score 3 (low)

Title: Potential inaccuracies when recording the method of contact (face to face, virtual, by phone)

As a result of COVID 19, many services are now having contact with patients in a variety of different ways including face to face, over the phone or virtually.

SystmOne has been reconfigured to enable staff to record these different contact methods, but there are multiple places where the information needs to be input.
There is a risk that the type of contact method recorded is not always consistent or accurate. This may impact on the Trust's ability to effectively monitor service delivery. It may prevent the Trust from identifying if new service developments are disproportionately adversely affecting specific communities within Leeds.
The Trust may not be able to understand the nature of the appointments taking place and be assured that waiting times are being reduced.

Controls in place:
There are reports on data quality for some specific services that monitor this issue.
A new contact method to identify digital contacts has been rolled out.

Actions include:
An options paper is in the process of being written
Rapid improvement event to be completed with the support of the QI Team, starting with the Musculo-skeletal (MSK) service
Clinical Commissioning Group (CCG) to be approached to request further support

Date anticipated reaching target risk score: 31/03/2021

New Risk 1025

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

Title: IT (Helpdesk) Support Capacity
Insufficient resources (IT Helpdesk staff) means some LCH staff are waiting excessively to access IT Helpdesk support or fail to obtain support altogether as demand for IT support has risen as a result of staff working from home, using new or unfamiliar technologies or having been redeployed to new and unfamiliar areas of the Trust.
There is a risk that staff may not being able to access or record patient information such assessments or care plans; they may not be able to access clinical appointments, corporate data to support meetings, or record incidents or risks.
This may lead to increased complaints from staff and patients, staff delaying or cancelling work and increased anxiety and stress for clinical, management and administrative and Helpdesk staff.

Risk score rationale based on:
Reports are being received of inadequate levels of support daily by Helpdesk Team and management, comments at Leaders Network and Telephony statistics demonstrate the number of calls received and the number of calls which are not answered

Controls in place:
Existing Helpdesk resources (3.6 WTE B4 IT Helpdesk Engineers and 0.6 Helpdesk Manager).
Self-help guides to resolve many common access (password) issues
Provision of self-serve password reset facilities for commonly used systems such as active directory and NHS Mail,
Fixed estate to be used as a backup to laptops suffering from connectivity issue

Actions include:
Recruitment x2 WTE B4 Helpdesk Engineers to increase capacity
Reorganisation of working practices to alleviate some of the routine tasks which the helpdesk are performing
Voluntary weekend working

Date anticipated reaching target risk score: 31/03/2021

9.2 No risks have been escalated to a score of 12 (high)

10 Risk profile - all risks

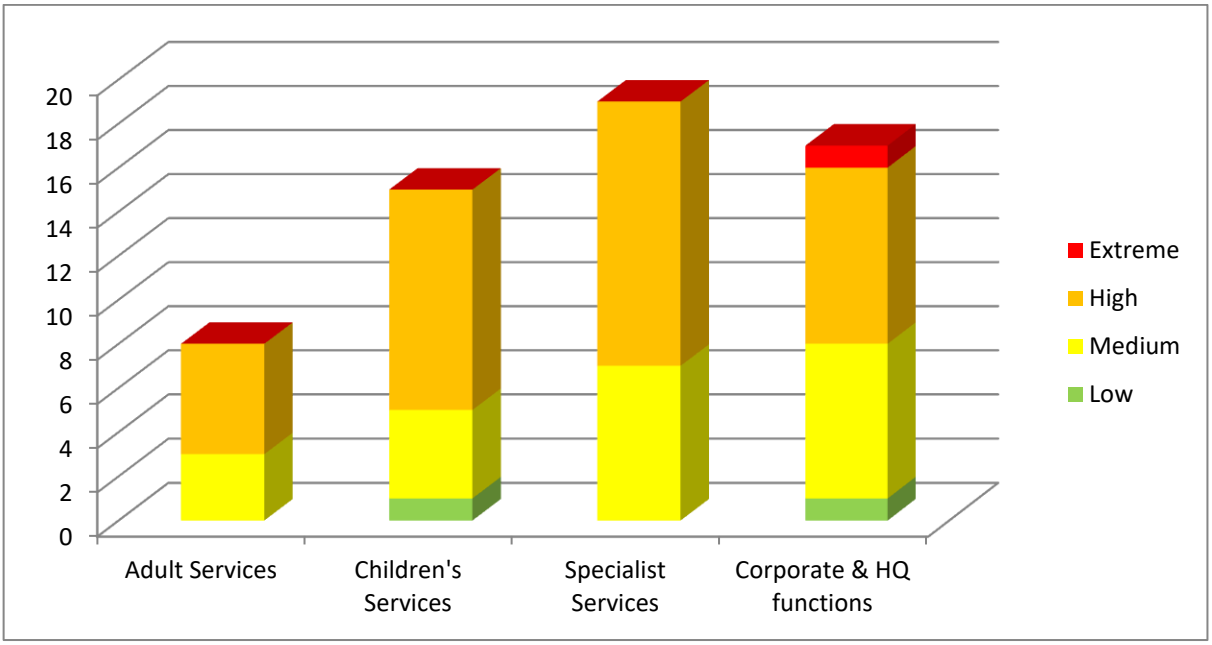
10.1 There are 16 open clinical risks on the Trust's risk register and 43 open non-clinical risks. The total number of risks on the risk register is currently 59. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk:

Risk profile across the Trust.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	0	0	0	0
4 - Major	0	2	2	0	0	4
3 - Moderate	2	15	16	11	1	44
2 - Minor	0	2	4	3	2	11
1 - Negligible	0	0	0	0	0	0
Total	2	19	22	13	3	59

11 Summary of all risks

11.1 The chart below shows the number of risks and level of risk by area of the business, logged on the Trust's risk management database as at 7 January 2021. There is one extreme risk on the risk register.



11.2 Corporate services risks include: estates matters, Electronic Staff Records (ESR), Children and Adolescent Mental Health Services (CAMHS) new build, data security, European Union (EU) directives compliance.

12 Impact:

12.1 Quality

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

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

12.2 Resources

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

13 Recommendations

The Board is recommended to**:**

- For new and escalated risks, consider whether Board is assured that planned mitigating actions will reduce the risk
- Seek additional assurance against Board Assurance Framework (BAF) strategic risks that are linked to the strong themes identified in this report

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (119)

Title: Safe Staffing Report

Category of paper: For assurance
History: Not presented at any other committee or group

Responsible director: Director of Nursing and AHP's
Report author: Clinical Leads for the Business Units and Director of Nursing and AHP's.

Executive summary

The paper describes the background to the expectations of boards in relation to nurse staffing, outlining where the Trust is meeting the requirements and highlighting if there is further work to be undertaken. The report is written in the context of the current system and local pressures which currently includes the Covid-19 pandemic.

The paper sets out progress in relation to maintaining safe staffing over the last six months (July to December 2020). It covers the range of services provided in the Trust as requested by the Board previously. The statutory requirements and data is contained in an appendix with the main body of the paper being used to provide assurance to the Board in relation to the effect of staffing pressures on services and how these are being mitigated. It also includes the significant impacts on staffing of the ongoing pandemic.

Safe staffing has been maintained across all inpatient units for the time period, however, this has only been possible through the use of temporary staff albeit in the main through LCH's internal staff bank (CLaSS). The usage of temporary staff is highlighted for all services where they are used within the appendices of the report. The paper sets out the mitigation in place and also triangulates elements of patient safety data to the staffing numbers where this is possible.

Recommendations

The Board is recommended to:

- note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting.

Safe Staffing Report

1 Introduction

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

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

2 Background

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

2.2 In addition to reporting on the in-patient areas the paper also provides information on all the Trusts services for the first time. It has previously focussed on the Neighbourhood Teams and Health Visiting but at the request of the Trust Board in February 2020 it now considers all services.

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

3 Current position/main body of the report

Specialist Business Unit:

3.1 By the beginning of September 2020 all staff had returned to their substantive roles following them being redeployed. On their return many staff needed help and support to integrate back into their role and assistance to adapt to implement the changes/new ways of working which had been put in place in response to the Covid-19 pandemic .

3.2 Many staff are now working remotely from home and when working in clinics the environment has changed and the number of patients which can be seen in a clinic session is reduced.

Within the Specialist Business unit the current staffing areas to highlight are as follows:

Podiatry

3.4 There are five vacancies within the service, staff from the internal LCH band are currently employed to cover them whilst the recruitment process takes place and therefore this is not having an impact on service delivery. There have been 2 complaints both due to service suspension as a result of following national guidance on urgent service prioritisation during the first wave of Covid-19.

MSK

3.5 The service has increased the number of available appointments and to ensure the service effectively utilises the capacity it has, administrative support has been increased.

Dental

3.6 There is currently no Paediatric Dentist employed within the service, this is a cause for concern. The service is working with Leeds Dental Institute and regional colleagues to find a solution.

Leeds Mental Wellbeing Service (LMWS)

3.7 Turnover is within expected parameters, conversations with commissioners to look at skill mix changes are planned in 2021. There has been one complaint related to a staffing issue and it was related to staff sickness.

Speech and Language Therapy (SLT)

3.8 Heads of service are reporting issues recruiting to posts which are temporary rather than permanent this situation is currently being reviewed.

Liaison and Diversion Service

3.9 All staff are now in post for the first time since LCH took over the contract.

Policy Custody Suites

3.10 Staff continue to offer additional shifts via the internal bank to enable shifts to be covered.

Wetherby YOI and Adel Beck

3.11 The recruitment process within the sub-contracted provider SWYPFT has improved and staffing levels in the CAMHS service and better. The new wave of Covid-19 has meant cross working cannot take place between the two units and therefore staffing is been managed in house.

Health Inclusion Team (HITT)

3.12 A review of the current team is underway following investment into the service and work is ongoing with commissioners to shape this.

Respiratory Team including Respiratory Virtual Ward

3.11 Has had x2 extra staff seconded in to the team to help with the demands placed on the team because of Covid-19 which is helping support the service.

There have been no complaints in any other services related to staffing issues other than those stated above.
There have been no significant incidents related to staffing issues.

Children's Business Unit:

Hannah House

3.12 As a C1 service Hannah House has remained open to support vulnerable children and families with respite since the initial lockdown in March 2020. A number of families chose to keep their children at home during this period which has resulted in reduced bed occupancy rates. The numbers of children accessing care at Hannah House increased when shielding ended but with the new restrictions in place it is likely that the numbers accessing will again reduce. The service continues to provide 24/7 care for a long term ventilated child in the "step-down bed". Regular liaison has continued with social care and commissioners regarding a foster care placement being facilitated and this is now being progressed and awaiting adaptations to the home environment.

Hannah House has maintained safe staffing levels throughout the reporting period; this has included use of Clinical and Support Service (CLaSS) staff at times and a Health Care Support Worker redeployed from the 0-19 Service who returned to her substantive role in November. The safe staffing data, including use of CLaSS staff can be seen in Appendix 3. There has been 3 nights (1 child – 2 nights and another child – 1 night) cancelled by the service in the reporting period due to low staffing. A meeting has been arranged with the Service Manager, Team Manager, workforce and Children's Business Unit Clinical Lead to review the eRostering data process.

All incidents within the unit have been in the category of no injury or minimal harm and none related to staffing issues. There have been three compliments recorded and no complaints.

Inclusion Nursing

3.13 Inclusion Nursing support children who attend a Leeds Specialist Inclusive Learning Centres (SILCs), and the children with complex health needs in partnership sites.

The service is a C1 service to ensure healthcare provision for vulnerable children and families, where children are attending school. The service extended by also providing a service during school holidays as SILCs remained open. With a slight reduction in workload in the SILC sites as some children remained at home, the nursing team have kept in contact with families digitally, ensuring assessments and care plans were meeting the child's needs. If clinically indicated children have been visited at home.

There have been a number of staff who have been shielding due to recognised health issues, and they have been supported to work from home undertaking activities for the service as a whole. A number of staff had to isolate due to track and trace during this period. As part of Covid-19 planning 0-19 practitioners and other community nursing colleagues have been redeployed to work in the service. Appropriate staffing levels have been maintained during this period.

There have not been any moderate or major harm incidents reported by the service. There have been no complaints received.

Continuing Health Care

3.14 The service continues to provide care to children in the family home. As there has been an increase in both long and short term staff sickness the remaining staff have been working flexibly alongside support from Hannah House staff, CLaSS and agency especially to provide night time cover. Generally parents have reported finding this most useful if available at night. All essential nights have continued to be covered during this reporting period. The service also supported private providers delivering care to children with complex needs, by providing advice and where necessary training for private provider staff.

There have not been any moderate or major harm incidents. There have been no complaints received.

Children's Community Nursing

3.15 The team provides a domiciliary service for children and young people with a wide range of nursing needs, providing advice and training for families and nursing assessments and interventions.

During the reporting period there has been an increase in staff sickness leading to the need for some reorganisation and the introduction of new ways of working this includes having a coordinator for the service working in the office ensuring clinical calls are handled promptly and appropriately.

The workload has increased due to the pausing of other LCH services, non-attendance at school and a reduction of clinic attendance at acute based outpatient services.

There have been no moderate or major harm incidents received by the service. There have been no complaints received.

CAMHS including Little Woodhouse Hall

3.16 CAMHS Adolescent Tier 4 Inpatient Service (AIS) is based at Little Woodhouse Hall and is categorised as a C1 service.

The unit has struggled to maintain safe staffing levels during this reporting period. The maintenance of this continues to require extensive use of temporary staff. Staffing levels are monitored on a daily basis by the Operational Manager who liaises with CLaSS and other agencies, and escalates staffing concerns as necessary. The safe staffing data, including use of CLaSS and agency staff can be seen in Appendix 4.

Colleagues from other services within the Children's Business Unit who were redeployed during the initial COVID response returned to their substantive posts in September, however one member of staff has been maintained on a part time basis.

In September and October there were factors that contributed to a lower number of permanent nursing and health care support worker staff available. This included a combination of sickness, staff having to isolate due to Covid-19, staff shielding and some staff leaving the service. Night shifts and weekends were safely staffed at this time although it was sometimes difficult to fill twilight shifts. During the working week, the wider multi-disciplinary team supported the nursing team on the unit including the psychologist, psychiatrist, managers and therapy staff.

All temporary staff have completed the required training to work in an Inpatient CAMHS service; however due to the ongoing COVID situation, updates for Prevention and Management of Violence and Aggression (PMVA) have been significantly delayed. Temporary staff are either from CLaSS, Leeds and York Partnership Foundation Trust bank or from a single agency where assurance is given that staff have completed required training.

There was ongoing concern about the high numbers of self-harm incidents on the unit during much of this reporting period, these continued to be monitored with regular reporting to Quality Committee. There has been a significant drop in incidents during November and December.

There have been no moderate or major harm incidents related to staffing issues during this period. There have been 2 complaints from 2 service users about 1 member of agency staff making inappropriate/insensitive comments. The complaints were responded to immediately involving feedback to the member of staff and the employing agency. The agency member of staff has not been employed by the service again.

Community CAMHS

3.17 Have continued to deliver care using a digital first approach where possible. There has been one reported concern regarding staffing involving a locum who has now left the Service following liaison with the agency.

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

3.18 The 0-19 PHINS consists of Specialist Public Health Nurses (Health Visitors & School Nurses), Staff Nurses, Family Support Workers and Health Care Support Workers working geographically within six citywide teams. The Admin Single Point of Access (SPA) based at Stockdale House is integral to service delivery.

The service is contracted to provide 145 Specialist Public Health Nurses (125 Health Visitors and 20 School Nurses). The table in Appendix 5 shows the total number of WTE practitioners in post between July and December 2020.

The lower than expected staffing levels continues to be an indicator of some of the challenges the service has had around recruitment of new staff, and in particular School Nurses due to national shortages and regional competition. The service works closely with the LCH recruitment team, developing a rolling programme of recruitment. Additionally in terms of thinking creatively the service has;

• recruited extra B5 Staff Nurses with the intention of putting more practitioners through the Specialist Community Public Health Nursing course and increasing capacity longer term.

• continued supporting the Differing Fields programme with 4 practitioners with dual qualification working across School Nursing and Health Visiting, and there was a proposal that more people are put through this course when the Universities restarted in September. However with the increasing demands on the service this was not possible. This will be reviewed and staff released to do this as soon as possible.

In September 2020 following the COVID-19 pandemic outbreak and NHS England's response to prioritisation of community health services, the PHINS reinstated the pre-COVID service offer. Some elements of the service remained a virtual offer. Some challenges remain due to the changing nature of infection, anxieties of families and schools to receive visits, the IPC regulations and restrictions in place including the need to limit all contacts.

There have been no moderate or major harm incidents reported during this time and no reported complaints.

Adult Business Unit:

Neighbourhood Teams:

3.20 As previously stated there are no nationally agreed staffing levels for community teams or evidence based tools. The Director of Nursing and AHP's is currently part of a national clinical reference group which is reviewing this. The Trust continues to develop the work to set safe staffing levels in community teams. There is information in Appendix 6 in relation to staff turnover and sickness rates. Also included is the breakdown of temporary staff used through the LCH CLASS system.

3.21 Staffing is monitored and managed during this period on a twice daily basis through the Capacity and Demand reporting tool with senior clinical and operational oversight seven days a week. Actions are initiated to ensure patient and staff safety is maintained. Staffing levels are monitored within the Adult Business Unit monthly via the performance process and any additional actions required considered by the Adult Business Unit senior leadership team. In addition a quarterly update report reviewing key indicators for Neighbourhood Team quality and workforce is provided to Quality Committee and Business Committee. The Patient Complexity Tool (PCI) has been successfully trialled in West 2 Neighbourhood Teams providing helpful qualitative detail to consider alongside other capacity and demand information. This information will also inform the skills and training needs within the teams. In Q4 the plan is to begin roll out to all Neighbourhood Teams, starting with Seacroft and Middleton NTs. In time this will add detail about the complexity of individual staff and team caseloads as well as size of caseload and will further support safe practice.

3.22 The main recruitment challenge in Neighbourhood Teams continues to be in recruitment of registered nurses reflecting the national shortfall in these roles. However, work continues on the career pathway for community nurses to further enhance recruitment and retention. Despite an ongoing national shortfall in therapists, there has been a recent increase in the number of appointable applicants for registered therapy roles in Neighbourhood Teams, reflecting the establishment of new clinical roles and career development opportunities. Whilst core staffing levels have improved, the next challenge for Neighbourhood Teams is to recruit in response to additional investment in community services (Physiotherapy, Occupational Therapy, Neighbourhood Nights Service, Pharmacy Technicians and Neighbourhood Clinical Assistants) with some encouraging progress already made in Neighbourhood Clinical Assistant recruitment with a cohort of new recruits starting in late January 2021. Close working with CLaSS ensures that available bank and agency staff are targeted at teams with the greatest staffing challenges. The Trust wide resourcing group co-chaired by the Director of Workforce and Director of Nusing and AHP's coordinates actions to support recruitment across the Trust including Neighbourhood Teams. In addition the contract continues with a local provider to support capacity in a number of teams with particular staffing challenges from a combination of vacancies and sickness.

3.23 Following wave 1 of the pandemic redeployed staff returned to work in their substantive services. During wave 2 and wave 3 staff have worked flexibly across Adult Business Unit services to support the Neighbourhood Teams to respond to additional demands or reduced capacity.

3.24 We have continued to progress Advanced Practice training with 15 staff starting the course in 2020 and also 16 staff members commenced the District Nursing training programme in September 2020. Internally we have continued to support Band 5 nurses with a development programme to enable them to progress to the next steps in their careers. We are exploring the impact of offering this programme as a part time offer to ensure equality of access to this development opportunity for part time staff. Investing in staff in this way supports staff recruitment and retention, and enables us to develop services in response to the NHS Long Term Plan.

3.25 Staff experience remains variable and is influenced by a number of factors Staff engagement is ongoing in all teams and a range of local initiatives continue to be implemented to improve staff experience and engagement in context of COVID-19.During COVID-19 the use of virtual technology has opened up new ways of

maintaining contact within and between teams and senior leadership. The Trust has implemented a wide range of additional support mechanisms to support staff health and wellbeing during the COVID 19 period, with ongoing efforts to ensure that these measures are responding to staff feedback, for example additional support in relation to End of Life care (EOL) delivery.

3.26 Monitoring patient safety incidents that are related to staffing issues or concerns constitutes a key area of work. This is being monitored very carefully within ABU incident investigations, mortality reviews and any complaints raised by patients, families and staff as always and any issues related to staffing levels will be escalated to the senior management team (SMT).

3.27 There have been a total of 17 complaints and 300 compliments in the reporting period July to December 2020 (an increase of 20% in compliments reported compared to the previous 6 months). This period included the ongoing impact of the COVID-19 Pandemic and the beginning of the 3rd wave of surge of COVID cases, it is of note that no new themes have emerged. A theme identified in the previous reporting period regarding the repeated cancelation and rescheduling of visits and specifically that it had not always been communicated and discussed with the patient has been investigated further. An audit process and specific actions at team level were commenced. This review of all Neighbourhood Team rescheduled and cancelled visits continues to make good progress and the number of visits affected each week has remained at single figures in most teams. None of the other complaints appear to have been related to staffing concerns or issues. This will continue to be monitored closely and any issues related to staffing will be escalated to Director of Operations/Director of Nursing and AHPs.

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

- All essential work is completed on the day
- Daily handovers
- Safety huddles
- Quality board-incidents, complaints and patient feedback
- Caseload (ongoing work continues to embed this further)
- Clinical supervision and safeguarding supervision
- Review meetings post incidents
- Sharing patient safety memos

4 Impact:

Quality

4.1 There is continuous review of incidents and complaints across the clinical services to ensure any impact on quality and safety is identified and addressed at the earliest opportunity.

Resources

4.2 There is the ongoing requirement to ensure staffing levels are maintained and this includes when there are episodes of sickness or other leave and this has potential financial implications that will be monitored.

Risk and assurance

4.3 The risks are articulated in the sections under each business unit and service area and will continue to be monitored and reviewed as required. Assurance is provided

throughout this report of the actions being taken to ensure safety of all services through ensuring adequate and safe staffing levels at all times.

5 Next steps

5.1 This paper presents the six monthly review to Board in relation to safe staffing. The paper demonstrates that the Trust has maintained safe staffing in the six month reporting period, despite considerable challenges. It has also triangulated the staffing data to patient safety incidents and complaints. Work to ensure the learning from these incidents and complaints is embedded continues.

5.2 The paper has once again captured some of the unique challenges associated with the current Pandemic and it is anticipated that these challenges will continue and the focus will remain on ensuring delivery of high quality, safe services to our patients.

6 Recommendations

The Board is recommended to:

- note the contents of the report and the progress being made and support six monthly reviews in a public Board meeting.

Appendix 1

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

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

Appendix 2
National Guidance

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

Appendix 3
Safe staffing data from eRoster

Hannah House	Day	Day	Night	Night
	Average fill rate Registered Nurse	Average Fill rate non-Registered Nurse	Average Fill rate Registered Nurse	Average Fill rate non-Registered Nurse
Jul-20	165%	87%	168%	72%
Aug-20	98%	64%	110%	45%
Sep-20	75%	67%	87%	56%
Oct-20	93%	61%	90%	57%
Nov-20	88%	58%	108%	94%
Dec-20	92%	58%	92%	52%

Use of CLASS and Agency staff in Hannah House

Hannah House	Day	Day	Night	Night
	Number of registered nurses	Number of care staff	No of registered nurses	Number of care staff
Jul-20	0	2	0	3
Aug-20	0	7	0	3
Sep-20	0	3	0	2
Oct-20	0	3	0	5
Nov-20	1	0	0	0
Dec-20	0	1	0	1

All of the above were CLaSS members of staff with the exception of one from an external agency.

Appendix 4

Safe staffing data from eRoster

Little Woodhouse Hall	Day	Day	Night	Night
	Average fill rate registered nurse	Average fill rate non-registered nurse	Average fill rate registered nurse	Average fill rate non-registered nurse
Jul-20	88%	96%	73%	211%
Aug-20	96%	96%	80%	210%
Sep-20	76%	81%	75%	194%
Oct-20	89%	96%	115%	192%
Nov-20	92%	92%	87%	159%
Dec-20	78%	94%	86%	157%

Use of CLASS staff in Little Woodhouse Hall

Little Woodhouse Hall	Day	Day	Night	Night
CLASS	Number of registered nurses	Number of care staff	No of registered nurses	Number of care staff
Jul-20	15	25	2	8
Aug-20	25	32	2	17
Sep-20	19	37	2	25
Oct-20	24	38	4	29
Nov-20	16	42	1	20
Dec-20	15	55	0	13

Use of Agency staff in Little Woodhouse Hall (including LYPFT bank)

Little Woodhouse Hall	Day	Day	Night	Night
	Number of registered nurses	Number of care staff	No of registered nurses	Number of care staff
Jul-20	0	25	0	68
Aug-20	0	41	0	31
Sep-20	1	34	0	25
Oct-20	0	30	0	47
Nov-20	0	20	0	31
Dec-20	0	48	0	26

Appendix 5

0-19 Public Health Integrated Nursing Service (PHINS)

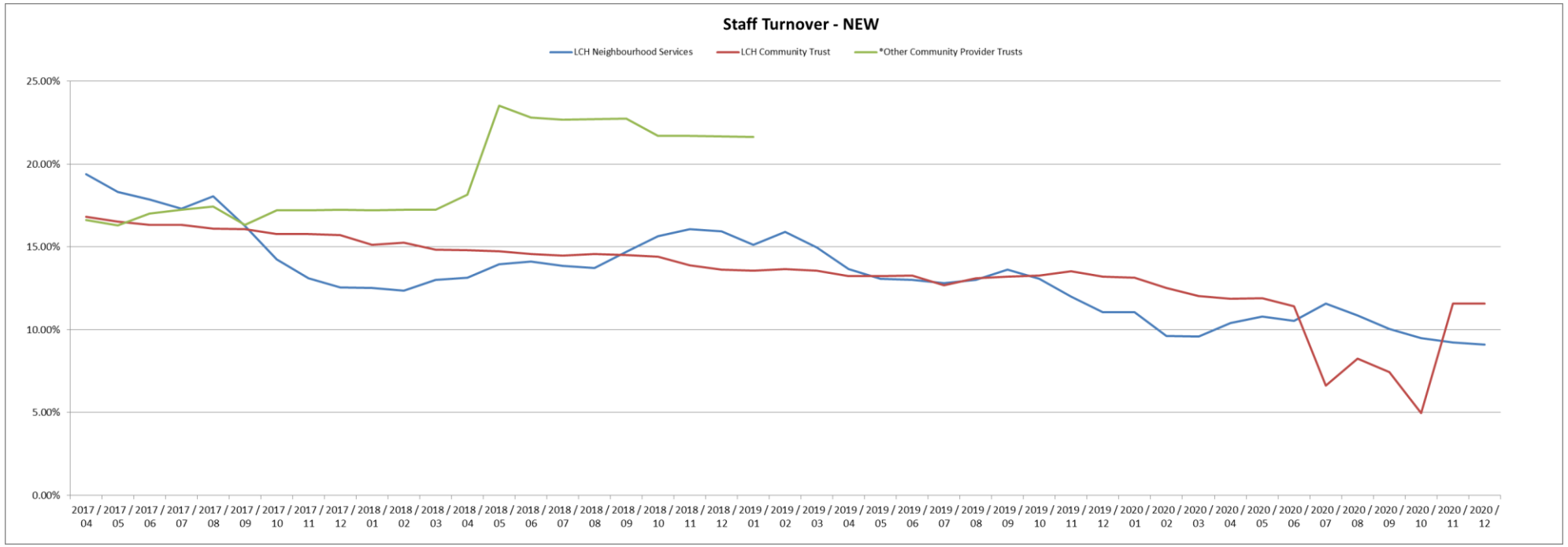
	July-20	Aug-20	Sept-20	Oct-20	Nov-20	Dec-20
WTE Health Visitors in post	114.60	112.30	117.58	116.65	118.25	118.25
WTE School Nurses in post	11.32	11.32	15	14	13	12

Appendix 6

Neighbourhood Teams

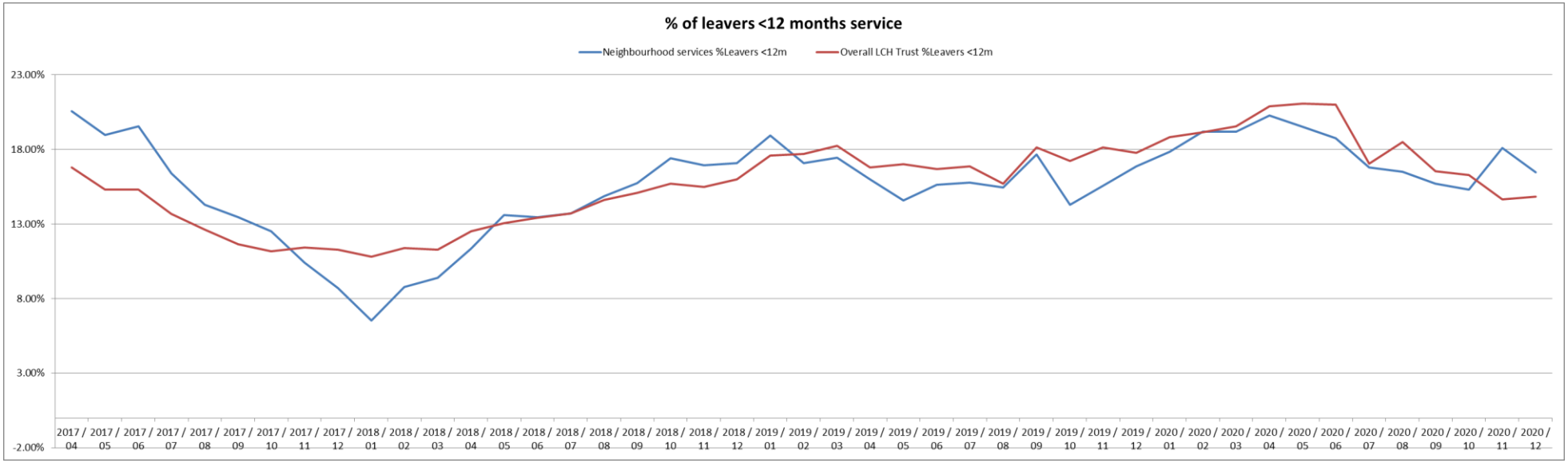
Staff Turnover

As shown in the chart below Neighbourhood Team staff turnover is relatively stable at about 10%. Neighbourhood Team turnover has continued to decrease in the last 6 months and it compares favourably with 2017 levels.



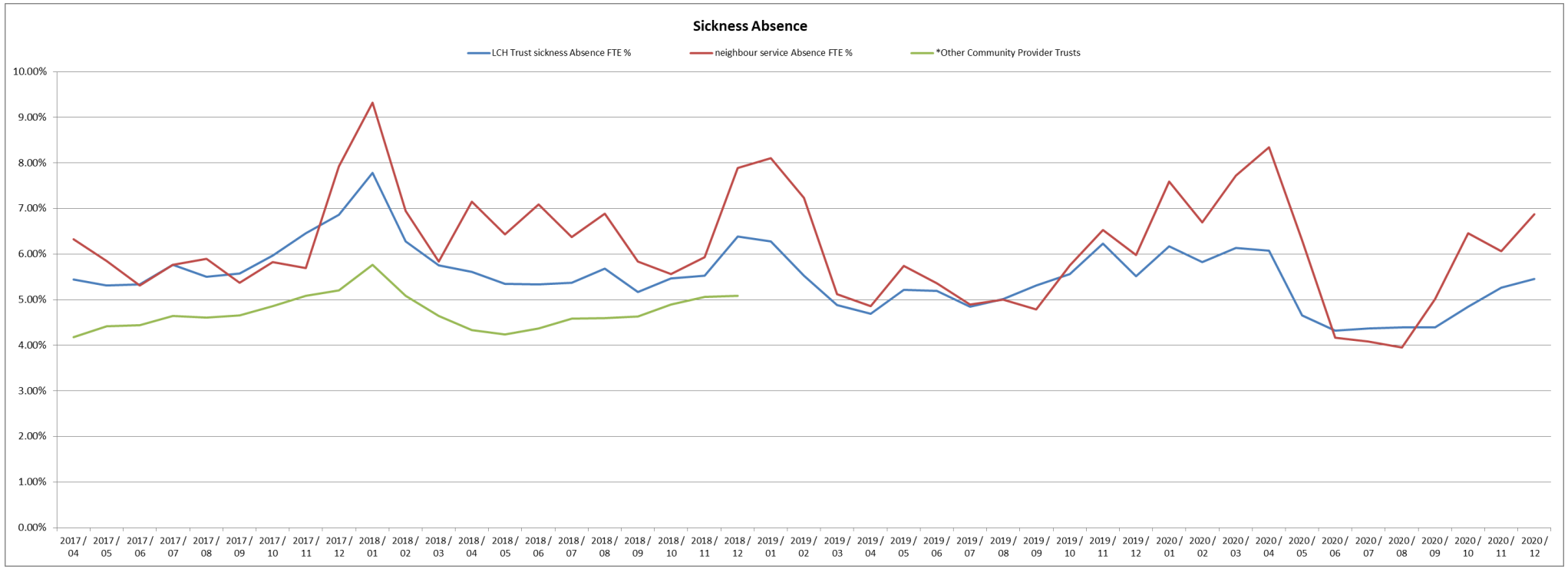
Number of leavers <12 months

As shown in the chart below, the number of leavers in their first 12 months of employment in Neighbourhood Teams continues at a similar level to the overall Trust position.



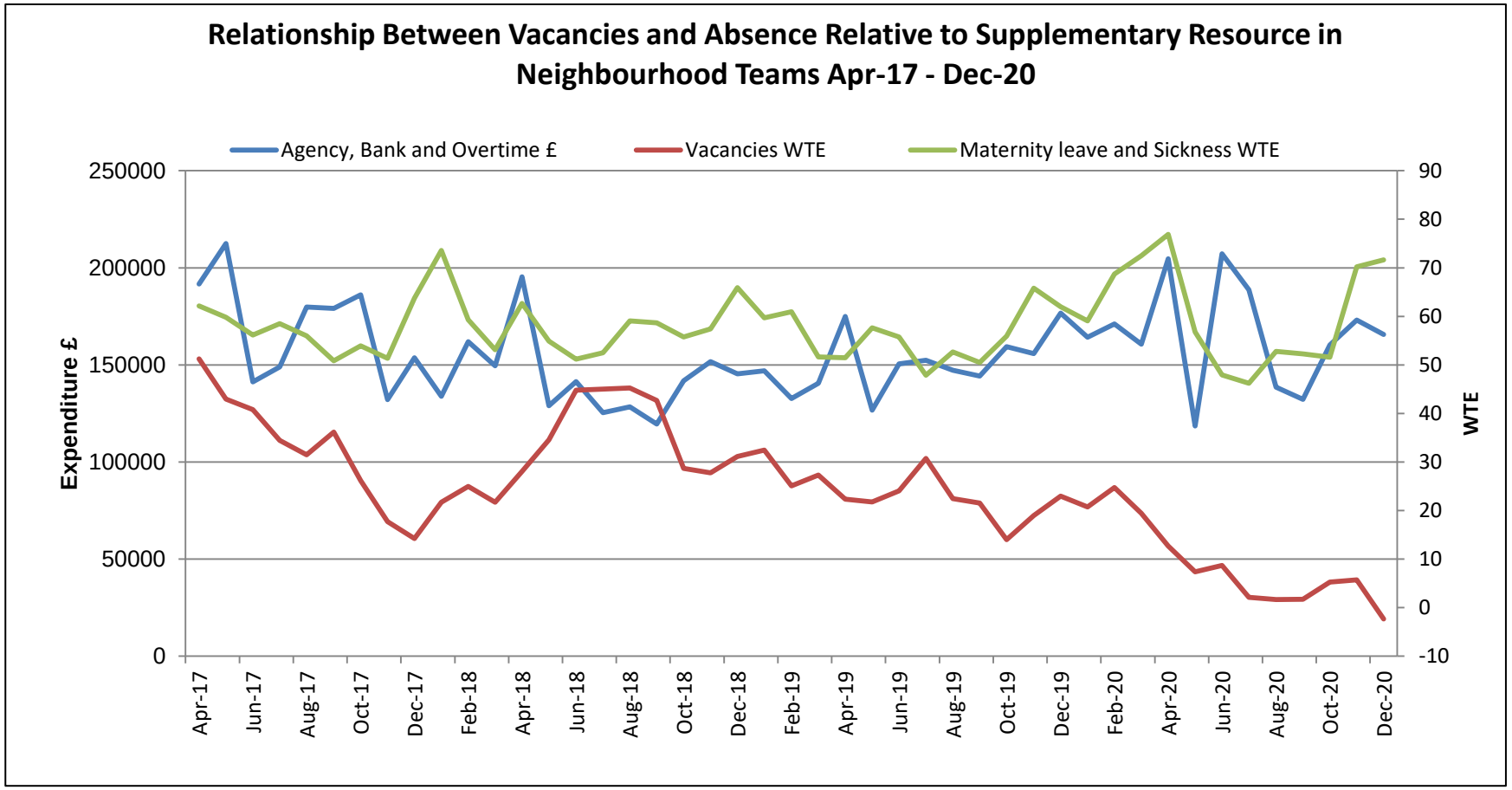
Sickness Absence

As shown in the chart below, Neighbourhood Team sickness absence increased during the early period of the COVID-19 pandemic, reducing in May and June 2020 and then increasing over winter months in 2020.



Supplementary staffing

This chart shows a further reduction in Neighbourhood Team vacancies, whilst maternity leave and sick leave has remained relatively consistent. Supplementary staff via bank and agency has also remained relatively consistent during the period.



Leeds Community Healthcare NHS Trust

Public Board Meeting: Friday 5 February 2021

Agenda item number: 2020-21 (120)

Title: Patient Experience Six Monthly Report.

Category of paper: For Assurance

History: Not applicable.

Responsible director: Executive Director of Nursing and Allied Health Professionals.

Report author: Patient Experience and Engagement Lead.

Executive summary (Purpose and main points)

Purpose:

1. This report provides the six monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH).
2. The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).
3. The report provides a review of Complaints and concerns, feedback via surveys and engagement activity, and wider feedback for the 6 month period 1 July 2020 to 31 December 2020; providing an overview of themes, learning and action. It compares the data and qualitative information with previous years, and presents key information in relation to Covid-19.
4. Information from the Friends and Family test is not included in this six monthly report due to a national hold on reporting FFT between April-December 2020, due to the Coronavirus pandemic.
5. This six month report does not provide comparison to local or national complaint data as this is not currently available at the time of writing.

Main points:

1. There has been a 22% decrease in complaints received 1 July-31 December 2020, compared to 1 July-31 December 2019.
2. The top 5 themes of complaints received remain consistent with the previous year.
3. The top themes for contact related to Covid-19 (complaints and concerns) are appointment issues and management of treatment/operations.
4. In response to Covid-19 patient experience activity has moved to engage with people and communities digitally and online, where it is appropriate to do so.
5. Patient engagement is a golden thread of reset and recovery; with 11 services already being supported to consider patient experience and engagement in service reset.

Recommendations

The Board is recommended to:

- Receive this report
- Note the updated information

PATIENT EXPERIENCE SIX MONTHLY REPORT

1.0 INTRODUCTION

1.1 This report provides the six monthly update of Patient Experience within Leeds Community Healthcare NHS Trust (LCH).

1.2 The report incorporates the information required for the complaints report as laid out in section 18 of The Local Authority Social Services and National Health Service Complaints (England) Regulations (2009).

2.0 BACKGROUND

2.1 This report will focus on the themes and learning emerging from patient feedback, and how this is shared across the Trust to ensure continuous quality improvement.

2.2 This report will pay particular focus to the impact of Covid-19 on complaints, concerns, compliments and patient experience.

3.0 LCH PATIENT EXPERIENCE

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

4.0 COMPLAINTS, CONCERNS & COMPLIMENTS

4.1 From 1 July – 31 December 2020, LCH received 69 complaints which were managed under the 2009 regulations. There is a 15% increase in incoming complaints in the latter 6 months of the year, in comparison to 01 January- 30 June 2020 when 51 complaints were received.

4.2 In comparison to the same period in the previous year 1 July- 31 December 2019, there has been a 22% reduction in complaints received, from 107 to 69 complaints.

4.3 The Trust acknowledged and responded to all received complaints within the statutory timeframes (3 and 180 working days respectively).

4.4 Of the 69 complaints received by LCH 1 July- 31 December 2020, 57 complaints entered into the formal complaints process. The remaining 12 complaints received were withdrawn by the complainant, or upon further investigation were for other organisations and were subsequently passed on.

4.5 Of the 69 complaints received; to date 44 have been closed. In addition to these, the Trust closed 7 complaints that were received prior to 1 July 2020 and are therefore counted in this report period.

4.6 48 out of 51 (94%) of complaints were closed within 40 working days of receipt. Two complaints were extended due to a delay in receiving the patient's consent; one complaint was placed on hold as per the complainant's request; and one complaint was extended over the 40 working day period due to an internal delay.

4.7 Of the 51 complaints closed 1 July - 31 December 2020, 18 (35%) were not upheld; 14 (28%) were partially upheld, 6 (11%) were fully upheld, 5 (10%) were withdrawn and 8 (16%) passed on to other providers.

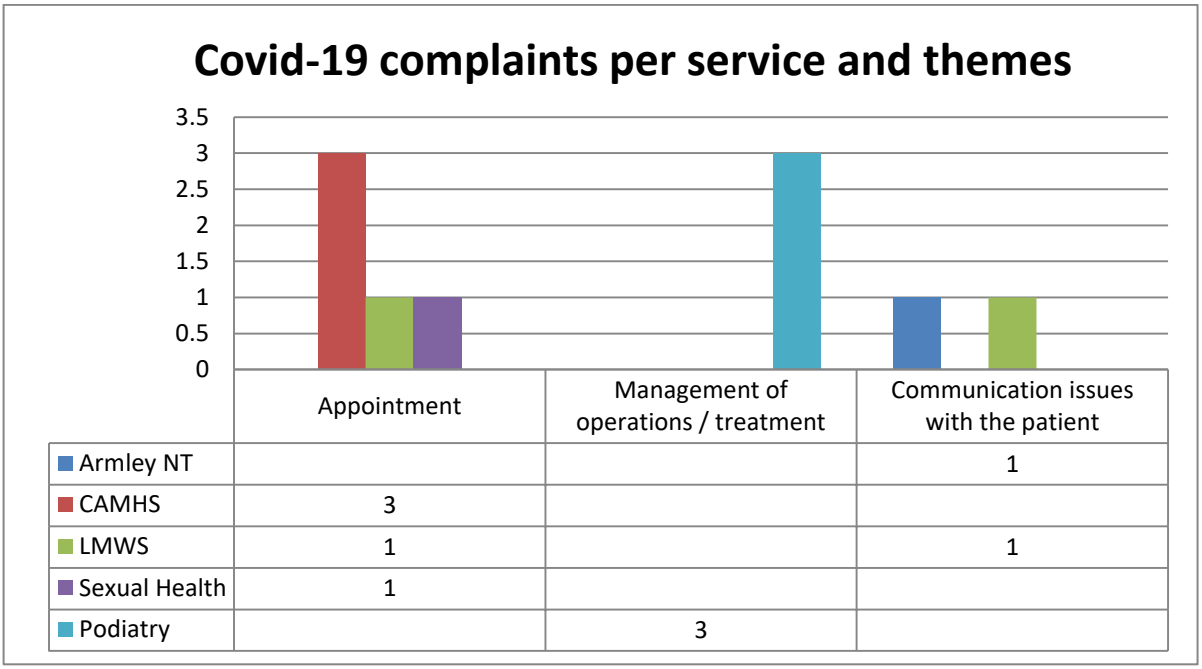
4.8 From 1 July- 31 December 2020, the Trust received 194 concerns; this is a slight decrease (6%) in the number of concerns in comparison to the same time period in the previous year when the Trust received 218 concerns. Appendix one shows more detail on this.

4.9 The Trust has received a total of 543 compliments during 1 July- 31 December 2020, this is a 13% increase on number of compliments received in the first half of the year (1 January- 30 June 2020). However by comparison to the same period for the previous year (1 July- 31 December 2019) where the Trust received 871 compliments there is a 23% reduction in compliments received, it is thought that the Covid-19 pandemic has an impact on this.

5.0 COVID- 19

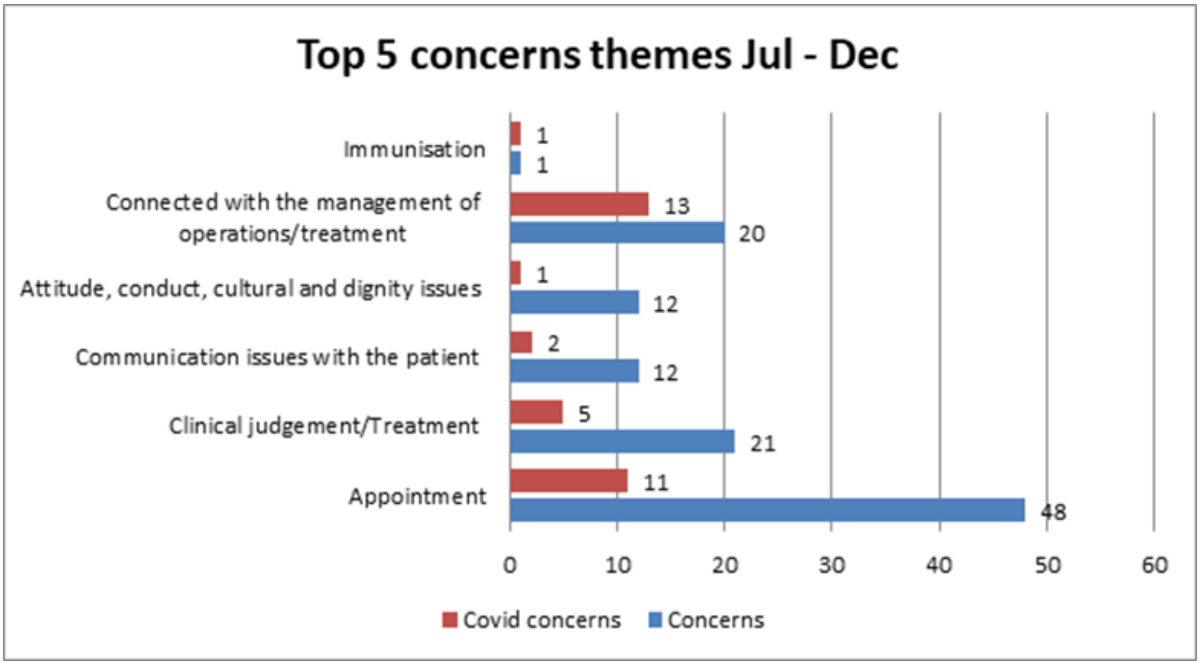
5.1 The Trust received a total of 10 Covid-19 related complaints throughout 1 July-31 December 2020; this was 14% of all complaints received by the organisation.

5.2 The graph below shows complaints received related to Covid-19 and themes per service for 1 July- 31 December 2020.



5.3 The Trust has received a total of 38 Covid-19 related concerns for the period 1 July- 31 December 2020; making up 20% of all concerns received by the organisation.

5.4 A graph to show concerns received and themes, with a breakdown of Covid-19 related concerns for 1 July- 31 December 2020.



6.0 PATIENT EXPERIENCE (COMPLAINTS) TRAINING

6.1 Due to capacity within the Patient Experience Team, and within teams to attend training, there have been no complaint training sessions delivered between July and December 2020. However support has been provided to

teams where needed and guidance given. The Complaint training is in the process of review, with bespoke sessions planned for delivery in early 2021.

7.0 OVERARCHING THEMES

7.1 This section provides an overview of the categorisation of issues raised 1 July- 31 December 2020.

7.2 The top five themes within LCH's complaints for period 1 July- 31 December 2020 ranked in the following order:

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

7.3 The top 5 themes for LCH over the last 6 months are consistent with the previous 6 months and with the same period in the previous year with the addition of Management of operations/treatment which has replaced confidentiality of information.

	ABU	CBU	SBU	Total
Clinical judgement/Treatment	8	4	9	21
Appointment	2	7	6	15
Attitude, conduct, cultural and dignity issues	2	3	8	13
Management of operations/treatment	1	0	2	3
Communication issues with the patient	1	0	1	2

8.0 Trends within clinical judgement/ poor treatment

8.1 The "top line" theme of clinical judgement / poor treatment has consistently been in the top three subject areas for complaints at LCH for the past five years. This is in line with the information that has been previously reported nationally.

8.2 During 1 July- 31 December 2020, 37% of all complaints received (21/57) were due to issues pertinent to clinical judgement/poor treatment and saw the biggest share of all complaints received across the organisation. The number of complaints related to clinical judgement/treatment was highest in Specialist

Services with 9 complaints, and lowest in Children's Services who received 4 complaints related to this subject area.

8.3 Out of the 21 complaints received; 11 have been closed to date; 1 complaint was fully upheld, 1 was partially upheld, 8 were not upheld, and 1 complaint was withdrawn by the complainant.

8.4 The complaint that was upheld was received by CAMHS West and was related to delays in referral for ADHD and sensory assessments, and failure to fully communicate with the parents. Support was given to the staff member involved to implement process to keep up with tasks arising from clinical work, to consider workload, and the approaches used when seeing families in an urgent capacity. Actions included to identify a target date for required components of an assessment for potential ASD for the young person, and to identify a clinician to consider medication with young person and their family to further help them to manage their symptoms.

8.5 Learning from these types of incidents has included investigation of an audit to ensure safe practice and a reminder to all staff about checking with patients about their preferences around care and treatment.

9.0 Trends within appointment issues

9.1 During 1 July- 31 December 2020 26% of all complaints received (15/57) were due to appointment related issues and saw the second biggest share of complaints received. The Specialist and Children's Business Units received the highest number of complaints related to appointment issues. The Adult Business Unit received the lowest number of complaints with 2 complaints.

9.2 Of the 15 complaints received; 9 were closed; 3 complaints were fully upheld, 4 were partially upheld, 1 was not upheld and 1 complaint was withdrawn.

9.3 The complaints upheld and partially upheld were received in CAMHS, Mindmate SPA, Podiatry and Leeds Mental Wellbeing Service (LMWS). These are all services who have operate waiting lists usually and this has been further impacted as a result of Covid-19.

9.4 The Child and Adolescent Mental Health Service (CAMHS) saw the biggest share of appointment related complaints received; a total of 6 appointment related complaints received. The complaints were a result of the length of time taken to be seen and waiting times to receive an ADHD/Autism assessment. This is recognised as an issue in the city and commissioners are aware of this and looking at ways to address this.

10.0 Attitude, conduct, cultural and dignity issues

10.1 Of all complaints received during 1 July- 31 December 2020 23% (13/57) were due to issues concerning attitude, conduct, cultural and dignity and this subject area received the third biggest share of all complaints received. The Specialist Business Unit received a higher number of complaints related to this subject area with 8 complaints, and the Adult Business Unit received the least receiving 2 complaints.

10.2 Out of the 13 complaints received; 8 have been closed to date; 2 fully upheld, 3 partially upheld and 3 were not upheld.

10.3 The upheld complaints were received by the Seacroft Neighbourhood Team and Leeds Sexual Health Service and both highlighted a need for training for the staff involved; to include record keeping, bespoke clinical training, and appropriate communication.

10.4 Examples of learning in this area include asking staff to reflect on their actions and modify future practice.

11.0 Trends with Management of operations/treatment

11.1 During 1 July- 31 December 2020 5% of all complaints received (3/57) were due to issues concerning the management of operations/treatment. The Specialist Business Unit received two of these complaints, and the Adult Business Unit received 1 complaint.

11.2 Out of the 3 complaints received; all 3 have been closed; 1 complaint was partially upheld and 2 were not upheld.

11.3 Complaints relating to the management of operations/treatment were mainly due to the impact of Covid-19; and saw Elland Road Custody Suite, Leeds Sexual Health Service and the Health Case Management (North) Team receiving complaints relating to this theme. These complaints were about the services that were stepped down as per National guidance during the pandemic.

12.0 Communication issues with the patient

12.1 For the period 1 July- 31 December 2020 4% (2/57) of all complaints received were due to communication issues with the patient. The Specialist Business Unit and Adult Business Unit received 1 complaint each.

12.2 Out of the 2 complaints received; 2 were closed; 1 complaint was partially upheld and 1 was not upheld.

12.3 The learning from these complaints included reviewing written communication and we are now working with the patient on co-production of future communications.

13.0 PATIENT ENGAGEMENT DURING COVID-19

13.1 Engagement Staff Champion Group

13.1.1 The Engagement staff Champion meetings have continued between 1 July-31 December 2020 and the frequency of the meetings was increased to monthly to provide greater support to the staff champions.

13.1.2 Attendance at the monthly meetings has consistently improved with average attendance being 30-35 staff members.

13.1.3 There are now 65 named staff engagement champions across all Business Units, with work ongoing to identify any services that are not represented.

13.1.4 Agenda items have included guest speakers from 100% Digital Leeds and the LCH Information Governance team, Digital storytelling, Reset, the engagement toolkit, service updates and sharing best practice/learning.

13.1.5 An engagement toolkit has been developed and uploaded onto the Oak Intranet to provide resources and guidance for patient, carer and public engagement.

14 Engagement in Reset and Recovery

14.1 The Patient Experience Team have met with 11 services to-date in order to complete the engagement pro-forma for service reset.

14.2 A number of services have received support from the Patient Experience team to develop more service-focused patient and carer surveys, with a view to gathering insights into recent service changes including the introduction of telephone and video consultations and how this has felt for people, what is working well and what could be improved upon.

14.3 The Speech & Language Therapy service have been supported to develop an easy-read online survey for patients with Learning Disabilities accessing the SLT service. The easy read version includes a number of images to support the text and these images have gone through service user consultation and were chosen by service users as images they liked and can understand.

14.4 The Leeds Sexual Health Service (LSH) launched their patient survey in late August and included a QR code, text message links and a paper copy to share the survey with service users.

14.4.1 The online method of return has proved the greatest currently for LSH, with 52 out of the current 89 responses (58.43%) being received online. The service has struggled to engage with patients historically, due to the highly confidential nature of the service, so this has shown a real improvement in their feedback returns since developing a more specific survey that can be accessed both digitally and in print. See appendix 2 for examples of feedback received.

14.5 Community Gynaecology – the service introduced a new survey in September, via paper copy only currently due to the demographic of patients accessing the service being largely elderly and without online access. So far they have received 49 responses and these have been overwhelmingly positive, with only 4 negative comments noted to date (4/49 = 8.16%). See appendix 3 for examples of feedback from the survey.

14.6 The 0-19 PHINS patient engagement staff highlighted some of their patient engagement work at the Patient Engagement Champion meeting in October.

14.6.1 As the 0-19 PHINS team also have an active social media account on Facebook, they have been able to engage with a parents and carers using this channel, sharing surveys, information, resources and signposting. This has also proved useful for creating feedback polls to gather feedback around some of the virtual clinics now on offer, such as the Virtual Breastfeeding, Well Baby and Breastfeeding Health Visitors Group.

14.7 As part of the six month Patient Experience report in July 2021, we will feature learning and service improvements made in response to the feedback detailed above, and as part of wider reset and recovery work.

15.0 Health inequalities

15.1 The Engagement pro-forma for reset has been useful in supporting services to consider the impact of service delivery throughout Covid-19 and service reset on health inequalities, in addition to thinking proactively around accessibility in line with the Accessible Information Standards. The process is encouraging services to understand ‘who’ their patient/carer groups are; what can we understand about these groups, and to identify gaps. Insights, experiences and understanding of the needs of community groups on a city wide level are incorporated, to be able to relate this to the data that we have in LCH, and identify areas for action.

15.2 Work has taken place over the last six month and is ongoing with the Communities of Interest network & Inclusion for All action hub to link insights from these with the data we capture to better understand and interpret clinical outcomes, and implement changes to support improved outcomes for specific communities. It is suggested that this should include priority system updates to capture protected characteristics (ethnicity, age, geography),

communication needs (including Learning disability), and contact method to include reasoning for when this is not digital.

15.3 A priority is to understand how communication methods for key messages may impact on different communities: data analysis from a relatively small sample during the first lockdown suggested that patients from particular areas in Leeds and from predominantly BAME communities were not engaging in some healthcare appointments. It could be determined that key messages from services had not always reached these communities, nor were they presented in an accessible way for these people. Work to sustain clear communication channels through the communities of interest, create narrated videos, update website documentation, contact via video/phone/written form continues. Key to this is consistently recording key patient information to guide communication formats for individuals, and to develop communication plans incorporating the lessons learnt.

16.0 Digital Inclusion

16.1 PET has supported the work to understand the impact of Digital Exclusion: understanding the barriers (Poverty, Age, Literacy & communication preferences, Skills & motivation, Precarious lifestyles, Privacy, Disability & specific conditions, Trust in IT) that could be present for communities and that can lead to digital exclusion from healthcare. A tool to support digital decision making for both staff and patients is in development.

17.0 Next steps

17.1 In response to Covid-19 patient experience activity has moved to engage with people and communities digitally and online, where it is appropriate to do so.

17.2 Work to engage with vulnerable communities and those at highest risk of health inequalities will continue.

17.3 Patient engagement is a golden thread of reset and recovery and services are being encouraged to seek support from the Patient Experience Team to ensure the patient and carer voice is at the centre of service reset.

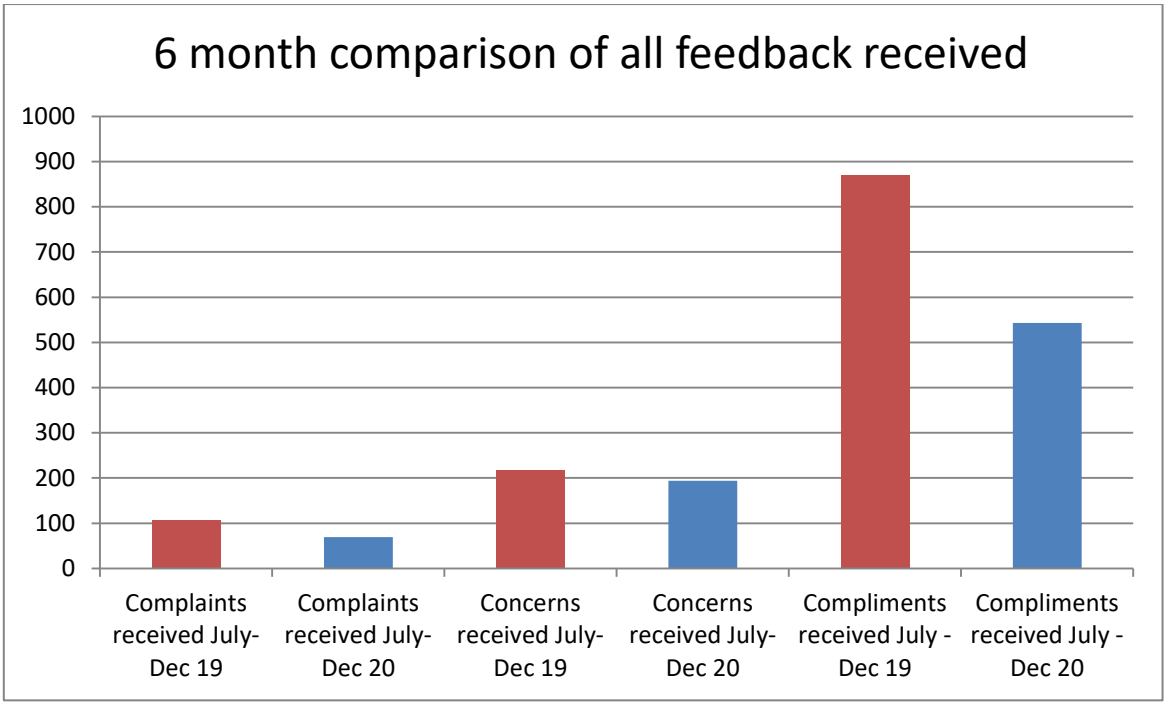
18.0 Recommendations

The Board is recommended to:

- Receive this report
- Note the updated information

Appendices

Appendix 1



Appendix 2

Examples of feedback received from the Leeds Sexual Health patient survey.

The comments received have been largely positive, particularly in regard to how parts of the service have changed in light of the COVID pandemic, including using telephone triage and a medication postal service. Some examples of positive feedback received include;

- *Very quick and efficient in getting an appointment the following day after a phone call from the clinic and access to the clinic was easy too.*
- *It's better as you have a time slot and it's not overcrowded.*
- *Very friendly & professional and kept me informed of any changes/updates.*
- *My experience is that every time I have called up, the receptionists have been very helpful and always managed to get me in for a telephone triage appointment with the nurse that day- what an exceptional service on offer. Based on my needs the nurse has assessed me and got me the treatment I need and made it available at a place easy for me to reach.*
- *Really easy, I used the online chat first to double check what I needed to do and the nurse I spoke to was really nice.*
- *The service that was given was amazing. Brilliant customer service, very caring, understanding and friendly staff. It was very embarrassing but they put me at ease straight away.*

Negative feedback is largely related to the telephone system, with less positive comments including;

- *I did not like the phone system hanging up when I couldn't get through; I would prefer a hold system.*
- *I think an online booking system would be much more efficient possibly?*
- *A hold system for the phone line so it doesn't hang up when busy.*
- *Better phone service [required]; could not get through to cancel last appointment, took me two days.*
- *It has been a hard task to actually get through on the phones.*

Appendix 3

Examples of positive feedback for Community Gynaecology so far include:

- *Excellent service at reception. All COVID standards in place for my safety.*
- *Feel happier coming to a face to face appointment, especially for this type of appointment.*
- *Everything is very clean. Chairs spaced out to accommodate social distancing. Nurse was very information, came out of the appointment feeling very positive.*
- *Went well, really good told you exactly what was happening.*
- *Great to be able to come to clinic so after discussion we could plan a course of action and continue treatment.*
- *Telephone appointment as a stop gap helpful.*

Glad to see the doctor face to face and felt like safety was managed well, so minimal risk involved.

Board Meeting: 5 February 2021

Agenda item number: 2020-21 (121)

Title: Quarter Three Serious Incident Summary Report

Category of paper: Assurance
History: SMT

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: Head of Clinical Governance

Executive summary (purpose and main points)

The Trust identified twenty new Serious Incidents in Quarter Three (Q3) 2020-21 which initially appeared to meet the Serious Incident criteria. Requests were made to de-log two of the twenty reported incidents from StEIS following investigation as it was concluded that they did not meet the criteria on further review.

The Trust was 88.9% compliant with reporting Serious Incidents within two working days in StEIS and 94.4% compliant with the statutory requirements of Duty of Candour.

An immediate action has been taken to mitigate the risk of non-compliance with StEIS and Duty of Candour reporting.

The Trust had one Never Event in Q3 2020-21.

Recommendations

The Board is recommended to:

- receive and note the contents of this paper

1. Purpose of the Report

1.1 A report on Serious Incidents is produced quarterly to provide assurance to the Board of Directors that Leeds Community Healthcare (LCH) patient safety incidents are being effectively and responsively managed within the Serious Incident process, to optimise the safety and experience of our patients and colleagues.

2. Serious Incident Decision Meeting (SIDM)

2.1 All LCH patient safety incidents that are initially assessed to have caused moderate and major harm are reviewed at the SIDM with an expert panel. The panel assesses whether there were any lapses in care by LCH that may have led to the patient harm.

2.2 In Q3 there were 138 patient safety incidents discussed by the SIDM panel: 39 in October 2020, 41 in November 2020 and 58 in December 2020.

3. Serious Incidents reported to the Strategic Executive Information System (StEIS)

3.1 There were twenty Serious Incidents identified by the SIDM panel that were notified externally via StEIS, which is the national Serious Incident reporting system, in Q3. A request has been made to de-register two of those incidents since. One where LCH was not assessed to be the lead organisation on further review, LCH will contribute to the investigation as required. There were no lapses in care assessed for the second on further review. Eighteen have continued to full investigation.

3.2 The requirement to submit investigation reports by sixty working days has been relaxed by the Clinical Commissioning Group due to the impact of Covid-19. However, LCH aims to maintain the sixty day timeframe for completion.

3.3 Q3 LCH Serious Incidents by Sub-Category and Month declared are detailed below:

- Abusive or self harming behaviour, one in October.
- Slips, trips, falls and collisions, one in November, three in December.
- Pressure Ulcers, three in October, two in November and ten in December, there is no explanation as yet as to why there is such an increase in December as the incidents are currently being reviewed.
- Delayed diagnosis, 1 in October.
- Treatment/Procedure, 1 in December which was the wrong site injection and a Never Event.
- Other (unexpected death in community), one in November.

Overall, there were five in October, four in November and nine in December, totalling

3.4 As at the 18th January 2021, two investigations have been completed, one within timescale and one with a five day extension, sixteen remain under investigation.

4. StEIS Reporting Timeframe

4.1 All Serious Incidents identified at the Serious Incident Decision Meeting are reported on the StEIS database within two working days of the decision that the incident meets the Serious Incident criteria. In Q3, sixteen of eighteen (88.9%) were reported within the timescale, the remaining incidents were reported on day three and seven. It is not known what caused the delay and there is no rationale in Datix.

5. Duty of Candour Compliance

5.1 Where statutory Duty of Candour is assessed required for a patient safety incident, LCH informs the people affected, apologise to them, provides an explanation of how the investigation will be completed and discusses any specific questions the patient or family would like to be answered within the investigation.

5.2 Statutory verbal Duty of Candour was completed within ten working days for seventeen of the eighteen (94.4%) incidents. One verbal Duty of Candour was completed on day thirteen, it is not known what caused the delay.

5.3 A letter confirming the initial discussion within the LCH standard of ten days is then sent. A follow up letter is recorded for fifteen of the eighteen incidents and two were declined. One letter was not sent, the operational team advise it was omitted in error. On review of the Datix the investigation started as an internal concise and was escalated to a Serious Incident during the review process which may have contributed to the omission.

5.4 Of the fifteen incidents where the initial Duty of Candour letter was sent, eleven were sent within ten working days. The remaining four were sent between day eleven and day twenty-six.

5.5 The service where the initial letter was not sent and where a letter was completed on day 26 are the same, work has been completed with the service to recognise the importance of Duty of Candour.

6. Learning from Serious Incidents in Quarter Three

6.1 Unrelieved pressure was identified as a root cause or causation factor in one pressure ulcer incident, in addition to the wound being contaminated due to incontinence.

6.2 Contributing factors were assessed as the patient's deteriorating health condition with reduced mobility. Staffing capacity within the team impacted by Covid-19 was also deemed to have contributed. The team have had significant staffing issues in the previous six months. The staffing capacity had been escalated every month and related to Staff Nurse and District/Senior Nurse vacancies. The investigation found although there had not been any resulting missed or deferred visits, the capacity issues did

potentially lead to less registered nurse reviews. This is being addressed by the senior leadership team in the Adult Business Unit (ABU).

6.3 Measures to address recurring themes within pressure ulcer incidents are a focus of the Pressure Ulcer Steering Group.

6.4 Cancellation of face to face contacts was assessed the root cause or causation factor for a patient with a delayed diagnosis of a spinal cord compression in MSK. Telephone consultation had been completed by MSK and the GP practice for 5 months.

6.5 Contributing factors were assessed to be the Covid-19 pandemic, that resulted in the suspension of normal service and staff being redeployed. In addition, staff stress and anxiety of managing complex cases remotely, and single handed at times, together with Neurosurgical communications that they are only accepting “life or limb saving“. A lack of estates across the city for patients unable to travel was also assessed to contribute. These issues are being addressed through reset and recovery.

6.6 There are quarterly patient safety summits that commenced in September 2020 that aim to share learning and consider themes. Incidents are also reviewed for themes and triangulated against additional data sources within LCH such as complaints and feedback. Themes are also discussed at the ABU and Clinical Governance Quality Performance Review Meeting and staff involvement is sought.

7. Continued Improvement

7.1 The reporting of pressure ulcers is to be reviewed and benchmarked against other organisations to ensure appropriate reporting; it is anticipated that this may lead to a reduction in Serious Incident reporting for Category Three pressure ulcers. This review will coincide with the change of focus in reporting and investigating incidents outlined in the Patient Safety Strategy.

8. Coroners’ Inquests

8.1 There were no new inquests reported during Q3.

9. Next Steps

9.1 As an immediate measure, a central spreadsheet has been developed and implemented within the Clinical Governance Team to log all Serious Incidents and internal concise investigations.

9.2 The aim is to ensure there is one quick reference source for information that is accessible by the Patient Safety Team, Quality Leads and Head of Clinical Governance and includes the investigation start date, StEIS report date, Duty of Candour dates and report due dates. Weekly meetings will be initiated to review the status of each investigation and ensure all statutory and organisational requirements have been completed and that the information is correct to that held in Datix.

9.3 There is an additional plan to review the incident and Serious Incident management process.

10. Recommendations

The Board is asked to:

- note the contents and actions from the report.

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (122)

Title: Q3 2020/21 Mortality Report

Category of paper: for assurance
History: Quality Committee 25 January 2021

Responsible director: Executive Medical Director
Report author: Deputy Medical Director & CCIO

Executive summary (Purpose and main points)
To provide the Board with assurance regarding the Mortality figures and process within Leeds Community Healthcare NHS Trust in Quarter 3 2020/21.

The Board is advised to note:

- Deaths are rising again in Q3 after a relative lull in Q2 but without the large spike seen in Q1
- There is a sustained trend of people choosing and being accommodated to die at home. This needs to be taken in to account with future resource / workforce planning
- COVID19 has been a challenge for everyone, not least the neighbour teams engaged in caring for people who are dying.
- The lack of cause of death data reduces our ability to understand health inequalities

Recommendations

The Board is recommended to**:**

- receive the assurance provided regarding the Trust mortality process
- acknowledge the ongoing high demands that are placed on the teams who are still able to provide excellent care.

Mortality Report

1.0 Purpose of this report

1.1 To provide the Board with assurance regarding the Mortality figures and processes within LCH NHS Trust in Quarter 3 2020/21.

2.0 Background

Leeds Community Healthcare NHS Trust has contact with a significant number of patients within the city, with very few in an inpatient environment. For many of the people who die under the care of the NHS this is an inevitable outcome particularly given we provide end of life care in peoples own homes, and many receive excellent care in the time leading up to their death.
The Francis Inquiry report into the care failings identified at Mid Staffordshire NHS Foundation Trust, identified one of the significant measures that was not acted on appropriately was a mortality rate significantly higher than expected for the Trust. The NHSE National Guidance on Learning from Deaths (2017) provides the underpinning for the framework that NHS Trusts now follow. Within this it emphasises that "Community NHS Trusts should carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach".

Our responsibility as a Trust encompasses the following requirements:

- Ensure we have adequate governance arrangements and processes that include, facilitate and give due focus to the review, investigation and reporting of deaths.
- Ensure that we share and act upon any learning derived from these processes.
- Ensure adequate training and support is provided to staff to support this agenda
- Have a clear policy for engagement with bereaved families, or carers, including giving them the opportunity to raise questions or share concerns and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage of the process
- Have a clear Mortality and Learning from Deaths Policy that details how we respond to, and learn from, deaths who die under our management and care
- Collect and publish on a quarterly basis specified information on deaths, through a paper and an agenda item to a public Board meeting in each quarter.

The LCH Mortality and Learning from Deaths Policy, 2020 (currently awaiting ratification) details our Trust response to both and clearly

articulates our assurance process and governance surrounding mortality reviews and shared learning throughout the Trust and the wider system.

3.0 Current position

3.1 The Quality Assurance & Improvement (QAIG) Group have met regularly and are quorate. The last meeting was the 21st January 2021.

3.2 Meetings of the Adult Mortality Governance Group (jointly with Specialist) and Child Mortality Governance Group have taken place regularly. Two additional mortality review meetings have occurred during Q3 to ensure we are up to date with the number of deaths, particularly when capacity was limited earlier in the year.

3.3 The Trust remains in contact with other providers of community care to share learning regarding the mortality review processes and whether benchmarking can be incorporated.

Adult & Specialist Business Units (Appendix 1 for combined Flash report)

3.3.1 Mortality Data for Adult

	2018/19	**2019/20**	**2020/21**			
	Total	Total	Q1	Q2	Q3	YTD
EPaCCs deaths	1665	1012	664	501	591	1756
Unexpected deaths	335	133	77	50	71	198
Expected deaths	83	1256	593	376	433	1402
Total of deaths*	**2073**	**2226**	**987**	**687**	**879**	**2553**
Total Level 1 reviews undertaken	1011	1270	670	426	490	1586
Total Level 2 review also undertaken	187	206	137	129	136	402
Deaths of patients with Learning Disability	Not collected	2	2	0	1	3
Deaths of patients with Serious Mental Illness	Not collected	2	0	0	0	0
Death of patients in Community Care Bed		12	8	4	4**	16**
Deaths on Virtual Ward				New in Q3	2	2
Deaths within 30 days of hospital discharge			New in Q2	3	11	14

3.3.2 Note - the total number of deaths (*) is the total number of deaths from all the Neighbourhood teams. Other totals are subsets of that total. There is some overlap between those groups. **Deaths in CCB for Q3 does not include those from the non-Alliance bed base.

3.3.3 **Specialist Mortality Data**

	Totals 2019-20	**Total 2020-21**			
Total Reported Adult deaths	40	Q1	Q2	Q3	YTD
		14	13	20	47
Unexpected deaths	17	5	9	15	29
Expected deaths	21	9	2	5	16
Death with Serious Mental Illness	4	0	0	0	0
Death with Learning Disability	1	0	1	1	0

3.3.4 Latest quarter figures are subject to slight change as deaths have to be recorded on the primary care system for the death to be counted. We will have already been notified via other means and acted accordingly.

3.3.5 The COVID-19 pandemic led to a marked increase in mortality during Quarter 1 (Q1) and there was a below average level of deaths during Quarter 2 (Q2). Consistent with the known increase in rates of Covid19 in the city during from October to December 2020, Quarter 3 (Q3) has seen a rise in mortality and is now above average. However, there has been no spike as was seen in April 2020.

3.3.6 The current year to date has experienced more deaths in the community in which the Trust has been involved in. This is illustrated in the chart below. The total for the first three quarters of the year is nearly 120% of what we would normally experience on average for a full year with 440 more deaths than would be expected (based on the average of the two preceding years data).

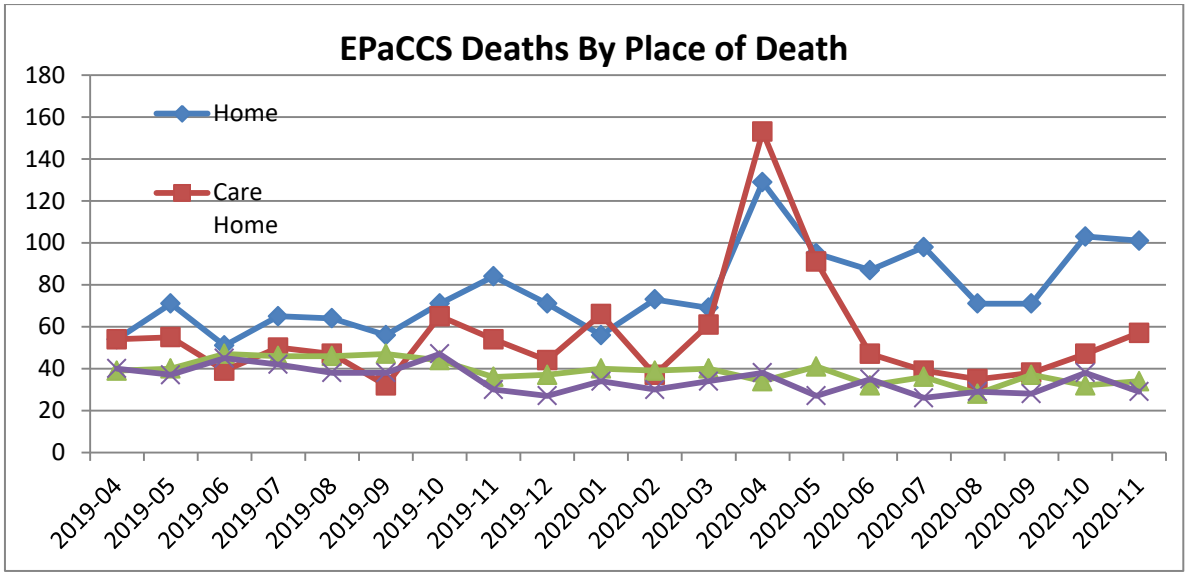


Figure 1

3.3.7 Palliative care activity did increase by over 30% in Q1, returning to more usual levels. However, we are seeing an increase of 25-30% in fast-track referrals as the year has progressed into Q3 and a 40% increase compared to the previous year's Q3 activity.

3.3.8 The number of people dying in care homes are showing a rise this quarter to their previous level pre-COVID.

3.3.9 As can be seen in Figure 1 above, there is a continuing trend, probably accelerated by COVID-19, of people dying in their own homes. Whilst this is something to be encouraged, it is putting a strain on our community teams.

3.3.10 The teams have been able to sustain a high level of preferred place of death with 81% (76-87%) achieving their first choice and 84% achieving their first or second choice. The main reasons for not achieving their preference were around an unsuitable home environment (56%) or transfer to hospital / hospice for clinical reasons (16%) / symptom control (9%). *Home environment* is a descriptor for when the patient's preference is unable to be supported / maintained due to a significant change in the patient presentation as EOL approaches. Care may become too challenging and sometimes unsafe to deliver at home (family / patient is unable to cope / home environment becomes untenable to provide care for example).

3.3.11 The majority of Neighbourhood teams (NTs) have been around average for the deaths, Kippax / Meanwood / Seacroft & Wetherby have all been above average in the last quarter but not reaching their control limits. Holt Park has breached its upper control limit this quarter in October & November, and more significantly than in the initial first wave. It is noted that the rise was with expected / EPaCCS deaths rather than unexpected deaths. The mortality review procedures didn't indicate any concerns with the care delivered by LCH teams or the nature of the deaths. We do from time to time have short term increases that then settle back into the normal range. We had had no

Serious Incidents, complaints or safeguarding concerns raised from / about the team during this two-month period. We continue to monitor the individual team mortality data, if the numbers stay within the normal SPC range for a further month in January, then we will not be taking any further action.

3.3.12 There were no End of Life (EoL) related serious incidents reported during Q3. There is one case being viewed on behalf of the non-Alliance Community Care Beds (CCBs) as a multi-agency level 2 review with LTHT, primary care and the care home. The case linked back to a lack of adequate post lower limb fracture venous thromboembolism (VTE) prevention. The case illustrates the need for more multi-agency reviews, and we are encouraging our primary care colleagues to contribute. A previous barrier was regarding the attendance at meetings and the move to online meetings benefits greater inclusion.

3.3.13 Lack of data regarding cause of death remains a challenge. LCH teams do not issue death certificates and it is variable as to whether primary care colleagues add the information to the electronic patient record (EPR). Even when this occurs there is no code / data field to enable reporting. A brief review of the EPR of recently deceased people showed only ~20% had any cause of death mentioned. Discussions have been made with the CCG & Public Health but linking the ONS death registration data to the primary care data set is fraught with information governance issues. We have yet to have a reply from the Coroner's office regarding how we could link with their data. It looks likely that the best interim method would be to have this data captured manually via the Level 1 questionnaire, as we do for people with Significant Mental Illness (SMI) or Learning Disability (LD).

3.3.14 We will report on COVID19 in Q4 when we can be confident that we have captured the data consistently.

3.3.15 The PL368 Mortality Review and Responding to Deaths Policy was ratified in January 2021.

3.3.16 **Learning Themes and Actions Taken**

- Deaths have increased this quarter in line with expectations following the citywide increase in cases of COVID and the beginning of the winter months
- More people are dying a home than previously
- There is continued evidence of lack of advanced care planning, with less than expected use of ReSPECT and completion of EPaCCS template in the SBU.

3.3.17 **Actions taken to policy / procedure or protocols**

- Following the case review on behalf of the non-Alliance CCBs regarding a Venous Thromboembolic associated death, a safety memo has been shared across all Adult Services (Appendix 3)

- The LCH Adult Mortality Review meetings have been expanded to include the GP Lead for EoL Care
- In November a meeting was held with the ABU & SBU Clinical and Quality Leads, the Palliative Care & Community Cancer Support service manager and Dr Sarah McDermott which discussed End of Life processes. The implementation of the updated mortality review process and its associated SOP.

3.4 **Childrens Business Unit** (Appendix 2 for Flash report)

Mortality Data
Deaths within Children's Business Unit cohort

	2019-20	**2020-21**			
Total Reported Children's deaths	24	Q1	Q2	Q3	YTD
		4	4	8	16
Unexpected deaths [SUDIC]	12	2	2	6	10
Expected Deaths [CDOP]	12	2	2	2	6

3.4.1 There are established robust processes within Children's Services around unexpected deaths via the Sudden Unexpected Death in Childhood (SUDIC) process and Child Death Overview Panel (CDOP).

3.4.2 Children Mortality Group meetings have occurred every 2 months and link to the Leeds CDOP process and the QAIG. The last meeting was 25th November 2020.

3.4.3 A key theme in Q3 has been the impact of reducing face to face contact with families due to the COVID-19 pandemic restrictions. Learning from this is contributing to the reset programme.

3.4.4 Despite the restrictions, services have continued to provide support for families and from September increased as the estate resets and restrictions improved.

3.4.5 **Learning points and actions**

- Team contributed to the PL368 policy review and the Standard Operating Procedures has been updated.
- Potential learning has been identified regarding the co-sleeping case. The child's parents have expressed their concerns regarding virtual contacts (which became the norm due to COVID) which was raised at the initial 5-7day statutory SUDIC meeting. This will be discussed further at CDOP in February.

- Following experience gained earlier in the pandemic, the PHINS team will remain in contact with families and not be redeployed.

4 Resources

4.1 The number of deaths investigated by the Adult Business Unit, and the proportion of deaths requiring Level 2 review requires a substantial amount of work by the senior clinical leadership team in the Business Unit.

4.2 The capacity within the Adult Business Unit team conducting the mortality reviews on behalf of the Leeds CCG will need to be carefully monitored to ensure that they can continue to conduct the number of reviews required to a sufficient quality and consistency. The team is looking to include more senior staff to undertake Level 2 assessments.

5 Next steps

5.1. Continuing work with the Business Intelligence team to further refine the processes of collecting mortality data, with a particular emphasis on capturing cause of death and any data helpful to understand health inequalities.

5.2. Look to increase the team's ability to process Level 2 reviews efficiently.

5.3. Maintain the resilience / health and well-being of the clinical team deal with the increasing demands of EoL care in the community.

6 Recommendations

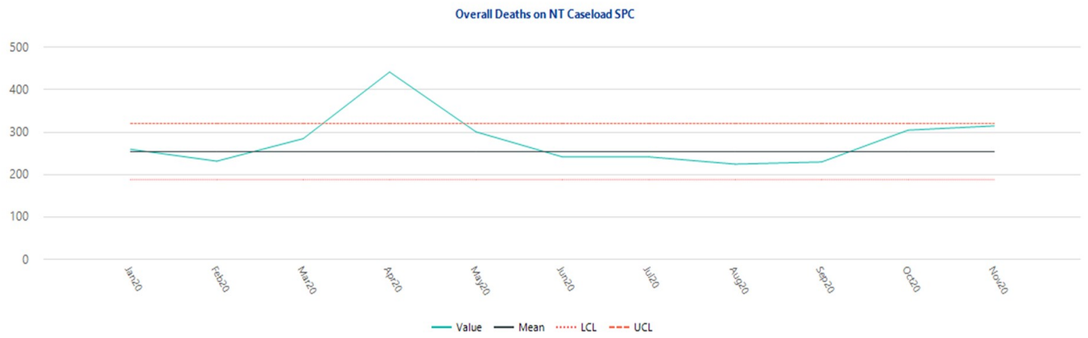
6.1 The Board is recommended to:

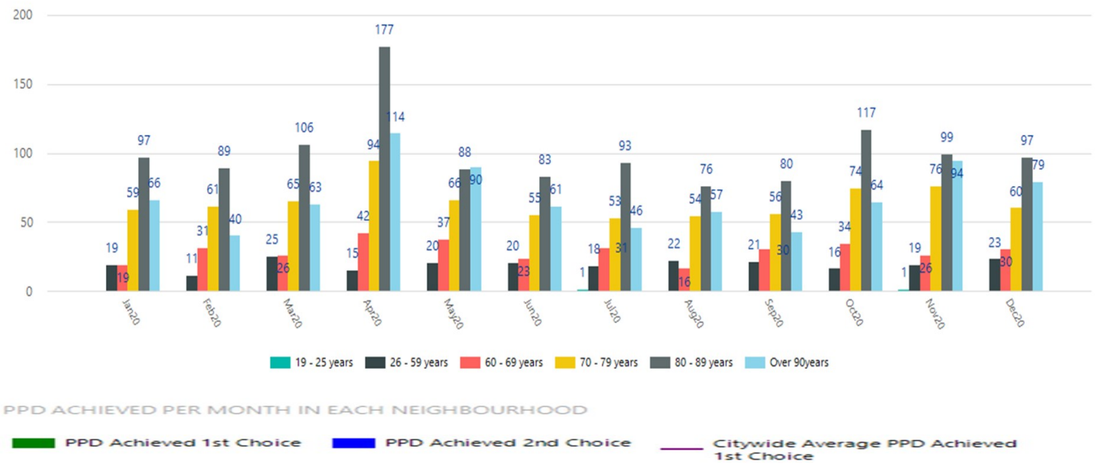
- receive the assurance provided regarding the Trust mortality process
- acknowledge the high demands that were placed on the teams who were still able to provide excellent care

RAG rating

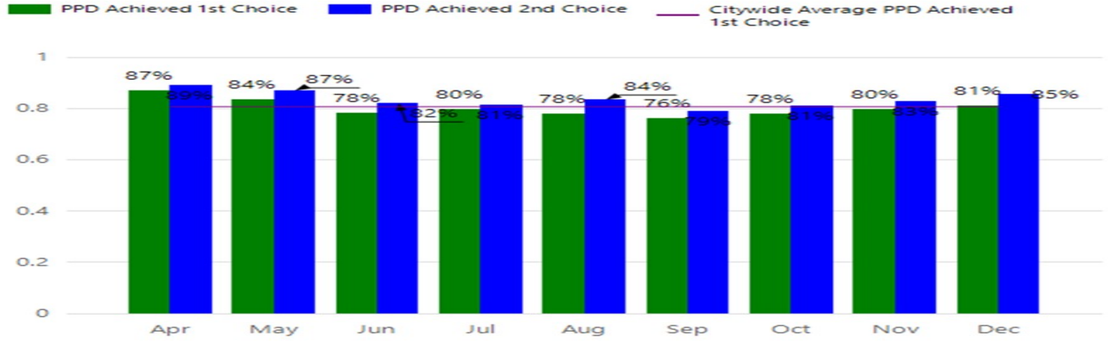
ABU Mortality Review October to December 2020

NHS Leeds Community Healthcare NHS Trust





PPD ACHIEVED PER MONTH IN EACH NEIGHBOURHOOD



Data	Q1	Q2	Q3	Q4
Level 1	670	426	392 (2019=275)	
Level 2	137	129	136 (2019= 43)	
Unexpected deaths	77	50	71	
Expected deaths	593	376	433	
Alliance CCB deaths (all cases reviewed in the MR Meeting)	3	2 (both expected deaths)	4 (1 expected and 3 unexpected deaths)	
Non-Alliance CCB Deaths (a/a)	5	2	tbc	
Virtual Ward deaths (commenced reporting in Q3)	N/A	N/A	2	
LeDeR	1	0	1	
Serious Mental Health	1	0	0	
Death with 30 days of Hospital discharge	New in Q2	3 but TBC	11	

Themes

The numbers of deaths occurring on an ABU caseload increased in Q3 compared to the reduced numbers of COVID-19 related deaths seen in Q2. Neighbourhood Team Palliative care activity was running at 40% over that seen in previous years Quarter 3s.

As previously reported in the Q2 report there continues to be an increased number of frail older adults choosing not to go into care homes or a hospice, favouring returning home. The Health Case Management where also receiving a 25-30% increase in fast track referral in Q3 . Both these factors are impacting on Neighbourhood Team capacity and pressures.

Care home deaths, the number of deaths has continue to fall below the average SPC line during Q3 whilst deaths at home had remained above with 2 weeks above the upper SPC line.

The increased in number of deaths on caseload continues to lead to an increased workload required to undertake the level 1 and level 2 mortality reviews within the teams and also for the subsequent monitoring and selection of mortality cases for formal review. Additional extraordinary mortality case review meetings are being held each month to ensure we are keeping the reviewing cases on a timely basis.

1 unexpected and 3 expected deaths occurred in the Alliance CCB Recovery Hubs in Q3 , I no concerns with care provided

Due to the difficulty in reporting accurate Covid-19 related deaths from SystmOne we are now recording this information on the NT mortality trackers and will start to report the data in Q4.

No EoL related serious incidents reported during Q2 2020.

Learning

The ongoing impact upon clinical staff providing the EoL care in Q1 and Q2 is understood and support and individual clinical supervision continues to be provided

Actions

Following the case reviewed on behalf of the non-Alliance CCBs that was reviewed as a Multi-Agency SI (case linked to lack of adequate post lower limb fracture VTE prevention.) we have developed a learning from safety memo that covers this concern to share across all Adult Services.

RISKS

- Managing the increased volume of deaths (reporting of at level 1, 2 and those selected for full case review. The number of cases being reviewed remains 40 % higher than in 2019/20.
- As the impact of the 3rd wave of COVID is felt there is a risk that services will be too stretched and unable to meet the demands of the volume of EoL Care, with consideration of the joint impact of winter pressures. The NT essential visit guidance has been updated to reflect the decision making required for a OPEL 3e situation
- Maintaining the resilience and health and wellbeing of clinical staff, affected by the high volume of EoL care related to COVID-19. Group and 1:1 support is offered to staff in addition to the trust health and wellbeing offer.

Contribution to Making Stuff Better

- The GP lead for End of Life Care has been invited to attend the LCH Adult Mortality Review meetings and joined the January meeting. Further joint mortality review with Primary Care is being explored with the support of Dr R Arnold and Dr G Pottinger
- BI are developing a new report to combine all adult deaths occurring on ABU and SBU caseloads, development of the report planned for Q3 ihas been delayed , further work is planned with BI to ensure the data accurately represents the total adult deaths.
- Updates to the ABU mortality review templates on S/One are supporting more efficient data reporting.

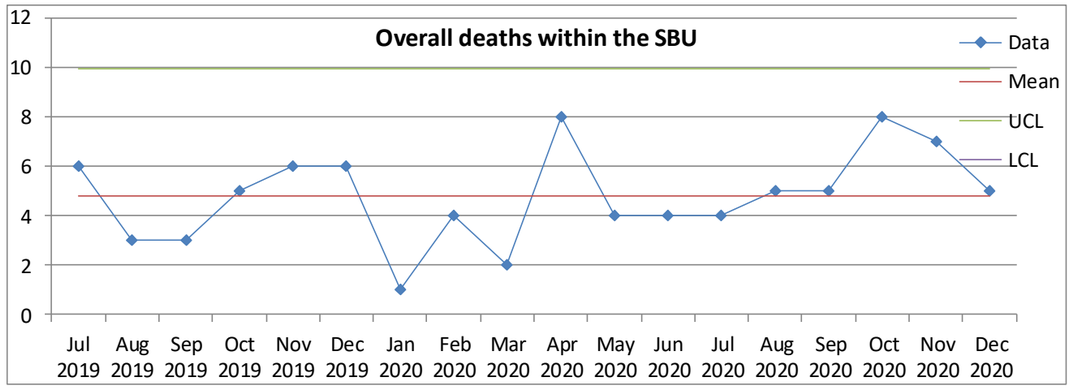
S1 Systems, processes & practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 lessons learned & improvements made	E1 Standards, legislation & evidence-based practice	E2 Outcomes of care & treatment	E3 Staff skills, knowledge & experience	R4 Listening & responding to concerns & complaints	ESF safe care & treatment	ESF staffing arrangements	ESF protection from abuse	ESF assurance, monitoring & risk management

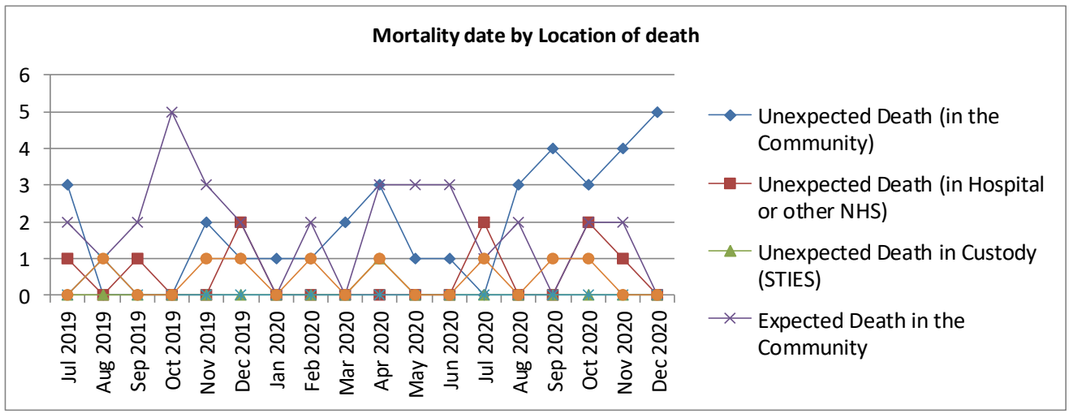
RAG rating

SBU Mortality Review October to December 2020

NHS Leeds Community Healthcare NHS Trust

Quantitative data: All deaths, deaths by severity





	Unexpected Death (in the Community)	Unexpected Death (in Hospital or other NHS)	Expected Death in the Community	Expected Death (in Hospital or other NHS)	Total
Oct 2020	3	2	2	1	8
Nov 2020	4	1	2	0	7
Dec 2020	5	0	0	0	5
Total	12	3	4	1	20

1 LeDer Death

Themes

- The overall deaths reported via Datix remains within the control limits of the SPC chart, with a slight deviation from the mean in October.
- There is continued evidence of lack of advanced care planning, ReSpect and completion of EPaCCS template
- Recent case reviews within the Mortality Governance Review Meeting have identified that tasks on S1 have been used as a means of communication for issues require an immediate response. These were not actioned due to working patterns of different Services.

Actions

- A meeting was arranged in November between ABU and SBU Clinical and Quality Leads and the Clinical Service Manager (Palliative Care and Community Cancer Support Services) to discuss End of Life process—this meeting went ahead as scheduled and there is further work required to implement ReSpect within the SBU
- The newly developed SOP is almost ready for release which will change the process of report and address the discrepancies between S1 and Datix

Issues

- The number of deaths evident on datix does not mirror those on S1, this will be resolved with the implementation of the new MR Policy and SOP for SBU.

NB: see joint action contribution to Making Stuff Better above

S1 Systems, processes & practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 lessons learned & improvements made	E1 Standards, legislation & evidence-based practice	E2 Outcomes of care & treatment	E3 Staff skills, knowledge & experience	R4 Listening & responding to concerns & complaints	ESF safe care & treatment	ESF staffing arrangements	ESF protection from abuse	ESF assurance, monitoring & risk management

RAG rating

ABU Mortality Reviews September to December 2020

NHS Leeds Community Healthcare ust

Month/ref	Summary of the case and learning	Actions taken
CCB Death Dec 19 re-viewed August 2020	84yr old lady with multiple LTCs including Alzheimer's Disease and on GSF since April Pt had capacity and stated PPD to be own home. Patient received good coordinated care from GP and NT. Two weeks prior to RIP patients condition began to deteriorate and support visits from NT and GP increased. Fast Track agreed and a DNACPR in place. Patient's niece became involved in the care despite spouse being the NOK and requested the Gp Ax of reversible cause for deterioration. This led to an ED/admission where patient was only prescribed the same anticipatory medication that could have been administered at home. Deemed not appropriate for further investigations as approaching EoL. Outcome—Patient was admitted to hospital in the last days of life, family and NT upset by the decision as felt it went against the patients wishes	• Closer joint working and communication with partners in Primary Care to coordinate patients care as approaching EoL. • Greater awareness of advanced care planning wishes • Progress the rollout of the Panning Ahead Template and ReSPeCT template on SystmOne within the NTs and Primary Care
CCB case re-viewed in the Oct meeting	80 yr old patient with # ankle NWB for 6 weeks, prescribed enoxaparin 40mg/day by ortho team. VTE prophylaxis not prescribed on the eDAN on discharge from hospital. Picked up on admission to a CCB by the nursing team but not followed up, or considered on review by the Community Geriatrician in the CCB. One month post fracture the patient attended ED/ #Clinic with a swollen lower leg and tight painful POP cast. 3/7 later Patent became acutely unwell and SOB, sadly despite resus in CCB patient RIP with a Pulmonary Embolism.	• Findings shared with acute trust and reflective learning session held with medical team • Share the learning from a new safety memo on YTE prophylaxis across all LCH Adult Teams and CCBs (pleased see attached)
SBU same case reviewed in the October meeting	Patient aged 80 years was admitted to hospital following a fall which was triggered by a urinary tract infection. She sustained a fractured ankle during the fall and was non weight bearing in a plaster cast for six weeks.	• Tasks are not for urgent response, if urgent, they must be followed up by a telephone call. • Tasks should following the SBAR format - Situation-Background-Assessment-Recommendation (SBAR) this is a communication tool designed to support staff sharing clear, concise and focused information. • A request was made for SBU Services (where appropriate) to advise the NHT's of their working hours and if there was a link for the teams area.

Learning from Incidents

NHS
Leeds Community Healthcare
NHS Trust

Team/service: Adult Business Unit – Neighbourhood Teams

Venous Thromboembolism (VTE) Prevention and Treatment

If you ever wanted an example of the holes in a Swiss cheese lining up to lead to a poor outcome, here you go. Yes, there were individual failures within this sequence of events, but unfortunately the various opportunities to intervene and change the end point, were successively missed by many good caring people. See if you can count them all.

What happened?

A patient aged 80 years was admitted to hospital following a fall which was triggered by a urinary tract infection. She sustained a fractured ankle during the fall and was non weight bearing in a plaster cast for six weeks.

The VTE risk assessment form was completed on admission to hospital and 'reduced mobility', comorbidities, obesity, age over 60 and lower limb plaster cast' were identified as risks for VTE. No bleeding risks were identified.

The patient was prescribed prophylactic enoxaparin 40mg once daily during her four-day admission. Virtual fracture clinic review by an orthopaedic surgeon confirmed that she required prophylactic enoxaparin whilst she remained non-weight bearing. It was clearly documented that the inpatient team should arrange this. The patient was then discharged to a nursing home but, prophylactic enoxaparin was not prescribed on the eDAN.

A VTE risk assessment was completed in the community and the lack of VTE prophylaxis with the need for low weight molecular heparin (LWMH) was identified. A plan was made to ask the patients GP to prescribe, but this did not happen.

In the coming weeks, the patient was reviewed on a number of occasions by a Community Doctor but the lack of LMWH was never escalated to them, and the need for it was never considered. As a result, LMWH was not prescribed.

One month later the patient attended LTHT because her cast had become tight and painful. She was fitted with a walker boot and returned to the nursing home. The possibility of a DVT does not seem to have been considered.

Three days later the patient became acutely unwell and short of breath, the GP was called but she deteriorated rapidly and became unresponsive. The nursing home tried to resuscitate her but unfortunately, they were unsuccessful, and she died.

Cause of death was recorded as Pulmonary Embolism.

Changes made to avoid recurrence

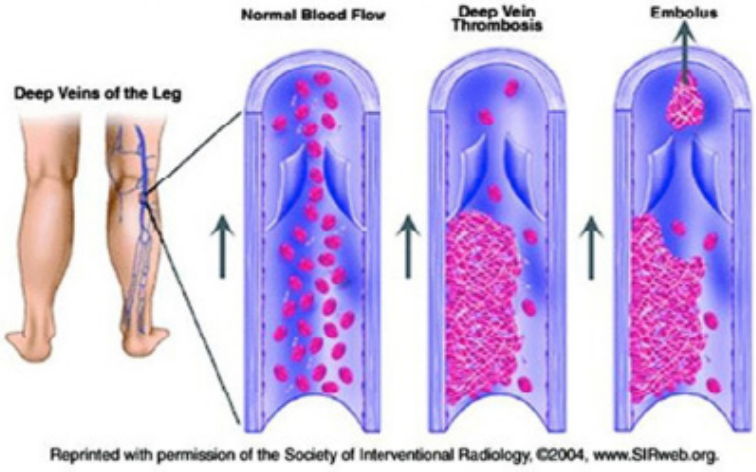
- Learning from incidents poster shared with relevant teams within LCH
- Review: To consider manadated inclusion of VTE risk assessment for all community care bed admissions and recent patients discharged from hospital.
- To explore use of key line of enquiry at team handovers.

Lessons learnt

- If extended prophylaxis is indicated it should be prescribed on the eDAN on discharge.
- Once it was identified in the community that LMWH had been omitted it should have been escalated to and prescribed by the community doctor at the first opportunity.
- Consider the possibility of DVT in patients who have been immobilised in a plaster cast. This is especially so if the plaster has been in place for some time and post traumatic swelling has settled.

Contact Kezia Prince, Incident and Risk Assurance Manager on **0113 220 8541** or **kezia.prince@nhs.net**

Deep Vein Thrombosis (DVT)



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Cr/CL > 30ml/min

Weight band	Dose of Enoxaparin Inhixa
< 50 kg	20mg daily
50 - 100 kg	40mg daily
101 - 150 kg	40mg twice daily
> 150 kg	60mg twice daily

Cr/CL < 30ml/min

Weight band	Dose of Enoxaparin Inhixa
< 50 kg	20mg daily with caution
50 - 100 kg	20mg daily
101 - 150 kg	40mg daily
> 150 kg	60mg daily

NICE Quality Standards for VTE prevention

- **Statement 1:** Medical, surgical or trauma patients have their risk of VTE and bleeding assessed using a national tool as soon as possible after admission to hospital.
- **Statement 2:** Patients who are at increased risk of VTE, are given information about VTE prevention on admission to hospital.
- **Statement 3:** Patients provided with anti-embolism stockings have them fitted and monitored in accordance with NICE guidance.
- **Statement 4:** Medical, surgical or trauma patients have their risk of VTE reassessed at consultant review or if their clinical condition changes.
- **Statement 5:** Patients assessed to be at risk of VTE are offered VTE prophylaxis in accordance with NICE guidance.
- **Statement 6:** Patients/carers are offered verbal and written information on VTE prevention as part of the discharge process.
- **Statement 7:** Patients are offered extended (post hospital) VTE prophylaxis in accordance with NICE guidance.

VTE Prophylaxis top tips

Risk assessment is:

A three-stage process

1. Why should a patient have VTE prophylaxis? - their clot risk
2. Why shouldn't a patient have 'blood thinners'? - their bleeding risk
3. Ok, so what prophylaxis options can they have if needed?

A dynamic process

- Risk assess 24-48 hours after admission AND
- Whenever the patients clinical status changes

An accurate process

- Carefully identify all the factors at play, be they clotting risks or bleeding risks

It's a tangible way that you can reduce harm and even death in our patients

VTE facts

Venous thromboembolism is a leading cause of death and disability worldwide. In Europe and the U.S., it claims more lives than AIDS, breast and prostate cancer, and motor vehicle crashes combined.

Heparin was first identified in 1916 by a second year Medical Student. Jay McClean named it Heparin because he extracted it from dogs' livers - the Greek for liver is 'Hepar'.

Did you know that 55% - 60% of VTE cases occur during or following hospitalisation

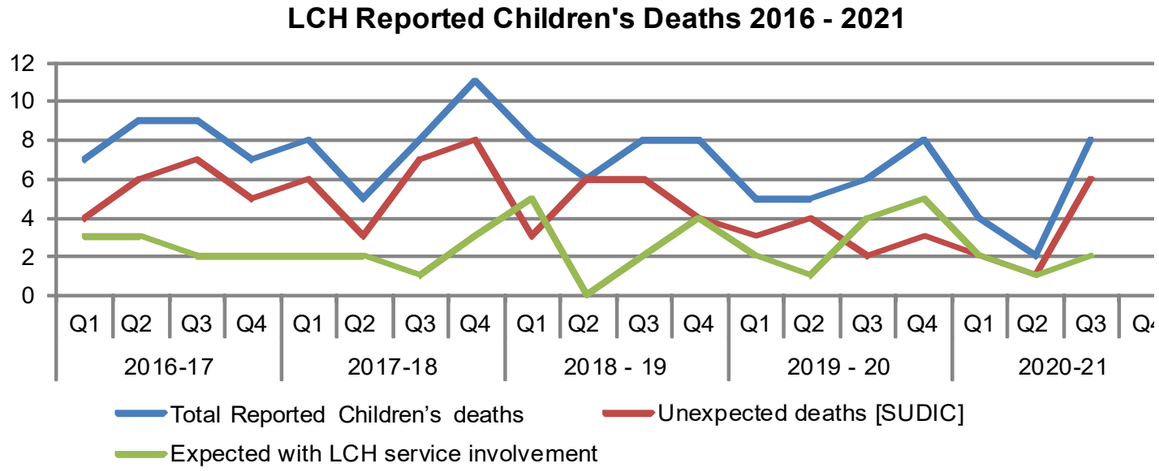
Someone in the western world dies from a venous thromboembolism (VTE) every 37 seconds.

Your patients' safety is in your hands - think VTE

RAG rating

Children's Mortality Group Q3 2020/21

Leeds Community Healthcare NHS Trust



Quarter 3 2020/21	Total	Unexpected/ SUDIC	Expected with LCH service involvement
October	3	3	0
November	4	2	2
December	1	1	0

Themes

Children's Mortality Group meet on 25th November 2020 in Quarter 3. All children's deaths (four), leading up to this date, were reviewed and discussed by all group members. On the 30th November 2020 the Leeds Child Death Overview Panel was cancelled due to technical issues.

The Impact of reducing face to face contacts with families due to Covid 19 continues to be a theme. Face to face service delivery was increased from September.

Learning and Actions

All learning shared and specific actions documented on the meeting minutes with named leads.

Potential learning has been identified as per a co-sleeping case*. The child's parents have expressed their worries regarding virtual contacts (due to COVID) which was raised at the initial 5-7 day statutory SUDIC meeting. This will also be discussed at CDOP in February.

The CBU Clinical Lead and Quality Lead are meeting with SUDIC team to review process of gathering information and sharing lessons in January.

Risks

Ensuring that group remains quorate in order to review learning from all expected and unexpected children's deaths where LCH have been involved in provision of care. This has been achieved in 2020/21 to date

Contribution to Making Stuff Better

0-19 PHINS have attended the initial 5-7 day statutory SUDIC meetings where the case was open to them.

The potential identified learning supports the decision that the PHINS will remain in touch with families going forward and not be redeployed. The virtual contact at the time was in line with 0-19 government instructions. The family were made aware that instruction and practice had changed already which was positively received.

S1 Systems, processes & practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 lessons learned & improvements made	E1 Standards, legislation & evidence-based practice	E2 Outcomes of care & treatment	E3 Staff skills, knowledge & experience	R4 Listening & responding to concerns & complaints	ESF safe care & treatment	ESF staffing arrangements	ESF protection from abuse	ESF assurance, monitoring & risk management

RAG rating

Children's Mortality Group Q3 2020/21

NHS Leeds Community Healthcare NHS Trust

Children's Mortality Meeting	Learning	Actions taken
October 2020	2 year 2 month old child SUDIC in the Paediatric Emergency Department LGI on 11th October 2020 following a cardiac arrest. The family was known to the PHIN Service. There was nothing obvious on the initial post mortem. Bruising was found but could be due to resuscitation, possibly thought to be sepsis or metabolic issues.	Awaiting further updates
October 2020	16 year old SUDIC taken to A&E but later died 11th October 2020. Potential fall/suicide at home Potentially intoxicated at the time No previous or current CAMHS involvement or referral Enquiry into sharing of indecent images also being considered	Enquiry into what happened is ongoing.
October 2020	4 month old baby SUDIC in the Paediatric Emergency Department LGI on the 12th October. Child was born during lockdown. Child was in bed with Mum, mum woke to child unresponsive. CPR attempted The Health Visitor had a conversation with mum about safe co sleeping. Health Visitor had some concerns re difficult contacting parents and their lack of engagement.	*Discussed possible new guidelines to make clear about dangers of alcohol and co sleeping.
November 2020	3 year 4 month old child SUDIC. Child had input from a range of services (PHINS, ICAN; Dietician and Paediatrician) , had significant developmental delay and was reliant of parents for all care. Child found unresponsive in bed and CPR attempted.	Awaiting results from standard post mortem.
November 2020	11 year old SUDIC Child found in bed around 7am, resuscitation given by mother but died in hospital. No immediate apparent cause. No suspicious circumstances but there were concerns initially Parents being supported by SUDIC Professional Lead	Awaiting results of the investigation.

S1 Systems, processes & practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 lessons learned & improvements made	E1 Standards, legislation & evidence-based practice	E2 Outcomes of care & treatment	E3 Staff skills, knowledge & experience	R4 Listening & responding to concerns & complaints	ESF safe care & treatment	ESF staffing arrangements	ESF protection from abuse	ESF assurance, monitoring & risk management

RAG rating

Children's Mortality Group Q3 2020/21

NHS Leeds Community Healthcare NHS Trust

Children's Mortality Meeting	Learning	Actions taken
November 2020	Expected death of a 15 year old child. had a diagnosis of osteosarcoma and relapsed last year with chest mets. She was palliative and had a syringe driver and we were visiting at the end of her life. She passed away at home and had her death verified by the Mc Millan nursing team. This was her preferred place of death. She was then taken to Martin House.	No actions. To be discussed at the next Child Mortality Group Meeting 27/01/21
November 2020	Expected death of a 1 year 1 month old child who was born with a genetic Defect EMA6B and had had involvement from PHINS, ICAN and CCNT.	Awaiting further information; Agency Report Form requests were sent to ICAN, PHINS and CCNT on the 01/12/2020 and awaiting further information. To be discussed at the next Child Mortality Group Meeting 27/01/21
December 2020	17 year old SUDIC following a road traffic accident on Leeds Inner Ring Road. The young man died in LGI approximately 90 minutes later. Support given from our SUDIC Professional Lead to the family. A lighter touch of support has been given due to the Police Family Liaison Officer giving support. Support has also been given to the families of the young passengers who survived the crash.	To await further findings when available.

S1 Systems, processes & practices to keep people safe	S4 Medicines management	S5 Track record on safety	S6 lessons learned & improvements made	E1 Standards, legislation & evidence-based practice	E2 Outcomes of care & treatment	E3 Staff skills, knowledge & experience	R4 Listening & responding to concerns & complaints	ESF safe care & treatment	ESF staffing arrangements	ESF protection from abuse	ESF assurance, monitoring & risk management

Public Board Meeting: 5 February 2021

Agenda item number: 2020-21 (123)

Title: Reducing Restrictive Interventions – Little Woodhouse Hall, 2020/2021 Quarter 3

Category of paper: For information
History: Not applicable

Responsible director: Executive Director of Nursing and Allied Health Professionals
Report author: CAMHS Service Manager, Childrens Business Unit Clinical Lead

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Executive summary (Purpose and main points)

This paper is to highlight the incidence of restrictive interventions at Little Woodhouse Hall for Q3 in 2020/2021.

The report highlights the restrictive practice in the unit, including the numbers of restraints and seclusions and the decisions regarding blanket restrictions.

The report also highlights the actions being taken by the unit to reduce restrictive practice.

Recommendations

The Board is recommended to:

- receive the information provided in this report.

Reducing Restrictive Interventions – Little Woodhouse Hall, 2020/2021 Quarter 3

1 Introduction

1.1 The Mental Health Act Code of Practice (2015) set an expectation for mental health services to commit to reducing restrictive interventions. These interventions include the use of restraint, seclusion and rapid tranquilisation, but also wider practices, for example imposing blanket bans that restrict a person's liberty and other rights, such as stopping them from accessing outdoor space.

1.2 This paper highlights the Q3 restrictive interventions used in Little Woodhouse Hall. There is a weekly clinical review of all restraint, rapid tranquilisation, and seclusion incidents that occur alongside review of blanket restrictions and this is shared with the Trust Senior Management Team.

1.3 Restrictive interventions should only be utilised when necessary, and should be proportionate and justifiable and only used to prevent serious harm.

2 Incidents of Restraint and Rapid Tranquilisation

2.1 In Q3 there were 38 incidents of restraint, in the previous quarter there were 25.

	Oct-20	Nov-20	Dec-20	TOTAL
Number of Restraint Incidents Recorded	12	14	12	38
Number of Restraint Incidents for Young People on a MHA Section	12	13	12	37
Physical Restraint - Prone	0	0	0	0
Physical Restraint - Excluding Prone	12	14	12	38
Rapid Tranquillisation	0	0	0	0
Number of Patients Restrained	2	4	2	

2.2 In all cases restraint was part of the risk management plan to address self-harming behaviours or use of nasogastric tube for feeding. Young people and their parents/carers were involved in the decision making process as part of the risk assessment and management process.

2.3 The higher numbers of restraint incidents during this quarter reflect individual patients who required intervention from other settings such as Secure Mental Health Hospital, Psychiatric Intensive Care Unit and Social Care Residential Placement and restraint for the insertion and feeding via a nasogastric tube.

2.4 There were no incidents of rapid tranquillisation (sedation administered via an Intramuscular injection) on the unit during this reporting period.

3 Incidents of Seclusion

3.1 There were no episodes of seclusion during Q3.

	Oct -20	Nov-20	Dec-20	TOTAL
Number of Seclusion Incidents Recorded	0	0	0	**0**
Number of Seclusion Incidents for Young People on a MHA Section	0	0	0	**0**
Number of Patients Secluded	0	0	0	**0**

4 Blanket Restrictions

4.1 During the reporting period blanket restrictions on the ward were locked doors (including slam lock doors) which prevent young people having unsupervised access to rooms that contain other risks e.g. accessing a beverage point with a kettle and ceramic mugs and batteries on the unit e.g. in remote control, clock.

4.2 A request has been made to Interserve for the Mind, Body and Soul room to be fitted with an anti-barricade mechanism to allow unsupervised access, which will mean one less restriction. This work is being completed in Q4.

4.3 The blanket restriction of batteries was introduced due to young people ingesting them on the unit. This was reviewed by the Clinical Team on 30th November 2020. The outcome of this review was shared with the Senior Management Team and it was agreed to continue with the restriction. The next review occurred on 4th January 2021 in Q4 when it was agreed with the Senior Management Team that this blanket restriction was no longer required.

5 Continued improvement work to reduce restrictive interventions

5.1 There were a number of developments that were initiated in Q2 to reduce the high levels of self harm on the unit, these have continued into Q3 and are becoming embedded into the culture of the ward. There has been positive feedback from staff on the implementation of these. They include:

- Safe wards approach
- Safety Huddles
- Regular updating of individualised risk management plans and involving young people in their “Our Plan”
- Search policy
- A large beanbag (POD) has been purchased and has been used for restraints and de-escalation
- Discharge planning and involvement of parents/carers and local CAMHS teams
- Weekly ward reviews involving young people and parents/carers
- Introduction of Clinical Governance group led by Consultant Clinical Psychologist
- Selected as pilot site for NHS England Quality Improvement Initiative

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (125a)

Audit Committee

(Via MSTs)
Friday 16 October 2020
9.00am–11.30am

Present:	Jane Madeley (JM)	Chair, Non-Executive Director
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	Non-Executive Director
In Attendance	Bryan Machin	Executive Director of Finance and Resources
	Diane Allison	Company Secretary
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	David Robinson	Internal Audit Manager (TIAA Limited)
	Beric Dawson	Counter Fraud Specialist (TIAA Limited)
	Mark Dalton	Director for the Public Sector (MAZARS)
	Nicola Hallas	External Audit Manager (MAZARS)
Apologies:		
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2020-21 (26)	**Welcome, introductions and preliminary business** The Chair welcomed members and attendees, particularly welcoming Nicola Hallas, External Audit Manager, MAZARS to her first Audit Committee meeting. It was agreed that the agenda items would be taken in the order reflected in these minutes and the items re-numbered accordingly.	
2020-21 (26a)	**Apologies** All members were present.	
2020-21 (26b)	**Declarations of interest** In advance of the meeting the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members. There were no additional declarations of interest made at the meeting.	
2020-21 (26c)	**Minutes of the previous meeting 17 July 2020** The minutes of the meeting held on 17 July 2020 were reviewed and agreed as an accurate record.	
2020-21 (26d)	**Actions' log** *Item 17b: Internal audit recommendation update* The Company Secretary confirmed that the attendance of staff at Corporate/ Trust wide training is recorded on ESR and would be included in the Equality and Diversity Annual Report presented to the Trust Board in December 2020.	

	Item 17b: Internal audit recommendation update – efficiencies 2020-21 Covered under Item 27b in these minutes. *Item 19b: Counter Fraud annual work plan* Covered by Item 29a in these minutes. *Item 20a: Risk management update – Covid assurance framework* The Executive Director of Finance and Resources reported on the progress being made by Senior Management Team (SMT) in documenting activities, decisions and actions in a COVID assurance framework. The Committee was advised that this document would continue to be reviewed and revised during the next phase of the pandemic however It was anticipated that a version of the framework would be received at Quality and Business Committees for scrutiny in November and proceed to Board in December 2020. *Item 20b: Information governance –clarification of the top three risks* It was noted that clarification about this issue had been provided by e-mail on 17 July 2020. *Item 21e: Investment decision making policy* The Executive Director of Finance and Resources referred the paper presented to the Committee which introduced an updated investment decision making policy for the Trust which now included consideration from a quality perspective. Members reviewed the amendments and accepted the changes proposed. A Non-Executive Director (IL) asked for the Terms of Reference for the Quality Committee to be amended to reflect the changes to the Investment Decision Making Policy **Action: The Terms of Reference for the Quality Committee to be reviewed and amended to reflect the changes to the Investment Decision Making Policy.** **Outcome:** The Committee: • accepted the changes proposed to the Investment Decision Making Policy. There were no other matters arising from the minutes.	**Company Secretary**
2020-21 (27a)	**Internal audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report. The Committee reviewed the progress against the annual audit plan for 2020/21, noting that two audits had been completed: Recruitment and Selection and Duty of Candour. The Committee discussed the executive summaries and management actions for each audit included in the report. *Recruitment and Selection* This audit had been determined as **substantial assurance** with no recommendations made. A Non-Executive Director (RG) queried the rigour of the process in terms of background to the audit which was to consider how the Trust was handling the backlog in recruitment processes. The Internal Audit Manager provided more detail about the scrutiny undertaken as part of the audit process. It was agreed that the Business Committee should review the audit in more detail at	

	its meeting on 28 November 2020. *Duty of Candour* This audit had been determined as **reasonable assurance** with one important recommendation related to the identification of one example where the Trust had not met the response target. It was noted that the Quality Committee would have the opportunity to review this audit at its meeting on 26 October 2020. It was agreed that a verbal update on the outcome of the discussion would be provided at the next Audit Committee meeting on 15 December 2020. **Action: Non-Executive Director (IL) to provide a verbal update on the outcome of the Quality Committee's scrutiny of the audit at the Audit Committee meeting on the 15 December 2020.** In response to a question from the Chair of the Committee in relation to the sequence of presenting audits to the various committees, the Company Secretary said that if these two audits had not been made available to the Audit Committee at this meeting then it would have been delayed until December 2020. The Chair of the Committee said that she acknowledged the difficulties presented by the timing of completed audits but in the interests of work not been duplicated she suggested that the sequence of presenting audits to the various committees needed to be considered. The Chair of the Committee referred to the reference in Appendix D of the report in relation to cyber security threats using the Covid-19 pandemic and the requirement for Audit Committees to seek assurance that a programme of protection measures were in place. The Executive Director of Finance and Resources provided assurance that the revised Data Protection Toolkit included requirements around a programme of protection measures being in place. <u>Progress against the Annual plan 2020/21</u> The Committee discussed the potential challenges to completing the full internal audit programme in the light of COVID response focus within the Operations directorate particularly, and asked that the Executive Director of Finance and Resources discuss with TIAA options for re-planning the audit programme for the remainder of the year, to ensure that sufficient assurance work can be successfully completed ahead of the year end and with audit scopes that would provide most value to the organisation during this period. The Committee offered a few suggestions that they thought could be considered and asked that the Executive Director of Finance and Resources would report back to the next meeting of the Committee with a proposal. It was also suggested that there might be some scope for conducting audits on COVID related fraud risks. **Action: The Internal Auditors and the Executive Director of Finance and Resources to consider adjusting the scope of the remaining audits within the 2020/21 plan and report to the Audit Committee meeting on 15 December 2020.** **Outcome:** The Committee noted the contents of the summary internal controls assurance report, including the completion and outcome of two audits.	**Non-Executive Director (IL)** **Executive Director of Finance and Resources/ TIAA**

2020-21 (27b)	**Internal audit recommendations** The Executive Director of Finance and Resources introduced the report. The Committee discussed the eight recommendations not completed by their due dates and the proposed revised dates for completion. The Committee discussed three overdue recommendations in more detail: *Budgetary Control and Cost Improvement Plans – efficiency plans to be included for 2020-21* The Executive Director of Finance and Resources explained the rationale behind the proposal to close this action. He said that all the work on identifying efficiencies had been paused due to Covid-19. No efficiencies were required in the first half of 2020/21 and it was not clear what would be required in the second half of 2020/21. He added that the approach suggested by the audit recommendation had been accepted and work would recommence during this quarter as part of the reset and recovery programme. The Committee discussed the proposal and agreed that it would be more appropriate for a broader discussion about the programme of work on efficiencies for 2020/21 to be taken forward by the Business Committee. On that basis the Committee agreed to the proposal that this recommendation be closed. ***Statutory and Mandatory Training –compliance programme to be completed by specified final milestone – revised deadline 31 December 2020*** ***Statutory and Mandatory Training – governance arrangements for monitoring statutory and Mandatory compliance levels to be reviewed –revised deadline 31 March 2021*** The Committee expressed concern about the revised completion dates for both these recommendations. The Chair suggested that it would be a more effective use of time and resources if the Business Committee considered whether the extended deadlines were reasonable. **ACTION: Business Committee to review the internal audit recommendations on statutory/mandatory training revised completion dates and seek explanation and assurance from the Director of Workforce that these will be met** **Outcome:** The Committee noted the status report.	**Business Committee**
2020-21 (28a)	**External audit** The External Audit Manager presented the report which provided an update on audit progress and included a section on national publications which might be of interest to Members of the Committee. Planning meetings had been held with the Director of Finance and Deputy Director of Finance and an indicative timetable of work for completion of the work in the 2020-21 audit year had been set. The Director for the Public Sector said that the current plan was for completion of the accounts by the end of May 2021 but this was subject to any national guidance which might be issued before the end of the year. The Chair of the Committee noted the publication of the *NAO report: Audit and Risk*	

	Committees on Financial Reporting and Management during COVID-19. She asked for this to be circulated to the Committee. **Action: *National Audit Office report: Audit and Risk Committees on Financial Reporting and Management during COVID-19* to be circulated.** The Committee noted the National Audit Office – Code of Audit Practice which came into force on 1 April 2020. It was agreed that an update on its implications for external audit work would be provided at the meeting on 15 December 2020. **Action: An update on the implications of the publication of the National Audit Office – Code of Audit Practice on external audit practice to be provided on 15 December 2020.** **Outcome:** The Committee received and noted the External Audit progress report.	**External Audit Manager** **External Audit Manager**
2020-21 (29a)	**Covid-related Fraud Risk** The Executive Director of Finance and Resources reminded members that the Committee had asked for consideration to be given to the fraud risks associated with Covid-19. The paper provided the Committee with the assessments against the risks identified. The Chair of the Committee suggested that some further assurance should be sought for the risk areas which were not included in the 2020-21 Internal Audit Annual Plan. The Executive Director of Finance and Resources agreed to consider whether there was any scope to include some audits in the 2020-21 Annual Audit Plan on for example, procurement and payroll. **Action: The Executive Director of Finance and Resources to consider the scope for including some audits on COVID related fraud risks.** **Outcome:** The Committee noted the assessments against the risks identified.	**Executive Director of Finance and Resources**
2020-21 (29b)	**Counter Fraud mid-year progress report** The Counter Fraud Specialist presented the report which updated the Committee on work carried out against the Counter Fraud work plan since April 2020. The Committee noted that in future there would be an increased emphasis on risk based proactive work, in line with local risk management policies and that there requirement to record all proactive and risk based activity on the new case management system CLUE. **Outcome:** The Committee received and noted the Counter Fraud mid-year progress report.	
2020-21 (30a)	**Board assurance framework (BAF) report** The Company Secretary presented the report. She explained that the report included a description of the revised assurance process, agreed by the Committee on 13 March 2020 and apprises the Committee on the progress made in implementing it, highlighting that the Business and Quality Committees had adopted the revised chair's assurance report template which focussed committee assurance decisions on risks rather than individual papers.	

	The Audit Committee was asked to review BAF risk 2.4 (maintain the security of its IT infrastructure). Members reviewed the sources of assurance (Committee papers) that it currently received for this BAF Risk to determine if the sources were of sufficient variety, focus, depth and frequency to enable the Committee to form an opinion of the level of assurance they provided. The Committee agreed that there was a limited picture of assurance as there were currently very few sources of assurance that were provided to the Committee and tasked the Executive Director of Finance and Resources with identifying additional sources of assurance to be added to the BAF and to the Committee's workplan. **Action: Additional sources of assurance to be added to the BAF and to the Committee's workplan.** **Outcome:** The Committee: • reviewed BAF risk 2.4 (security of IT infrastructure) which is assigned to Audit Committee • noted the revisions made to the BAF sources of assurance by the Business Committee • noted the progress made with implementing the revised BAF process • noted the additional BAF Risk agreed by the Board	**Executive Director of Finance and Resources**
2020-21 (30b)	**Risk appetite statement** The Company Secretary presented the report which included the Trust's current risk appetite statement. The requirement was for the statement to be reviewed annually by the Senior Management Team (SMT) and any changes to be advised to the Audit Committee. The Committee discussed the current risk appetite levels and agreed with SMT that this accurately reflected the environment the Trust was working in. Some minor changes had been proposed by SMT including recognition of the importance of other health providers in the system; these were approved by the Committee. In addition the Committee agreed to remove the phrase (operating in a) 'competitive healthcare market' and replace it with 'challenging environment' to reflect that the NHS was shifting away from competitiveness and towards collaboration. **Outcome:** The Committee: • noted the revisions made to the risk appetite statement • agreed the risk levels	
2020-21 (30c)	**Well-Led Framework – update** The Company Secretary presented the report which updated the Committee on the Care Quality Commission's current approach to its regulatory duties and the Trust's activities in relation to CQC requirements. **Outcome:** The Committee received and noted the update report.	
	Non-Executive Director (IL) left the meeting	
2020-21 (31)	**Information Governance** The Executive Director of Finance and Resources advised the Committee that during 2020/21 there was no requirement to conduct a mid-year baseline assessment for the Data Security and Protection Toolkit (usually submitted at the end of October each year). The Committee was advised that there would be a further update on the toolkit at the next Audit Committee meeting on 15 December 2020.	

	Action: An update on the Data Security and Protection Toolkit to be provided to the Audit Committee on 15 December 2020. **Outcome:** The Committee noted the verbal update.	**Executive Director of Finance and Resources**
2020-21 (32a) **2020-21** (32b)	**Financial controls** **Losses and special payments report** The Executive Director of Finance and Resources advised that there was no report for this meeting. **Outcome:** The Committee noted that no report was presented for this meeting. **Tenders and quotations waiver report** The Executive Director of Finance and Resources introduced the report which included an extract of the 2019/20 register of waivers that have been completed this financial year. There have been a total of 6 waivers since the last Audit Committee report in July 2020; these were detailed in the report. **Outcome:** The Committee noted the report.	
2020-21 (33a) **2020-21** (33a-33b)	**Leeds Community Healthcare Charitable Funds and Related Charities draft annual report and accounts 2019/20** The Committee noted the position outlined in the covering paper. **Covering paper** The Committee received the annual report and accounts for the Trust's charity together with the findings of the independent examination. The independent examination had been undertaken by Sedulo Leeds Limited (accountants). There were no concerns and the accountants had come across no other matters in connection with the examination to draw to the Trust's attention.	
2020-21 (33c) **2020-21** (33d)	**Letter of Comment** The Committee noted the letter of comment received from Sedulo who had carried out an independent examination of the charitable funds accounts. There were no areas of concern to note. **Letter of Representation** The Committee noted the letter of representation from Leeds Community Healthcare NHS Trust to Sedulo Leeds Limited. **Outcome:** The Committee: • noted the annual report and accounts 2019/20 and associated documentation • recommended the adoption of the annual accounts by the Charitable Funds Committee at its next meeting on 8 December 2020.	
2020-21 (34)	**Committee's Workplan** There were no items removed or changes made to the workplan.	
2020-21 (35)	**Minutes of noting** **Information Governance Group: 22 July 2020 and 3 September 2020** The Chair referred to Item 104c in the minutes of the 22 July 2020 which related to a reportable incident at Little Woodhouse Hall. She asked for more information about the incident and confirmation that the incident had been reported to the Information Commissioner's Office (ICO).	

	Action: More information to be provided about the reportable incident at Little Woodhouse Hall and confirmation that it had been reported to the ICO. **Outcome:** The Committee noted the minutes.	**Executive Director of Finance and Resources**
2020-21 (36)	**Matters for the Board and other committees** The Chair noted the following items to be referred to Board colleagues: • Internal audit plan and prioritisation • Board Assurance Framework – review of BAF risk 2.4 • COVID Assurance Framework • Information Governance • Risk appetite statement	
2020-21 (37)	**Any other business** No matters of any other business were raised.	
	Date and time of next meeting Tuesday 15 December 2020 13.00-15.30pm (Via MST) Boardroom Stockdale House Leeds LS6 1PF Stockdale House Leeds LS6 1PF	

Leeds Community Healthcare NHS Trust

Quality Committee Meeting
Monday 23 November 2020
Microsoft Teams
11:00 – 12:30

AGENDA ITEM 2020-21 (125b)

Present	Professor Ian Lewis	Committee Chair
	Brodie Clark	Trust Chair (Items 57, 58, 60a and 60e)
	Steph Lawrence	Executive Director of Nursing and Allied Health Professionals (AHPs)
	Ruth Burnett	Executive Medical Director
	Sam Prince	Executive Director of Operations
In Attendance	Diane Allison	Company Secretary
	Sheila Sorby	Assistant Director of Nursing and Clinical Governance
	Dr Stuart Murdoch	Deputy Medical Director
Minutes	Lisa Rollitt	PA to Executive Medical Director
Apologies	Helen Thomson	Non-Executive Director

Please note:

Items 59b – 60d were held as an informal discussion due to the Committee not being quorate.

The meeting was quorate for item 60e

Item no	Discussion item	Actions
Welcome and introductions		
2020-21 (57a)	**Welcome and Apologies** The Committee Chair opened the meeting and welcomed attendees. Apologies were received from a Non-Executive Director (HT).	
2020-21 (57b)	**Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda content to ensure there was no known conflict of interest prior to papers being distributed to Committee members. The Chair asked if there were any additional interests. There were no additional declarations of interest received.	
2020-21 (57c)	**Minutes of meeting held on 26 October 2020** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2020-21 (57d)	**Matters arising and review of action log** 2020-21 (42d) Quality Improvement Plan (CQC) It was noted that the item was on the agenda and agreed that the action was closed.	

	2020-21 (42e) Board Assurance Framework It was noted that the item was on the agenda and agreed that the action was closed. 2020-21 (52c) Little Woodhouse Hall assurance update It was noted that the item was on the agenda and agreed that the action was closed. 2020-21 (52d) Reset update It was noted that the item was on the agenda and agreed that the action was closed.	
KEY ISSUES		
2020-21 (58a)	**Covid-19 update** The Executive Director of Nursing and AHPs presented the update on the current position within the Trust. The Trust Chair asked about the figures relating to the Trust's Flu campaign and queried what more could be done to improve the position. The Executive Director of Nursing and AHPs stated that work was underway to capture as many staff as possible, including weekend clinics. Communications had also been recirculated advising staff of the potential health consequences of contracting Flu and Covid-19 together. The Executive Medical Director gave an update highlighting that the roll out of voluntary asymptomatic testing was due to begin this week and the Quality, Assurance and Improvement Group (QAIG) had held a focused workshop to look at how we are assured we can evidence that we continue to deliver safe and high quality care during the Covid-19 pandemic. The Executive Director of Operations also gave an update, stating that the number of patients in hospital due to Covid-19 had increased from approximately 308 – 330 at the end of the previous week, although there had been a slight decrease in the number of cases reported which coincided with the beginning of the national lockdown. The Committee heard about the work that the Trust was involved in to ensure patients were moved out of hospital and into community care beds and virtual wards. Overall, the Trust was reported to be at Opel level 3 and was meeting regularly as Silver Command. The Trust Chair asked for assurance around the services which were being monitored (Podiatry, Musculoskeletal and Stroke). The Executive Director of Nursing and AHPs spoke about the processes in place to ensure that the services were safe. The Executive Director of Operations stated that the Community Neurological Rehabilitation Centre (CNRC) was currently closed and the staff had been redeployed to tackle the high demand. It was noted that staff absence levels were normal for this time of year, and the Executive Director of Operations spoke about the health and wellbeing packages available to help with resilience and wellbeing of staff. The Trust Chair asked if the Trust had enough staff to meet demand. The Executive Director of Operations responded, stating that there were enough staff to meet the current demand, but not to take on extra work. Work was underway to look at what could be stopped and in what order to ensure that patient safety was maintained.	

	The Executive Director of Nursing and AHPs stated that Corporate teams were also assisting in areas to release additional clinical capacity. <u>Vaccination</u> The Executive Director of Operations stated that the first delivery of the Covid-19 vaccine was due to be received week commencing 7 December 2020. It had been agreed that Stockdale House would be used as a site to vaccinate staff.	
2020-21 (58b)	**Little Woodhouse Hall assurance update** The Executive Director of Nursing and AHPs presented the report and updated the Committee on the plans for new admissions over the next few weeks. It was reported that overall, there was evidence of positive improvements and outcomes and increasing assurance. The Committee heard that conversations were taking place between LCH and the Leeds and York Partnership Foundation Trust (LYPFT) Executive Directors of Nursing in preparation for the transfer of the service.	
QUALITY GOVERNANCE AND SAFETY		
2020-21 (59a)	**Performance Brief and Domain reports** The Executive Director of Nursing & AHPs presented the paper and highlighted the pressure ulcer incidence in excess of the Trust target. In response to a query from the Trust Chair, the Executive Director of Nursing and AHPs assured the Committee that work was in progress to address the current issue. Learning in relation to systems and processes was discussed and the Executive Director of Operations acknowledged that the required SystmOne improvements were within the digital strategy priorities and was within the risk register. Delayed progress with this critical improvement was acknowledged and it was agreed that Quality Committee would raise this concern to Board. The data in relation to safe staffing fill rates was acknowledged, and the Executive Director of Nursing & AHPs reported this was related to a reduction in children requiring respite in Hannah House due to Covid-19 and therefore associated reduction in staffing levels which needed to be reflected more accurately in future reports. It was also reported that bank and agency staff had continued to be accessed for Little Woodhouse Hall however safe staffing levels had been maintained. The Committee Chair referred to the increase in complaints which were Covid-19 related. The Executive Director of Nursing and AHPs stated that the increase was inevitable particularly for the patients who have had to wait for treatment.	
2020-21 (59b)	**Clinical Governance report** The Executive Director of Nursing & AHPs presented the report and highlighted the changes due in relation to the Patient Safety Specialist role and the recruitment to a Learning Disability Lead post. The Paediatric Dental situation was also discussed, acknowledging the aim for LTHT to support with assessments. The Committee requested an update in January 2021 to provide clarity on the position and plan for the Dental Service. **Action: Executive Medical Director to provide an update on the position and plan for the Dental Service**	**Executive Medical Director**

2020-21 (59c)	**Quality Improvement plan (CQC)** The Executive Director of Nursing & AHPs confirmed the position presented in the paper with the outstanding actions being in relation to final assurance. This was expected to be completed by January 2021 and the Committee requested an update on the position at the January 2021 meeting. **Action: Executive Director of Nursing and AHPs to provide an update on the progress of the Quality Improvement plan at the meeting in January 2021.**	**Executive Director of Nursing and AHPs**
2020-21 (59d)	**Mortality report (Q2)** The Executive Medical Director presented the report and stated that it would also be presented to the Board. The Committee Chair referred to the table on page 3 and it was acknowledged that the figures were incorrect. It was agreed that this would be updated before presentation to the Board. The Committee Chair also referred to the uncertainty of ethnicity data and stated that more generally; the Trust would need to be prepared in order to gather data around inequalities in mortality. The Chief Executive spoke about learning themes and stated that it would be helpful to include the plans to address the evidenced lack of advanced care planning. **Action: Executive Medical Director to include themes for learning in terms of data gathering around inequalities in mortality and the lack of advanced care planning.**	**Executive Medical Director**
2020-21 (59e)	**Risk Register** The Company Secretary presented the report and summarised the changes to note to clinical and operational risks on the risk register. The Committee Chair asked for the reason for the decrease in scoring of Risk: 1019: Long waiting list for patients for type 2 diabetes structured education. The Company Secretary agreed to investigate this. **Action: Company Secretary to confirm the reason for the decrease in scoring of Risk 1019: Long waiting list for patients for type 2 diabetes structured education.**	**Company Secretary**
2020-21 (59f)	**Board Assurance Framework (QC response)** The Company Secretary stated that a meeting had taken place to review the sources of assurance for the Board Assurance Framework (BAF). It was confirmed that the matter was resolved and the Company Secretary would circulate the outcome of the meeting to Committee members following this meeting. **Action: Company Secretary to circulate the outcome of the meeting to review the sources of assurance for the Board Assurance Framework (BAF) Committee members.**	**Company Secretary**

Clinical Effectiveness		
2020-21 (60a)	**Patient Group Directions** The Committee received and ratified the Patient Group Directions.	
2020-21 (60b)	**NICE compliance update** The report was presented by the Executive Medical Director who acknowledged the ongoing work within the Quality, Assurance and Improvement Group (QAIG) to answer the question of how we provide assurance in the current climate given the ceasing of previous assurance processes. This would feed in to future Committee meetings via QAIG.	
2020-21 (60c)	**Outcomes measures approach** The Executive Medical Director stated that the Outcomes work was linked closely with Business Intelligence and Health Inequalities work. The Committee Chair asked about the accuracy of the graph relating to the Clinical Outcome Measures ladder in Appendix 1. The Executive Medical Director agreed to review the data. **Action: Executive Medical Director to review data reported in the Clinical Outcomes Measures ladder.** The Committee Chair suggested that it would be helpful to consider how Outcomes would be reported to the Committee and Board in future.	**Executive Medical Director**
2020-21 (60d)	**Clinical audit update** The report was presented by the Executive Director of Nursing & AHPs who highlighted the ongoing work within QAIG to answer the question of how we provide assurance in the current climate given the ceasing of previous assurance processes. It was noted that this work would feed in to future Committee meetings via QAIG. The Committee Chair asked if any gaps could be seen. It was agreed that this was not the case. The Executive Medical Director confirmed that the audit flash reports were included in the report to evidence sharing of learning from the audits.	
2020-21 (60e)	**Internal audit report: Duty of Candour** The report for Duty of Candour was discussed and accepted as providing reasonable assurance. The Executive Director of Nursing & AHPs confirmed assurance and evidence had been provided in relation to the one action, and compliance in October 2020 was at 100%.	
QUALITY COMMITTEE WORK PLAN		
2020-21 (61a)	**Work plan** The work plan was acknowledged.	
2020-21 (61b)	**Work plan items not on agenda** The items on the work plan which were not on the agenda were acknowledged.	

2020-21 (62)	**Matters for the Board and other committees including assurance levels** It was agreed that the Company Secretary and Assistant Director of Nursing and Clinical Governance would discuss the assurance levels outside of the meeting and would include these in the Chair's Assurance report for Board.	
2020-21 (63)	**Reflections on Committee meeting** No issues discussed.	
2020-21 (64)	**Any other business** There was no further business discussed.	
	Dates and times of future meetings and workshops: **09:30 – 12:30** 25 January 2021 - meeting 22 February 2021 - workshop 22 March 2021- meeting 26 April 2021 - workshop 24 May 2021- meeting 21 June 2021- workshop 26 July 2021- meeting 27 September 2021- meeting 25 October 2021 - workshop 23 November 2021- meeting	

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (125c)

Business Committee Meeting
Microsoft Teams / Boardroom, Stockdale House
Wednesday 25 November 2020 (9.00 am to 10.30 am)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sam Prince	Executive Director of Operations
	Richard Gladman	Non-Executive Director (RG)
	Helen Thomson	Non-Executive Director (HT)
Attendance:	Jenny Allen	Director of Workforce
	Diane Allison	Company Secretary
	Mahliqa Nisar	Sustainability Project Lead
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to the Exec Director of Finance & Resources

Item	Discussion Points	Action
2020/21 **(52)**	**Welcome and introductions** The Committee Chair welcomed everyone to the meeting. Participants were in attendance by video conference arrangements. **a) Apologies**: None recorded. **b) Declarations of Interest** Prior to the Committee meeting, the Committee Chair considered the Trust Directors' declarations of interest register and the agenda to ensure there was no known conflict of interest prior to papers being distributed to Committee members. No additional potential conflict of interest regarding the meeting's agenda were raised. **c) Minutes of last meeting** The minutes of the meeting dated 28 October 2020 were noted for accuracy and approved by the Committee. **d) Matters arising from the minutes and review of action log** The Committee reviewed the action log and noted updates.	
2020/21 **(53)**	**Covid and Rest and Recovery** **a) Covid update** The Committee received updates on the current infection rates, the latest information on the vaccination programme and on the impact of the pandemic on the workforce in terms of health and wellbeing, resources and capacity. The Chief Executive said that the overall rates were decreasing in Leeds but stressed that there was still a significant pressure on hospitals. She said the	

plan was to model and project ahead of wave two in mid-January/February 2021 following the Christmas period.

b) Reset and recovery progress update (presentation)

The Committee received a presentation with an update on the reset and recovery programme following a request by the Committee in October 2020 for a deep dive.

The following key points were noted:

- A reset dashboard provided three months of data. Work was ongoing to test data quality and consistency.
- Fifteen service areas had exceeded the previous year's activity levels. The majority of children services was showing improving trajectories.
- The school immunisation programme had effectively stopped during the lockdown period in the spring/summer term. An increased capacity in the last term had brought that back on track.
- The area of concern was in community dentistry due to lack of paediatric dentists in the service.
- There was previously insufficient admin cover in the MSK service and that had impacted on service and the activity.
- Podiatry activity was down compared to last year. The majority of patients brought in were assessed as being at higher risk.
- The next steps included improving analysis and addressing data quality issues and then developing clear narratives and plans to further address the backlog if required.

The Committee Chair noted that the presentation described a recovery programme particularly when comparing against previous performance. He asked about the different ways people were working and how that was being captured. The Executive Director of Operations said that the intention was to standardise and to automate all the work. She said that at the next update on progress in January 2021 she plans to provide a spotlight on services doing well and highlight those areas with concerns. A regular dashboard would help to understand the difficulties in some areas.

The Committee Chair thanked the Executive Director of Operations for the update and the presentation.

c) Covid vaccination programme update

(Please see private minutes)

d) Workforce update

The Director of Workforce (JA) highlighted the key issues as follows in her workforce report and said that it remained fairly steady and consistent with pattern of last 7-10 days and similar to previously reported figures.

- Supporting staff to keep well and at work throughout this period.
- Staff absence at the end of October 2020 was 5.2% which was higher than the previous three months but lower than this time last year.
- Sickness absence included 1% Covid related sickness.
- Ensuring and understanding and maximising the staffing resource available.
- Good progress had been made in the neighbourhood team posts to

	support End of Life care; advert continues to run and was being short listed for a second time. A Non-Executive Director (RG) asked about any further development on mass testing and whether that was having an impact on people having to self-isolate or on asymptomatic people. The Director of Workforce (JA) said that it was complicated as there were issues and concerns over the type of tests being rolled out initially.	
2020/21 **(54)**	**Project Management** **a) Child and Adolescent Mental Health Service (CAMHS) Tier 4 update** The Executive Director of Finance and Resources and the Executive Director of Operations provided an update on progress with transferring responsibility for the CAMHS Tier 4 new build project and the current service to Leeds and York Partnership Foundation NHS Trust (LYPFT). The Project Board responsibilities had been handed over to LYPFT to begin to extricate the Trust from those arrangements and to start the process of changing the membership of the Project Board and the work streams. The Committee heard that the new build was progressing well and was on schedule to open in November 2021. There were some issues still to be resolved concerning CQC registration of the transfer of the current service. The Executive Director of Operations was leading on the service transfer project. **Outcome:** The programme was progressing well for opening in November 2021. **b) Sustainability action plan update** The Committee Chair welcomed the Sustainability Project Lead to the meeting. The Business Committee received the second draft of the plan, having previously reviewed it in September 2020. Comments from the previous review had been incorporated into the current draft version, with more emphasis on specific objectives. Information about financial resource had also been included. The Committee heard that despite the impact of Covid pandemic on everyone's lives, the management plan demonstrated that staff continued to be engaged in and committed to the sustainability agenda. A Non-Executive Director (RG) said it was a good read and he was content with the set of proposals. He asked about keeping in touch with the citywide board to board meetings to ensure the plan dovetailed with other things that people were doing across the City and it was noted that there were quarterly meetings across the City. The Director of Workforce (JA) welcomed the connection to staff survey results referenced in the document; ways of engaging with staff and keeping them informed was considered and building on things happening in the Trust. The Committee Chair noted that staff engagement was very evident within	

	the list of programme work and how that would be delivered across the organisation. He said he had a couple of points to raise and would email out to the Sustainability Project Lead to consider. The Committee felt the plan needed to incorporate measurable aims and these would be added at an early stage. The Committee recommended that the Board approves the current draft plan when it meets in December 2020, with a view to the plan being further updated as required. **Action:** The Committee to receive the updated plan at the end of April 2021 for its first quarterly review to include more detailed ambition around targets. **Outcome:** The Committee agreed to recommend the plan to the Trust Board for its approval in December 2020.	**SP**
2020/21 **(55)**	**Business and commercial** • **SystmOne extension** (Please see private minutes)	
2020/21 **(56)**	**Performance management** **a) Performance brief and domain reports** The Committee focused on the well-led domain and noted the high level of workforce stability, with turnover at 9.5% this month. The Committee agreed that whilst the turnover of staff leaving in the first twelve months of employment was below the target, the Trust should maintain a focus on this and ensure that new nurse starters were well supported. The Committee Chair said detailed discussion took place at the Quality Committee meeting on Monday 23 November on safety and caring. The Director of Workforce (JA) stressed that in the well-led grid the turnover for staff less than twelve months service had been calculated using the old method. She said the narrative had been corrected but not the grid. The Director of Workforce also pointed out that the escalated risk in the neighbourhood teams around sickness in adults had not been reflected in the October 2020 sickness figure but had been reflected in the daily capacity report. **FINANCE** The Trust was in its first month of the new finance regime and the plan was to achieve a balanced position by end of the year. Expenditure plans were weighted towards the waiting lists in the fourth quarter. Funds were available to support waiting list recovery plans but there were concerns that the staffing resource and external capacity may not be available. The Executive Director of Finance and Resources provided the Committee with an overview of the Integrated Care System financial picture including best and worst case scenarios. He said it was early days for the second six months but broadly everything would depend on the amount that could be spent on the waiting list recovery externally. The focus at the moment was on	

	ensuring the Trust made the best use of resources available to use within this year. **b) Operational and non-clinical risks register** The main issues for consideration were as follows: • Two extreme risks on the risk register were; coronavirus (COVID 19) increased spread of infection which had been escalated to an extreme risk, and managing the complexity of young people admitted to CAMHS Tier 4 inpatient unit. • One new risk had been added to the Trust risk register since the last report; long waiting list for patients for type 2 diabetes structured education. • One risk had been escalated; sickness levels in the neighbourhood teams. A Non-Executive Director (HT) queried the increased spread of infection risk in terms of description. It was noted that the report did not contain the full risk description which was the impact on patients and the workforce. **Outcome:** The Committee noted the revisions made to the Trust risk register. **c) Internal audit report: Children's Business Unit review** The Executive Director of Finance and Resources introduced the internal audit report covering the completed audit opinion related to Children's Business Unit. The scope of this audit had not been specified at the beginning of the year in the internal audit programme. The scope had been determined by the business unit itself and the intention was that the focus would provide value to the service. There were some concerns that the audit did not provide the necessary assurance envisaged for a business unit model. The Executive Director of Finance and Resources said that the Audit Committee needed to be more specific about a particular area to carry out the audit relevant to the risks and assurance that the organisation wished the internal audit programme to help it deliver. A Non-Executive Director (HT) agreed that it was not a useful audit. It did not reflect some of the conversations about the children's business unit. The Executive Director of Operations said that this audit was an area she was interested in and concerned the service's contractual requirements. **Outcome:** The Committee noted the findings of the internal audit and its limitations. The Executive Director of Finance and Resources agreed to feed back to the Audit Committee on what might be more useful and effective for the audit programme.	
2020/21 **(57)**	**Business Committee work plan** The work plan was reviewed by the Committee members and agreed. A number of items had been deferred this month in light of the short agenda	

	and these would be monitored.	
2020/21 **(58)**	**Matters for the Board and other Committees** **Assurance levels** The Committee reviewed and discussed the levels of assurance for the strategic risks related to the agenda items and agreed that reasonable assurance was provided for BAF risks 3.1, 3.2 and 3.6, with limited/reasonable assurance for BAF risk 2;2. It was agreed that the following agenda items should be included in the Chair's assurance report to the Board: Covid update, Sustainable development management plan, CAMHS Tier 4, Reset and Recovery, Performance Brief Well Led and Finance	
2020/21 **(59)**	**Any other business** None discussed.	

SCRUTINY BOARD (ADULTS, HEALTH & ACTIVE LIFESTYLES)

TUESDAY, 5TH JANUARY, 2021

PRESENT: Councillor H Hayden in the Chair

Councillors C Anderson, J Elliott, N Harrington, M Iqbal, C Knight, G Latty, S Lay, D Ragan, A Smart, P Truswell and A Wenham

Co-opted Member present – Dr J. Beal

53 Appeals Against Refusal of Inspection of Documents

There were no appeals.

54 Exempt Information - Possible Exclusion of the Press and Public

There were no exempt items.

55 Late Items

There were no late items.

56 Declaration of Disclosable Pecuniary Interests

There were no declarations of disclosable pecuniary interests.

57 Apologies for Absence and Notification of Substitutes

There were no apologies for absence.

58 Minutes - 24 November 2020

RESOLVED – That the minutes of the meeting held 24 November 2020 be approved as an accurate record.

59 Performance Update - Adult Social Care, Public Health and Active Lifestyles

The Director of Adults and Health and the Director of City Development submitted a report that presented an overview of outcomes and service performance related to the council priorities and services within the Scrutiny Board's remit.

The following were in attendance:

- Councillor Rebecca Charlwood, Executive Member for Health, Wellbeing and Adults
- Councillor Mohammed Rafique, Executive Member for Environment and Active Lifestyles
- Cath Roff, Director of Adults and Health
- Victoria Eaton, Director of Public Health
- Shona McFarlane, Deputy Director Social Work and Social Care Services
- Steve Hume, Chief Officer, Resources and Strategy, Adults and Health
- Anna Frearson, Chief Officer Consultant in Public Health (Healthy Living and Health Improvement)
- Phil Evans, Chief Officer, Operations, City Development
- Steve Baker, Business Manager, Active Leeds
- Peter Storrie, Head of Service, Performance Management & Improvement

The Executive Members introduced the headline performance issues, as set out in the report. While recognising positive performance across a number of areas despite the COVID-19 pandemic, Members discussed a number of specific matters, including:

- *Delayed transfers of care.* Members made reference to the indicator showing delayed transfers of care from hospital that are attributable to NHS and adult social care and queried the increased figure reported for 2018/19. In response, it was highlighted that a decision was taken during this period to also include patient bed numbers associated with the Leeds and York Partnership Foundation Trust as joint responsibility pending further clarity on this position.
- *Smoking prevalence and inequality.* Members were advised that there is continued focus on deprived areas of Leeds due to the disparity in rates, however there had been an increase in over 40% of people accessing online support for smoking cessation, particularly from the most deprived areas of Leeds. Related to this, Members queried whether future reports should include a Leeds Deprived indicator linked to the drug and alcohol abuse data too.
- *Life expectancy of women.* In response to a query, concerns were noted in regards to the falling life expectancy of women in most deprived areas of the city, which has also been raised as an issue nationally.
- *Suicide rates.* Members were assured that real-time data from the COVID-19 period has shown no rise generally in suicide rates nationally.
- *Domestic violence and abuse.* In response to a query, Members were advised that there was an initial drop in referrals to social care in regards to domestic violence during the first lockdown, which have since increased beyond levels for the same period in 2019.
- *Non-institutional care for people with learning disabilities.* Members noted that the number of people in Leeds with a learning disability who live independently is below the national average, and sought more information on the steps taken to address this. Members were advised

that teams are considering cost effective ways of promoting and supporting independent living, as part of the budget discussions taking place.

- *Reduced activity levels in minority groups.* Members expressed concern that activity levels have dropped more significantly in minority groups and deprived communities, and were advised that this data will largely inform programmes moving forward.

RESOLVED - That the contents of the report and appendices, along with Members comments, be noted.

60 Financial Health Monitoring 2020/21 - Month 7 (October)

The Head of Democratic Services submitted a report that introduced information regarding the projected 2020/21 financial health position of those service areas that fall within the Board's remit at Month 7 (October 2020).

The following were in attendance:

- Councillor Rebecca Charlwood, Executive Member for Adults, Health and Active Travel
- Councillor Mohammed Rafique, Executive Member for Environment and Active Lifestyles
- Cath Roff, Director, Adults and Health
- Victoria Eaton, Director of Public Health, Adults and Health
- Shona McFarlane, Deputy Director Social Work and Social Care Services
- Steve Hume, Chief Officer, Resources and Strategy, Adults and Health
- John Crowther, Head of Finance, Resources and Housing
- Jill Stuart, Principal Financial Manager
- Steven Baker, Active Leeds Business Manager, City Development
- Phil Evans, Chief Officer, Operations, City Development

The Head of Finance introduced the report, highlighting some of the key messages and continued challenges for provision of social care and public health, including specific COVID-19 related pressures resulting in an overspend of £12.6m. The Executive Member for Environment and Active Lifestyles and the Chief Officer for Operations also provided a brief overview of the current financial position relating to Active Leeds.

RESOLVED – That the contents of the report and appendices be noted.

61 Initial Budget Proposals for 2021/22

The Head of Democratic Services submitted a report that introduced the Executive Board's initial budget proposals for 2021/22 for consideration, review and comment on matters and proposals that fall within the Scrutiny Board's remit.

The report acknowledged that Scrutiny Boards had already considered the proposed budget savings proposals that were approved by Executive Board in September, October and November and that a composite Statement summarising Scrutiny feedback during this first phase of consultation was presented to the Executive Board during its meeting on 16th December 2020 for consideration.

However, a further £5.2m of potential savings across the Council were also approved by the Executive Board during its meeting on 16th December 2020 and subsequently submitted for wider consultation with stakeholders, including Scrutiny. A copy of the relevant Executive Board report was therefore appended for the Scrutiny Board's consideration.

It was noted that any additional comments or recommendations made by the Scrutiny Board would inform a further 'phase 2' composite Statement by Scrutiny to be submitted to the Executive Board for consideration at its meeting in February 2021.

The following were in attendance:

- Councillor Rebecca Charlwood, Executive Member for Adults, Health and Active Travel
- Councillor Mohammed Rafique, Executive Member for Environment and Active Lifestyles
- Cath Roff, Director, Adults and Health
- Victoria Eaton, Director of Public Health, Adults and Health
- Shona McFarlane, Deputy Director Social Work and Social Care Services
- Steve Hume, Chief Officer, Resources and Strategy, Adults and Health
- John Crowther, Head of Finance, Resources and Housing
- Jill Stuart, Principal Financial Manager
- Steven Baker, Active Leeds Business Manager, City Development
- Phil Evans, Chief Officer, Operations, City Development

The Chief Officer for Resources and Strategy introduced the report, noting that no additional budget saving proposals for Adults and Health and City Development had been identified in the December Executive Board report at Appendix 1 to the report.

Members discussed a number of matters, including:

- *Leeds Sailing Activity Centre.* Reference was made to the service review proposal surrounding Yeadon Tarn Sailing Centre as it was noted that the Phase 1 Scrutiny Statement to Executive Board had made reference to this facility predominantly being used by schools primarily within the Yeadon area. However, it was clarified during the meeting that while the facility is still predominantly used by schools, these are primarily from the North Leeds area. It was therefore noted that this correction would be reflected within the Scrutiny Statement being submitted to the Executive Board for its February meeting. In the

meantime, Members requested the full list of schools who use the centre.

- *Neighbourhood Networks.* Reference was again made to the Strategic Commissioning (Older Adults) proposals to reduce funding to a number of third sector organisations, including Neighbourhood Network Services. While acknowledging that consultation with the sector on this proposal was still ongoing, Members were informed of the Council's attempt to mitigate some of the impact on Neighbourhood Networks in particular by seeking to provide a £0.5 million one off payment through the use of the Test and Trace funding in recognition of the key support that the Neighbourhood Network Service gave during the pandemic. This was considered a significant amount in the context of the annual budget for the Neighbourhood Network Service being around £2.5 million.

RESOLVED –

a) That the 2021/22 budget proposals as presented be noted;
b) That the Board's comments are reflected as part of the Scrutiny submission to Executive Board for its consideration.

62 Compliments and Complaints Annual Report 2019-2020

The Director of Adults and Health submitted a report that introduced the 2019/20 Annual Report for Compliments and Complaints.

The following were in attendance:

- Councillor Rebecca Charlwood, Executive Member for Adults, Health and Active Travel
- Cath Roff, Director, Adults and Health
- Victoria Eaton, Director of Public Health, Adults and Health
- Shona McFarlane, Deputy Director Social Work and Social Care Services
- Steve Hume, Chief Officer, Resources and Strategy, Adults and Health
- Judith Kasolo, Head of Complaints, Adults and Health

The Executive Member introduced the report and particularly highlighted the 100% compliance rate of complaints reviewed by the Ombudsman. The Head of Complaints then provided an overview of the key points set out in the report, as well as some of the challenges experienced and trends in issues raised through the complaints process.

It was particularly acknowledged that 1680 compliments were received by the service during this reporting period compared with 1131 the previous year, representing a 49% increase. It was also highlighted that while 651 complaints were recorded compared to 520 in the previous year (representing a 25% increase), this was regarded as positive linked to the ongoing strategy to encourage more people to talk to the directorate and help services understand their experiences as complaints are recognised as a valuable

source of intelligence to help inform commissioning activities and service improvements.

Members discussed a number of matters, including:

- *Independent sector and day services for learning disabilities.* Members noted an increase in complaints related to independent services for those with learning disabilities, and sought clarity on the reasons for the rise. Members were advised that the team have worked with independent providers to encourage reporting of complaints to the Council, as a useful tool to inform reassessment needs and commissioning activities. As a result, reporting of complaints has increased which is reflected in the data.
- *Blue Badge assessments*. Members were advised that new legislation has been introduced which allows hidden disabilities to be taken into consideration as eligibility for a Blue Badge. Members sought clarity on how hidden disabilities are identified, and were advised that evidence must be submitted via a professional supporting the claim that an individual's ability to travel is inhibited by their condition, which has resulted in challenges to assessment outcomes where evidence submitted has not been deemed as sufficient.

On behalf of the Board, the Chair welcomed the comprehensive report and thanked the Complaints Team for their hard work.

RESOLVED – That the contents of the report, along with Members comments, be noted.

63 Work Schedule

The Head of Democratic Services submitted a report that invited Members to consider the Board's Work Schedule for the remainder of the current municipal year.

RESOLVED – That the report and outline work schedule presented be agreed.

64 Date and Time of Next Meeting

Tuesday, 9th February 2021 at 1.30 pm (pre-meeting for all Board Members at 1.00 pm)

Leeds Community Healthcare NHS Trust

Agenda item 2020-21 (126)

Version 11: 28 January 2021

Topic	Frequency	Lead officer	2 October 2020	4 December 2020	5 February 2021	26 March 2021	28 May 2021	6 August 2021	1 October 2021	3 December 2021
Preliminary business										
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X	X	X
Patient story	every meeting	EDN&AHPS	X Neuro rehab	X Community Dental	X	X	X	X	X	X
Quality and delivery										
Chief Executive's report	every meeting	CE	X	X Inc COVID19	X Inc COVID19	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X	X	X
Perfromance brief:Measures for inclusion in the performance brief	Annual	EDFR				X				
Perfomance Brief: annual report	Annual	EDFR					X			
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X	X	X
Care Quality Commission inspection reports	as required	EMD								
Quality account	annual	EDN&AHPS	X Deferred from May				X			
Health inequalities	3 x year (December,March, August)	EMD		X First report		X taken at Board workshop 5 March 2020		X		X
Mortality report	4 x Year	EMD		X	X		X	X		X
Staff survey	annual	DW				X		X		
Safe staffing report	2 x year	EDN&AHPS			X			X		
Seasonal resilience (Business Continuity Mnagement Policy)	annual	EDO	X taken at Board Workshop Nov 2020						X	
Business Coninuity Management Policy	As required	EDO					X			
Serious incidents report	4 x year	EDN&AHPS		X Q2	X Q3		XQ4	X Q1		X Q2
Patient experience: complaints and incidents report	2 x year (Annual report August)	EDN&AHPS			X Six monthly report			X Annual report		
Reducing restrictive interventions –Little Woodhouse Hall	4x year	EDN&AHPS		X first report	X		X	X		X
Freedom to speak up report	2 x year	CE		X				X Annual report		X
Guardian for safe working hours report	4 x year	EMD		X		X		X Annual report&Q12020-21		X
Strategy and planning										
Organisational priorities position paper	3 x year	EDFR	X			X 2021-22	x End of year report		X	
Third Sector Strategy	2x year		X First report		X Deferred				X	
Service Strategy	as required	EDFR								
Digital Strategy	2x year	EDFR	X			X			X	
Engagement Strategy	2 x year (Mar &Oct from 2020)	EDN&AHPS	X			X			X	
Quality Strategy	annual	EDN&AHPS				X				
Workforce Strategy	every meeting from May 2019	DW	X	X part of CE report	X part of CE report	X	X	X	X	X
Research and Development Strategy	annual	EMD			X Deferred					
Governance										
Medical Director's annual report	annual	EMD						X		
Nurse and AHP revalidation	annual	EDN&AHPS						X		
Well-led framework	as required	CS								
Annual report	annual	EDFR					X			
Annual accounts	annual	EDFR					X			
Letter of representation (ISA 260)	annual	EDFR					X			
Audit opinion	annual	EDFR					X			
Audit Committee annual report (part of corporate governance report)	annual	CS								
Standing orders/standing financial instructions review (part of corporate governance report)	annual	CS					X			
Annual governance statement (part of corporate governance report)	annual	CS					X			
Going concern statement (part of corporate governance report)	annual	EDFR				X				
NHS provider licence compliance	annual	CS					X			
Committee terms of reference review	annual	CS					X			
Board and sub-committee effectiveness	annual	CS					X			
Register of sealings	annual	CS					X			
Declarations of interest/fit and proper persons test (part of corporate governance report)	annual	CS				X				
Corporate governance update	as required	CS								
Reports										
Equality and diversity - annual report	annual (Dec)	DW		X						X
Safeguarding -annual report	annual	EDN&AHPS						X		
Health and safety compliance report	Annual	EDFR						X		
Infection prevention control annual report	annual	EDN&AHPS	X						X	

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
EMD	**Executive Medical Director**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required